**2015 Reporting Rules**

**What is PQRS?** The Physician Quality Reporting System (PQRS) is a program through the Centers for Medicare and Medicaid Services (CMS) designed to improve the quality of care to Medicare beneficiaries by tracking practice patterns.

**Who should participate?** Audiologists who bill outpatient Medicare Part B beneficiaries on the CMS 1500 form or equivalent must participate in the Medicare Physician Quality Reporting System (PQRS) to avoid deductions to claims in 2017. This applies to audiologists in independent practices as well as those providing services in otolaryngology offices or university clinics, billing with their individual NPI as the rendering provider of the service. The Group Practice Reporting Option (GPRO) may exempt audiologists from the penalties, if the practice includes physicians, has enrolled with CMS in the GPRO option, and the participating physicians meet all of the requirements for the GPRO measures. The GPRO measures include documentation of medication, along with immunizations, diabetes prevention, and other health screenings. **Audiologists in practices with physicians should consult with their administrators regarding PQRS participation.**

Audiologists providing services in hospitals that are classified in the Medicare program as “Critical Access Hospitals,” when the hospital has elected to participate in Method II billing are also subject to the requirements of PQRS. **Note: Effective May 4, 2015 due to clarification from CMS, audiologists in CAH settings are excluded and not required to report on PQRS measures.** Audiologists may also be required to report PQRS if the hospital clinic is enrolled as a group practice and does not bill under the hospital NPI or Outpatient Prospective Payment System (OPPS). **Audiologists in hospitals need to check with their billing department or administration regarding PQRS eligibility and participation requirements.**

**What is required for 2015 reporting?**

CMS has provided an illustration of how the payment adjustment will apply:
The Centers for Medicare and Medicaid Services (CMS) finalized rules that require providers to report at least 9 measures and 1 “cross-cutting measure” for a minimum of 50% of the eligible Medicare patient visits in order to avoid future penalties. Because audiologists do not have 9 measures that apply, their claims will be subject to a Measure Applicability Validation (MAV) process that confirms they have positively reported on a minimum of 50% of the eligible Medicare patient visits for the following:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2015 Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>#261 Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness</td>
<td>One referral to a physician per calendar year for a minimum of 50% of the eligible Medicare patient visits for BBPV or dizziness.</td>
</tr>
</tbody>
</table>

**AND**

<table>
<thead>
<tr>
<th>Measure</th>
<th>2015 Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>#130 Documentation of Current Medications in the Medical Record</td>
<td>Medication must be documented for a minimum of 50% of every eligible Medicare patient visit.</td>
</tr>
</tbody>
</table>

**OR**

<table>
<thead>
<tr>
<th>Measure</th>
<th>2015 Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>#134: Screening for Clinical Depression and Follow-Up Plan</td>
<td>Screen and follow-up plan must be documented one time per calendar year for a minimum of 50% of the eligible Medicare patients. This measure should be reported if you routinely utilize a depression screening tool and is within your state scope of practice. If you do not report measure #130, you must report #134 to meet the cross-cutting measure requirement. This measure applies to CPT code 92625, assessment of tinnitus.</td>
</tr>
</tbody>
</table>

**How does the penalty apply?**

If benchmarks are not met in 2015, a -2% penalty will apply as payment reductions on all 2017 Medicare claims submitted for services provided by the individual provider who did not meet the requirements. PQRS is tracked by the Taxpayer Identification Number (TIN) of the clinic/practice which submitted the claim with the National Provider Identifier (NPI) of the audiologist listed on the claim as the “rendering provider.” If an audiologist in a practice does not meet the 2015 requirements, all services submitted from the practice with the audiologist as the rendering provider will be reduced by 2% in 2017.

The MAV process will determine if providers met minimum requirements. All claims from audiologists will be subject to this process because there are less than the required 9 measures on which to
The claims are analyzed to determine if the audiologist reported all applicable measures in a sequential process:

- All measures have options for a “positive” action (performed what the measure indicates), exclusion (patient/service did not qualify), or non-action (did not perform this measure). If the positive action or the exclusion is not reported for a minimum of 50% of the patient visits, the MAV is failed and the penalty applies. Reporting a non-action does not help you meet your minimum requirements and avoid the penalty.
- If a cross cutting measure - #130 or #134 - is not reported with a positive action or exclusion for a minimum of 50% of the eligible patient visits, the penalty will automatically apply and the analysis is complete.
- If Measure #261 is also reported by an audiologist, it will be analyzed to confirm that the positive action and/or exclusion was reported a minimum of 50% of the applicable patient visits. If the reporting codes indicate less than 50%, the MAV is failed and the penalty applies.
- If Measure #261 is reported the minimum of 50%, the rest of the claims will be analyzed to see if there were other clinically related measures that should have been reported. Measures #261, #130, and #134 are not matched with other measures, so the audiologist would pass the MAV and no penalty would be applied.
- If the audiologist does not provide services for patients with these specific dizziness ICD-9/ICD-10 codes, the MAV will recognize that Measure #261 was not applicable and the MAV is passed. In this case and no penalty will be assessed.

**When should we start?**

Audiologists should start immediately in order to avoid the 2% penalty to be retained on all 2017 claims for failure to report on 2015 eligible measures.

**What do we do?**

Reporting is easy! Any time you perform a CPT code in the tables below, you must determine if there is a corresponding G code and report it on the claim form. Satisfactory reporting is based on the number of patients for whom you provide a service represented by one of the CPT codes, or one of the combinations of CPT code(s) and an ICD-9/10 code(s) when an ICD-9/10 is indicated, as in the case for Measure #261 (referral for otologic evaluation for patients with acute or chronic dizziness). The ICD-9 coding system is to transition to the ICD-10 coding system on October 1, 2015. If the CPT code is reported with the ICD-9/10 code, the appropriate G code must also be reported, and placed in box 24 D on the CMS 1500 claim form like a billable service. If the ICD-9/10 code chosen is not listed in the measure requirements, you do not report on that measure and you will not be penalized for not reporting. See the Step-by-Step Guide for instructions and examples.
2015 Physician Quality Reporting System (PQRS) Measure-Applicability Validation (MAV) Process Flow for Claims-Based Reporting of Individual Measures for Payment Adjustment

**Claims MAV Applies To:**
- Eligible Professionals (EPs) reporting via Claims
- EP did not have a face-to-face encounter or EP has a face-to-face encounter and satisfactorily report at least one cross-cutting measure
- Reporting less than 9 measures OR 9 or more measures with less than 3 domains
- EPs with all measure(s) satisfactorily reported (≥ 50% of applicable Medicare Part B FFS Patients)

**Claims MAV Does Not Apply To:**
- Measures Group, EHR, GPRA WI, Registry, Certified Survey Vendor (CG-CAHPS) or QCDR Reporting
- If EP had a face-to-face encounter and a cross-cutting measure was not satisfactorily reported
- Reporting 9 or more measures across at least 3 domains (satisfactorily or unsatisfactorily)
- EPs that have NOT satisfactorily reported (< 50% of applicable Medicare Part B FFS Patients)
- EPs with any reported measure(s) that have a zero percent performance rate OR if an inverse measure, a 100% performance rate

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**Flowchart Description:**

1. **Satisfactorily Report on a 50% of Applicable Medicare Part B FFS Patients for 9 or More Measures**
   - NO
   - YES
     - Satisfactorily Report on ≥ 50% of Applicable Medicare Part B FFS Patients for 1-8 Measures
       - NO
       - YES
         - Subject to MAV For Measures
           - NO
           - YES
             - Clinical Relationship and Domain Test:
               - Were the 1-2 satisfactorily reported measures in a clinically related cluster?
                 - NO
                 - YES
                   - Are There Measures in the Clinical Related Cluster Not Reported?
                     - NO
                     - YES
                       - Additional Measures Should Have Been Reported
                         - NO
                         - YES
                           - Minimum Threshold Test:
                             Do any of these measures have a 15 denominator eligible instances?
                               - NO
                               - YES
                                 - Subject to Payment Adjustment
                                   - Avoid Payment Adjustment
                                     - Subject to Payment Adjustment

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**Note:** Please refer to the 2015 PQRS Measure-Applicability Validation Process for Claims-Based Reporting of Individual Measures. Eligible Professionals that have less than 9 measures or less than 3 domains would be subject to MAV but could still be able to avoid the payment adjustment.

*Please refer to the PQRS Website for further information on the qualifying face-to-face encounters and a list of cross-cutting measures. Those EPs who do NOT have face-to-face encounters are not required to report a cross-cutting measure but could be subject to MAV.

**Additional Domains Should Have Been Reported**

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**Subject to MAV For Domains**

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**Subject to Payment Adjustment**

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**Avoid Payment Adjustment**

---

**Subject to Payment Adjustment**

---

**Step 1**

**Step 2**

**Step 2 Minimum Threshold Test:**
Do any of these measures have a 15 denominator eligible instances?

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**Step 1 Clinical Relationship and Domain Test:**
Were the 1-2 satisfactorily reported measures in a clinically related cluster?
Step-by-Step Guide

Example:
A patient presents with a referral from internal medicine with a diagnosis of 780.4 (dizziness and giddiness). The audiologist performs, among other tests, a comprehensive audiology evaluation (92557). The following measures are eligible to report:

First Step: Review Patient Eligibility and Codes for Each Measure

- CPT code 92557 is included in these measures:

<table>
<thead>
<tr>
<th>Measure: #261</th>
<th>Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure: #130</td>
<td>Documentation and Verification of Current Medications in the Medical Record</td>
</tr>
</tbody>
</table>

- Because 780.4 is included in Measure #261, you report the code that best matches the action you took on that date of service:
  - G8856, referral to a physician for otologic evaluation performed, if you are referring this patient to an otorhinolaryngologist
    OR
  - G8857, patient is not eligible for referral for otologic evaluation measure (e.g., patients who are already under the care of a physician for acute or chronic dizziness), if you are referring this patient to their referring primary care physician
    OR
  - G8858, referral to a physician for an otologic evaluation not performed, reason not specified

It is the combination of the CPT code and the ICD-9/10 code that triggers the patient eligibility for reporting, not the measure description.

Step One: Review the Codes for Each Measure

Each measure is reportable via the CMS 1500 claim form using the International Classification of Diseases Ninth Revision, Clinical Modification (ICD-9-CM) and, after 10/1/15, the International

- ICD-9-CM codes (and effective 10/1/15, the ICD-10 codes)
  - Indicate the diagnosis of the patient.
  - Represent the measures' denominator (the eligible patients for a measure) in conjunction with CPT codes.
- CPT Codes
  - Indicate the procedure performed on the patient.
  - Represents the measures' denominator (the eligible patients for a measure) in conjunction with the ICD-9-CM/ICD-10-CM codes.
- G Codes
  - Represents the measures' numerator (action required by the measure for reporting and performance) as well as when the action does not occur because the patient fits into the denominator exclusion (patient that fits into the denominator but is not eligible for the measure).

Eligible PQRS Measures for Audiologists:

- Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness
- Documentation of Current Medications in the Medical Record
- Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Measure Requirements in detail:

Measure: #261: Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness

Reporting Criteria: Patients of any age with the following procedure codes and associated diagnosis codes. Should be reported a minimum of once per calendar year per patient.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92540, 92541</td>
<td>780.4, 386.11</td>
<td><strong>G8856</strong>: Referral to a physician for otologic evaluation performed</td>
</tr>
<tr>
<td>92542, 92543</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92544, 92545</td>
<td></td>
<td><strong>G8857</strong>: Patient is not eligible for the referral for otologic evaluation measure (e.g., patients who are already under the care of a physician for acute or chronic dizziness)</td>
</tr>
<tr>
<td>92546, 92547</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92548, 92550</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92557, 92567</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92568, 92570,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92575</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Measure: #130: Documentation of Current Medications in the Medical Record

Reporting Criteria: Patients ≥ 18 years with the following procedure codes. Should be reported for every patient visit.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92541, 92542</td>
<td></td>
<td><strong>G8427</strong>: List of current medications (includes prescription, over-the-counter, herbs, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency, and route</td>
</tr>
<tr>
<td>92543, 92544</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92545, 92547</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92548, 92557</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92567, 92568</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92570, 92585,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92588, 92626</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No specific ICD-9 codes are included for this measure</td>
<td></td>
<td><strong>G8430</strong>: Provider documentation that patient is not eligible for medication assessment</td>
</tr>
</tbody>
</table>
Measure: #134: Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Reporting Criteria: Patients ≥ 12 years with the following procedure codes. Should be reported a minimum of once per calendar year per patient.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92625</td>
<td>No specific ICD-9 codes are included for this measure</td>
<td>G8431: Positive screen for clinical depression using an age appropriate standardized tool and a follow-up plan documented</td>
</tr>
</tbody>
</table>

- G8450: Negative screen for clinical depression using an age appropriate standardized tool, follow-up not required
- G8433: Screening for clinical depression using an age appropriate standardized tool not documented, patient not eligible/appropriate
- G8432: No documentation of clinical depression screening using an age appropriate standardized tool
- G8511: Positive screen for clinical depression using an age appropriate standardized tool documented, follow-up plan not documented, reason not specified

Step Two: Fill Out the CMS-1500 Claim Form

A sample 1500 claim form [PDF] is available on the Centers for Medicare & Medicaid Services (CMS) website. CMS also has a sample claim form filled out for PQRS in Appendix D of its 2015 Physician Quality Reporting Initiative Implementation Guide.

- ICD-9/10 codes are placed in box 21
- CPT codes are placed in box 24D
- G-codes are placed in box 24D following the CPT codes of the procedures performed.

Step Three: Make Sure You Meet CMS' Minimum Reporting Requirements

Medicare requires that eligible professionals report on at least 9 quality measures in 2015 for at least 50% of eligible patient visits (a professional's Part B patients for whom the measure applies according to the measure frequency specification). If less than 9 measures are available for reporting, such as is the case for audiologists, CMS will permit a professional to report on fewer than 9 measures for at least 50% of eligible patient visits and a minimum of one cross-cutting measure (#130 and #134). This is when the Measures Applicability Validation (MAV) process applies.

To avoid the 2% penalty in 2017, in 2015 audiologists must:
- Report a positive action or exclusion on a minimum of 50% of the Medicare patients that are eligible for Measure #261

AND

- Report a positive action or exclusion on a minimum of 50% of the Medicare patients that are eligible for Measure #130 OR Measure #134.

For more information about the MAV process that applies to audiologists, see the 2015 Reporting Rules.

Resources

CMS PQRS Analysis and Payment page: Measure specific information, including reporting toolkits, flow charts, clinical scenarios and corresponding CMS 1500 claim forms can be found here.

FOR QUESTIONS, CONTACT:

Debbie Abel, AuD., senior specialist, practice management, American Academy of Audiology, at dabel@audiology.org

Kim Cavitt, AuD., Academy of Doctors of Audiology at kim.cavitt@audiologyresources.com.

Lisa Satterfield, M.S., CCC/A, director of health care regulatory advocacy, American Speech-Language-Hearing Association, at lsatterfield@asha.org
Payment Adjustments and Appeals

The Patient Protection and Affordable Care Act (PPACA) transitioned the PQRS program from an incentive-based program to a penalty program for providers who do not participate or meet benchmarks set by the Centers for Medicare and Medicaid Services (CMS). CMS determined, through rule-making process, that penalties would apply on the following schedule:

<table>
<thead>
<tr>
<th>Year of Participation</th>
<th>Benchmark</th>
<th>Year of Penalty</th>
<th>Penalty %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1 payable claim</td>
<td>2015</td>
<td>1.5%</td>
</tr>
<tr>
<td>2014</td>
<td>50% eligible visits</td>
<td>2016</td>
<td>2.0%</td>
</tr>
<tr>
<td>2015</td>
<td>50% eligible visits</td>
<td>2017</td>
<td>2.0%</td>
</tr>
<tr>
<td>2016</td>
<td>50% eligible visits*</td>
<td>2018</td>
<td>2.0% + 4.0%*</td>
</tr>
</tbody>
</table>

*PQRS benchmarks and penalties change annually. In 2016, the value-based modifier program applies to audiologists, which may result in an additional 4% penalty for providers who did not meet 2016 PQRS benchmark requirements.

In January 2015, CMS issued adjustment penalty notices to audiologists in private practice, group practice, or university clinics who billed Medicare for outpatient services (Part B) in 2013, but did not report a PQRS quality code with a payable claim. The -1.5% adjustment on all 2015 claims submitted for Part B services is based on the 2013 benchmark of one patient and one claim. 2014 and 2015 claims are based on reporting on a minimum of 50% eligible patients.

Appeals Process

If audiologists believe the -1.5% payment adjustment has erroneously been applied, there is recourse available through February 28, 2015. After this date, there is no option to appeal the application of the -1.5% deduction to any 2015 claims.

Audiologists should:

1. Go to the CMS QualityNet Informal Review for Physician Quality Reporting System (www.qualitynet.org/portal/server.pt/community/informal_review_request) and select "Individual Eligible Professional."
2. Enter your Legal Business Name (as indicated in Medicare enrollment), the Billing Tax Identification Number (TIN), the individual National Provider Identifier (NPI), and other contact information requested on the form.
3. If you have included PQRS codes on a claim in 2013, choose "Issue with measure calculation on the part of CMS" as your Justification Reason. If you have another reason, choose from the options available.
4. In the Rationale text box, indicate that you submitted the code and include the date of service and the Internal Control Number (ICN) from the remittance that indicates the PQRS submission. The remittance should include remittance code "N365: This procedure code is not payable. It is for reporting/information purposes only."
5. Click "I accept the user agreement" and hit "Submit."
The informal review is the **only** mechanism for appealing the -1.5% deduction.