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 for services provided for outpatient traditional Medicare Part B beneficiaries on the CMS 1500 form or its electronic equivalent must participate in the Medicare Physician Quality Reporting System (PQRS) to avoid deductions on all Medicare payments. This applies to audiologists in independent practices as well as those providing services in otolaryngology offices and/or university clinics, where they are 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 physician(s)
- the physician(s) has enrolled with CMS in the GPRO option
- and the participating physicians meet all of the requirements for reporting the measures, which include documentation of medication, smoking cessation, immunizations, diabetes prevention, and other health screenings.


Audiologists may 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 2016 reporting?
The Centers for Medicare and Medicaid Services (CMS) requires providers to report at least 9 measures and at least 1 “cross-cutting measure” for a minimum of 50% of the eligible Medicare patient visits in order to avoid future penalties. If an audiologist provides services to less than 15 Medicare beneficiaries in the calendar year, they are exempt from reporting. Reporting requirements for 2016 include 3 cross-cutting measures (#130, #134, and #226), listed below in detail. Because there are not 9 or more measures to choose from, audiologists must report on all 3 cross-cutting measures when eligible to do so. Additionally, all of their Medicare claims are 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 all of following measures:
<table>
<thead>
<tr>
<th>Measure</th>
<th>2016 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 for hearing, tinnitus, or balance evaluations.</td>
</tr>
<tr>
<td><strong>AND</strong></td>
<td></td>
</tr>
</tbody>
</table>
| #134: Screening for Clinical Depression and Follow-Up Plan             | Screen and follow-up plan must be documented one time per calendar year for CPT code 92625 - assessment of tinnitus, 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. |
| **AND**                                                               |                                                                                                                                                                                                           |
| #154 Falls: Risk Assessment                                            | Screen (and follow-up plan #155) must be documented one time per calendar year for a minimum of 50% of the eligible Medicare patients for vestibular evaluations.                                                   |
| **AND**                                                               |                                                                                                                                                                                                           |
| #155 Falls: Plan of Care                                               | This measure is paired with #154 and must be reported one time per calendar year for a minimum of 50% of eligible patients for vestibular evaluations.                                                               |
| **AND**                                                               |                                                                                                                                                                                                           |
| #226 Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention | Report once per reporting period for comprehensive hearing, tinnitus, and vestibular evaluations. Patients are to be asked if they use tobacco and if they respond “yes,” advise them to quit and offer them, at a minimum, the Tobacco Use and Hearing and Balance Disorders document found at the end of this document. |
| **AND**                                                               |                                                                                                                                                                                                           |
| #261 Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness | One referral to a physician per calendar year for a minimum of 50% of the eligible Medicare patients diagnosed with BPPV or                                                                                     |
**How does the penalty apply?**

If the 50% benchmark is not met for each measure in 2016, a 2% penalty will apply as payment reductions on all 2018 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 2016 requirements, all services submitted from the practice with the audiologist as the rendering provider will be reduced by 2% in 2018.

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

- To meet reporting requirements, an audiologist must report:
  - a “positive” action (performed what the measure indicates) OR
  - exclusion (patient/service did not qualify)

- The **exclusion** removes the patient from the reporting requirement and removes the patient from the total Medicare eligible visits (denominator).

- The **positive action** must be reported for a minimum of 50% of the total Medicare eligible patient visits or the MAV is failed and the penalty applies.

- If measures #130, #134 and #226 are not reported with a positive action for a minimum of 50% of the eligible patient visits, the penalty will automatically apply and the analysis is complete.

- Measures #154, #155, and #261 are also required for reporting by an audiologist. They will be analyzed to confirm that the positive action was reported for a minimum of 50% of the applicable patient visits.

**When should we start?**

Audiologists should start immediately in order to avoid the 2% penalty to be retained on all 2018 claims for failure to report on 2016 eligible measures.

**What do we do?**

Reporting is easy! All you have to do is:

- Know the CPT codes in the measures
- Perform the actions of the measure, AND
- Put the appropriate code 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 the CPT/ICD-10 combination for Measure #261) that do not meet the exclusion criteria. When the CPT code is billed on the claim form, the appropriate measure codes must also be reported in box 24D on the CMS 1500 claim form, similar to a billable service. If the CPT (or ICD-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 below for instructions and examples.
Audiology Quality Consortium

2016 Reporting Audiology Quality Measures

Step-by-Step Guide

Example:
A patient presents with a referral from internal medicine with a diagnosis of R42 (dizziness and giddiness). The audiologist performs, among other tests, a comprehensive audiology evaluation (92557).

CPT code 92557 is included in these measures:

<table>
<thead>
<tr>
<th>Measure: #130</th>
<th>Documentation and Verification of Current Medications in the Medical Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure: #226</td>
<td>Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
</tr>
<tr>
<td>Measure: #261</td>
<td>Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness</td>
</tr>
</tbody>
</table>

- Because R42 is included in Measure #261, report the code that best matches the action taken on that date of service; reporting G8858 will not be included in your PQRS reporting and the penalty will **not** be averted.
  - 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 to their referring ENT.
- In addition to reporting on measure #261, you would also report on measures #130 and #226 as determined by the patient visit, for a total of 3 measures.

*It is the combination of the CPT code and the ICD-10 codes, R42 or H81.11 (BPPV, right ear), H81.12 (BPPV, left ear) or H81.13 (BPPV, bilateral) 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 (or electronic equivalent) using, **Current Procedural Terminology (CPT) codes**, the International Classification of Diseases **Tenth Revision, Clinical Modification (ICD-10-CM)** codes and codes specific for each measure.

- **CPT Codes**
  - Indicate the procedure performed on the patient.
  - Represents the measures' **denominator** (the eligible patients for a measure) in conjunction with the ICD-10-CM codes.
- **ICD-10-CM codes**
  - Indicate the diagnosis of the patient.
  - Represent the measures' **denominator** (the eligible patients for a measure) in conjunction with CPT codes.
- G code and CPT II Measure Codes
  - Represents the measures' *numerator* (action required by the measure for reporting and performance). For measures #261, #130, and #134, these are G codes, and for measures #154, #154, and #226, these are CPT II codes with the possibility of modifiers.

**Eligible PQRS Measures for Audiologists (total of 6 measures to report)**

- #130: Documentation of Current Medications in the Medical Record
- #134: Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan
  **NOW REQUIRED for tinnitus evaluations**
- #154: Falls: Risk Assessment **NEW**
- #155: Falls: Plan of Care **NEW**
- #226: Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention **NEW**
- #261: Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness

**Measure Requirements in detail:**

**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-10-CM Codes</th>
<th>G Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626</td>
<td>No specific ICD-10 codes are included for this measure</td>
<td><strong>G8427</strong>: List of current medications (includes prescription, over-the-counter, herbas, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency, and route</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-10-CM</th>
<th>G Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626</td>
<td>No specific ICD-10 codes are included for this measure</td>
<td><strong>G8430</strong>: Provider documentation that patient is not eligible for medication assessment because they are in an emergency situation (meets exclusion criteria)</td>
</tr>
<tr>
<td>Codes</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>92625</td>
<td>No specific ICD-10 codes are included for this measure</td>
<td></td>
</tr>
</tbody>
</table>

**G8431**: Positive screen for clinical depression using an age appropriate standardized tool and a follow-up plan documented

**G8510**: 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 (meets exclusion criteria)

### Depression Screening Tools
Available tools include, but are not limited to:

- **Patient Health Questionnaire (PHQ-9)**
- **Beck Depression Inventory (BDI or BDI-II)**
- **Center for Epidemiologic Studies Depression Scale (CES-D)**
- **Depression Scale (DEPS)**
- **Duke Anxiety-Depression Scale (DADS)**
- **Geriatric Depression Scale (GDS)**
- **Cornell Scale Screening**
  - [http://geropsychiatriceducation.vch.ca/docs/edu-downloads/depression/cornell_scale_depression.pdf](http://geropsychiatriceducation.vch.ca/docs/edu-downloads/depression/cornell_scale_depression.pdf)
- **PRIME MD-PHQ2**

### Measure: #154: Falls: Risk Assessment

**Reporting Criteria:** Patients ≥ 65 years with a history of falls.

A “history of falls” is indicated when a patient has fallen twice in the previous 12 months or one time resulting in an injury that required medical attention.

A “fall” is defined as a “sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.”

An “injury” is an event that results in the need for medical intervention.
Should be reported a minimum of once per calendar year per patient if any of the CPT codes below were performed:

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-10-CM Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92540</td>
<td>No specific ICD-10-CM codes are included for this measure</td>
</tr>
<tr>
<td>92541</td>
<td>10-CM codes are</td>
</tr>
<tr>
<td>92542 and/or 92548</td>
<td>measure</td>
</tr>
</tbody>
</table>

**Patient Reports:**

**Exclusion 1:**
Documentation of no falls in last 12 months or only one fall without injury in the past year

**Step 1**
Code on claim **1101F**

**Exclusion 2:**
Two or more falls in past 12 months OR 1 fall with an injury

**Step 1**
Risk assessment not performed for medical reasons (patient is not ambulatory, bedridden, immobile, confined to wheelchair)

**Step 2**
Perform 92540, 92541, 92542 and/or 92548

**Step 3**
Code on claim **3288F with 1P modifier and 1100F**

1P is to report documented circumstances that appropriately exclude patients (i.e., immobile, confined to bed, chair or wheelchair)

**Step 4**
Perform and report measure #155: Falls Risk Plan of Care

**Positive Reporting:**
Two or more falls in past 12 months OR 1 fall with an injury

**Step 1**
Risk assessment completed by performing a standardized scale and review and document whether current medications may or may not be contributing to falls, dizziness, imbalance or vertigo.

**Step 2**
Perform 92540, 92541, 92542 and/or 92548

**Step 3**
When warranted, refer for assessment of supine and standing blood pressure, vision assessment, home falls risk hazards, and/or medication review.

**Step 4**
Code on claim **3288F and 1100F**

**Step 5**
Perform and report Measure #155: Falls Risk Plan of Care

**Falls Risk Assessment Tools:**
Falls risk assessment tools include, but are not limited to:

- Get Up and Go:
  - [https://www.aan.com/Guidelines/home/GetGuidelineContent/273](https://www.aan.com/Guidelines/home/GetGuidelineContent/273) and
Measure: #155: Falls: Plan of Care

Part two of Measure #154. **This measure should also be reported if the patient meets the reporting criteria, even if a falls risk assessment was not performed.**

Reporting Criteria: Patients ≥ 65 years with a history of falls

A “history of falls” is indicated when a patient has fallen twice in the previous 12 months or one time resulting in an injury that required medical attention.

A “fall” is defined as a “sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.”

An “injury” is an event that results in the need for medical intervention.

Should be reported a minimum of once per calendar year per patient if any of the CPT codes below were performed and Measure #154 indicated the patient met the reporting criteria.

1P is to report documented circumstances that appropriately exclude patients (i.e., immobile, confined to bed, chair or wheelchair)

<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0518F</td>
<td>Create a plan of care for the patient regarding their falls risk which must include:</td>
</tr>
<tr>
<td></td>
<td>• referral to the ordering and/or primary care physician for Vitamin D supplement advice</td>
</tr>
<tr>
<td></td>
<td>• referral of the patient to a vestibular rehabilitation program, and/or providing vestibular rehabilitation within your practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0518F with 1P modifier</td>
<td>Plan of care not documented for medical reasons (patient is not ambulatory, bedridden, immobile, wheelchair bound) (meets exclusion criteria)</td>
</tr>
<tr>
<td></td>
<td>PLEASE NOTE: The AQC would still recommend referral to the ordering and/or primary care physician for Vitamin D supplement advice.</td>
</tr>
</tbody>
</table>
**Measure: #226: Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention**

Reporting Criteria: Patients ≥ 18 years

Should be reported a minimum of once per calendar year per patient.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-10-CM Codes</th>
<th>Measure Codes</th>
</tr>
</thead>
</table>
| 92540 92557 and /or 92625 | No specific ICD-10-CM codes are included for this measure | **4004F**: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user  
**1036F**: Current tobacco non-user (meets exclusion criteria) |

See the AQC document, *Tobacco Use and Hearing and Balance Disorders*, for assistance with patient counseling.

**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-10-CM Codes</th>
<th>G Codes</th>
</tr>
</thead>
</table>
| 92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92575 | R42 H81.11 H81.12 H81.13 | **G8856**: Referral to a physician for otologic evaluation performed
**G8857**: 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) (meets exclusion criteria) |
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 *2016 Physician Quality Reporting Initiative Implementation Guide*.

- ICD-10-CM codes are placed in box 21
- CPT codes are placed in box 24D
- G-codes or CPT II codes are placed in box 24D following the CPT codes of the procedures performed.
- If the reporting for a specific measure requires two codes, those should be placed on consecutive lines.
- If the measure code requires a 1P modifier, it is placed in the modifier box next to the measure code it is modifying.

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

Medicare requires that eligible professionals report on at least 9 quality measures in 2016 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. This is when the Measures Applicability Validation (MAV) process applies. The AQC recommends audiologists report on all six measures whenever the patient qualifies.

To avoid the minimum 2% penalty in 2018, in 2016 audiologists must:

- Report a positive action on a minimum of 50% of the eligible Medicare patient visits for hearing evaluation, vestibular evaluation, and/or tinnitus evaluations for Measure #130, #134, and #226.

AND

- Report a positive action on a minimum of 50% of the eligible Medicare patients seen for vestibular evaluations for Measure #154, #155, and #261.
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 notifies Medicare providers by letter of their penalty status in the fall prior to the application of the penalty and the 2% penalty applies in two-year cycles.

<table>
<thead>
<tr>
<th>Year of Participation</th>
<th>Year Notification</th>
<th>Year of Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td>2015</td>
<td>2016</td>
<td>2017</td>
</tr>
<tr>
<td>2016</td>
<td>2017</td>
<td>2018</td>
</tr>
</tbody>
</table>

There is a time-limited informal review (appeals) process that must be pursued in order to overturn the incorrect application of the penalty.

All informal review requests MUST be submitted electronically via the Quality Reporting Communication Support Page. Members of the AQC or your professional organization(s) cannot appeal on your behalf; it requires online submission by the Medicare provider or an authorized staff in the provider practice.

Resources for Audiologists

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.

PQRS QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or Onetsupport@hcqis.org Monday-Friday from 7:00 a.m. to 7:00 p.m. Central Time. (To avoid security violations, do not include personal identifying information, such as Social Security Number or TIN, in e-mail inquiries to the QualityNet Help Desk.)

For Questions, Contact:
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Lisa Satterfield, M.S., CCC/A, director of health care regulatory advocacy, American Speech-Language-Hearing Association, at lsatterfield@asha.org

Kate Thomas, Director of Payment Policy and Legislative Affairs, American Academy of Audiology, at kthomas@audiology.org

DISCLAIMER

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place of legal counsel. Reporting within, documentation for, and claims related to the Physician Quality Reporting System are ultimately the responsibility of the provider themselves.
What Patients Need to Know
Recent data from the Centers for Disease Control (CDC) report that 17.8% of American adults (age 18 or older) smoke. This translates into an estimated 42.1 million adults in the US alone.

Cigarette smoking is the leading cause of preventable disease, responsible for 480,000 deaths a year (approximately 1/5).

Smoking increases the risk of:
- Coronary heart disease
- Stroke
- Cancer, including but not limited to:
  - Lung
  - Stomach
  - Leukemia
  - Bladder, kidney, cervix, colon
  - Kidney, liver, pancreas
  - Esophagus, trachea, larynx, throat, tongue

**Smoking has been correlated to hearing loss, especially when combined with noise exposure.**

To Quit Tobacco Use:
The AQC recommends discussing all treatment options for smoking and/or tobacco cessation with your physician. Some possible treatment recommendations from a physician may include:
- Individual or group counseling.
- Behavioral therapies
- Medications for quitting that have been found to be effective include the following:
  - Nicotine replacement products
    - Over-the-counter
    - Prescription
  - Prescription non-nicotine medications

Helpful Resources
- Quitline Services
  - Call 1-800-QUIT-NOW (1-800-784-8669) if you want help quitting. This is a free telephone support service that can help people who want to stop smoking or using tobacco.
- Smokefree.gov
  - [http://smokefree.gov](http://smokefree.gov)
- American Cancer Society
- American Lung Association
  - Call 1-800-LUNGUSA
- [http://www.lung.org/stop-smoking/]