**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 (does not apply to Part B hospital and skilled nursing facilities) must participate in the Medicare Physician Quality Reporting System (PQRS) program to avoid deductions to claims in 2015.

**When should we start?** Audiologists can start at any time. However, until December 31, 2014, a 0.5% bonus will be given for all Medicare eligible charges when reporting on a minimum of three (3) measures for all eligible cases. Beginning on January 1, 2015, the Centers for Medicare and Medicaid Services (CMS) has proposed that the current voluntary incentive program will terminate and a payment adjustment will be assessed if eligible professionals do not report on at least one (1) quality measure. In 2015, for those who did not report on eligible measures in 2013, a 1.5% payment reduction on each Medicare claim will be retained by Medicare. Similarly, for those who don’t report on at least one measure in 2014, a payment deduction of 2.0% on each claim submitted for payment will be retained by Medicare contractors in 2016. Thus, there is a two year delay in assessing the payment reduction, which will technically be applied to each claim in 2015 and 2016, respectively.

**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 and ICD-9 code if there is an ICD-9 indicated. If the CPT code is reported with the ICD-9 code, the appropriate G-modifier code must be on the claim, placed in box 24 D on the CMS 1500 claim form.

**Example:**

A patient is seen for a comprehensive audiology evaluation (92557). The following measures are both eligible to report:

<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: #134</td>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
</tr>
</tbody>
</table>

The patient also presents with unspecified sensorineural hearing loss (389.10). The following measure also is eligible for reporting:

| Measure #190 | Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressing Hearing Loss |

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Even if the patient does not present with the sudden or progressive hearing loss, a G-code must be reported. In this case, the G-modifier G8567 “Patient does not have verification and documentation of sudden or rapidly progressive hearing loss” would be reported in box 24D on the claim form. It is the combination of the CPT code and the ICD-9 code that triggers the patient eligibility for reporting, not the measure description.

Each measure, listed below in the charts, has a numerator, a denominator, and denominator exclusions.

- The *numerator* describes the action required by the measure for reporting and performance.
- A *denominator* describes all the eligible patients for a measure.
- *Denominator exclusions* are those patients that fit in the denominator but are not eligible for the measure for specific reasons.

The specifications of the measures are available on the [Audiology Quality Consortium (AQC) website](https://www.aqc.org) under the "Quality Measures" section. Further [detailed specifications with applicable codes](https://www.cms.gov) are available on the CMS website.

### Step One: Review the Codes for Each Measure


- **ICD-9-CM 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 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 Congenital or Traumatic Deformity of the Ear
- Referral for Otologic Evaluation for Patients with a History of Active Drainage From the Ear Within the Previous 90 Days
- Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressing Hearing Loss
- 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
Measures in detail:

Measure #188: Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear

Reporting Criteria: Patients of any age with the following procedure codes and associated diagnosis codes

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G-modifiers</th>
</tr>
</thead>
</table>
| 92550, 92557, 92567, 92568, 92570, 92575 | 380.00, 380.01, 380.02, 380.03, 380.10, 380.30, 380.31, 380.32, 380.39, 380.51, 380.81, 380.89, 380.9, 744.01, 744.02, 744.03, 744.09 | **G8556**: Referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation  
**G8557**: Patient is not eligible for the referral for otologic evaluation measure (e.g., for patients for whom an assessment of the congenital or traumatic deformity of the ear has been performed by a physician (preferably a physician with training in disorders of the ear) within the past 6 months, patients who are already under the care of a physician (preferably a physician with training in disorders of the ear) for congenital or traumatic deformity of the ear).  
**G8558**: Not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not specified |

Measure #189: Referral for Otologic Evaluation for Patients with a History of Active Drainage From the Ear Within the Previous 90 Days

Reporting Criteria: Patients of any age with the following procedure codes and associated diagnosis codes

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G-modifiers</th>
</tr>
</thead>
</table>
| 92550, 92557, 92567, 92568, 92570, 92575 | 381.01, 382.00, 382.01, 382.02, 382.1, 382.2, 382.3, 382.4, 382.9, 388.60, 388.61, 388.69 | **G8560**: Patient has a history of active drainage from the ear within the previous 90 days  
**G8562**: Patient does not have a history of active drainage from the ear within the previous 90 days  
**G8559**: Patient referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation  
**G8561**: Patient is not eligible for referral for otologic evaluation for patients with a history of active drainage measure (e.g., patients who are already under the care of a physician for active ear drainage)  
**G8563**: Not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not specified |
Measure #190: Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressing Hearing Loss

Reporting Criteria: Patients of any age with the following procedure codes and associated diagnosis codes

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G-modifiers</th>
</tr>
</thead>
</table>
| 92550, 92557, 92567, 92568, 92570, 92575 | 389.00, 389.01, 389.02, 389.03, 389.04, 389.05, 389.06, 389.08, 389.10, 389.11, 389.12, 389.13, 389.14, 389.15, 389.16, 389.17, 389.18, 389.20, 389.21, 389.22, 389.8, 389.9 | **G8567**: Patient does not have verification and documentation of sudden or rapidly progressive hearing loss  
**G8565**: Verification and documentation of sudden or rapidly progressive hearing loss: Report G8565 in addition to:  
**G8564**: Patient was referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation  
**G8566**: Patient is not eligible for the “Referral for Otologic Evaluation for Sudden or Rapidly Progressive Hearing Loss” measure (e.g., patients who are under current care of a physician for sudden or rapidly progressive hearing loss)  
**G8568**: Patient was not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not specified |

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

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G-modifiers</th>
</tr>
</thead>
</table>
| 92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92575 | 780.4, 386.11 | **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)  
**G8858**: Referral to a physician for an otologic evaluation not performed, reason not specified |

In addition, audiologists are eligible and encouraged to report on the following measures:

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

Reporting Criteria: Patients ≥ 18 years with the following procedure codes

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G-modifiers</th>
</tr>
</thead>
</table>
| 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92585, 92588, 92626 | No specific ICD-9 codes are included for this measure | **G8427**: List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency, and route  
**G8430**: Provider documentation that patient is not eligible for medication assessment  
**G8428**: Current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) with drug name, dosage, frequency, and route not documented by the provider, reason not specified |
Measure: #134: Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Reporting Criteria: Patients ≥ 12 years with the following procedure codes

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G-modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>92557, 92567,</td>
<td>No specific ICD-9 codes</td>
<td>G8431: Positive screen for clinical depression using an age appropriate</td>
</tr>
<tr>
<td>92568, 92625,</td>
<td>are included for this measure</td>
<td>standardized tool and a follow-up plan documented</td>
</tr>
<tr>
<td>92626</td>
<td></td>
<td>G8510: Negative screen for clinical depression using an age appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>standardized tool, follow-up not required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G8433: Screening for clinical depression using an age appropriate standardized</td>
</tr>
<tr>
<td></td>
<td></td>
<td>tool, patient not eligible/appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G8432: No documentation of clinical depression screening using an age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>appropriate standardized tool</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G8511: Positive screen for clinical depression using an age appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>standardized tool documented, follow-up plan not documented, reason not specified</td>
</tr>
</tbody>
</table>

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 [2012 Physician Quality Reporting Initiative Implementation Guide](ZIP).

- ICD-9 codes are placed in box 21
- CPT codes are placed in box 24D
- G-codes are placed in box 24D

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

For realizing the incentive payment, CMS requires that PQRS participants report on at least three measures on 50% of the patients they see that would fit into an individual measure. To avoid the 1.5% deduction of claims in 2015, reporting must occur on at least one measure during the 2013 reporting period.

Example for Measure Reporting:

Using Measure #190 - Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressing Hearing Loss -

Review the Patient Eligibility and Codes for Each Measure

- Examine patient age AND the CPT code(s) indicated for the measure that were performed AND
- Confirm patient has an ICD-9 diagnosis code listed for the measure (Note: not all measures include diagnosis codes)
Determine which measure reporting options apply and choose appropriate G-code modifier

- For patients with sudden or rapidly progressive hearing loss, if the patient does not have verification or documentation of the hearing loss, report G8567. This completes the reporting requirement for patients without verification or documentation of sudden or progressive hearing loss.
- If the patient presents with a sudden or rapidly progressing hearing loss, report G8565

Determine if the patient is under the care of a physician for the reportable condition

- If the patient is already under the care of a physician for the reportable condition above, report the modifier G8566 for “Patient not eligible for the referral…”
- If the patient is not already under the care of a physician for the reportable condition, refer the patient to a physician for an otologic evaluation and report G8564 for “Patient referred to physician…”
- If the patient should have been referred to a physician for the reportable condition, and there is not a documented reason for not doing so, report G8568 for “Patient was not referred…reason not specified.

FOR QUESTIONS ON REPORTING, CONTACT:

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