More Updates for 2010

By Joy Newby, LPN, CPC, PCS
Newby Consulting, Inc.

Part B Medicare Deductibles and Co-insurance

CMS announced the 2010 Part B Medicare deductible and coinsurance amounts. Our patients are going to freak-out! The 2010 deductible is $155.00 up from $135 in 2008 and 2009. Coinsurance remains at 20 percent of the Medicare approved amount once the patient's deductible has been satisfied.

2010 - Physician Quality Reporting Initiative (PQRI)

As always times seems to fly by! It is time to think about reporting PQRI measures for 2010. If you have procrastinated participating in PQRI, you may be tempted not to report again in 2010. Some of you may have worked very hard in a previous year and did not receive a bonus payment and elected "never to do that again." 2010 is a little different in that it is the last year Congress has funded the bonus. As much as I want to see all ophthalmologists receive a bonus, the most important reason to participate in 2010 PQRI has nothing to do with money!

According to Section 1848(m)(5)(G) of the Social Security Act, eventually CMS will post the names of eligible professionals who successfully report PQRI measures:

> The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the following:
> (i) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who satisfactorily submitted data on quality measures under this subsection.
> (ii) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who are successful electronic prescribers.

Top reasons physicians did not receive incentive payments

- Incorrect *HCPCS* - Incorrect *HCPCS* code for the measure – Reported the cataract measure 0014F on the visit claim instead of the surgery claim
- Incorrect Diagnosis - Incorrect diagnosis code on claim – Visit code was included on the claim but the diagnosis code related to the measure was not submitted
- Incorrect Diagnosis and *HCPCS* - Combination of incorrect *HCPCS* code and incorrect diagnosis code on claim – Physician reported code for glaucoma measure, but the claim did not include a visit code and a glaucoma diagnosis code
- Only the Qualifying Denominator Code (QDC) (measure code, e.g., 2027F) was submitted on the claim - Missing a qualifying denominator code (e.g., visit code) (all lines were QDCs)
- Only QDC and Incorrect Diagnosis - Combination of missing qualifying denominator code (e.g., visit code) and an incorrect diagnosis code on the claim –Reported measure code, but the diagnosis code is not correct, e.g., reported 2027F with diabetes as the diagnosis
- Resubmitted QDCs - Submissions invalid due to resubmission of claims only to add QDCs
- Unattributed/No NPI - Submissions where the rendering NPI was missing

Review your PQRI process to

- Ensure the QDC reported (e.g., visit code) matches the diagnosis and the *CPT* service listed in the denominator for the measure
- If two diagnoses are required for a measure, ensure both are listed on the claim
- Understand the numerator (Measure code): Report QDCs as instructed. If 2 QDCs are required, both should be listed on the claim
- If claim is denied or if service is not covered, that claim will not be counted toward PQRI incentive
- Ensure individual rendering NPI is correctly listed on the claim

For the most part, physicians can participate in the 2010 PQRI program with little change from the 2009 measures. As promised, at the end of this article you will find the 2010 PQRI ophthalmic cheat sheet.

To participate in the 2010 PQRI program, physicians may chose to use claims-based reporting (information is included on the patient's claim) or report information through a qualified PQRI registry. A listing of CMS "qualified PQRI" registries can be found on the CMS website at http://www.cms.hhs.gov/PQRI/Downloads/QualifiedRegistriesPhase1Rvsd120709_1.pdf

New for 2010, there are two (2) PQRI reporting period. Physicians may chose to report a 12- or 6-month reporting period.

- 12-month reporting period – January 1 through December 31, 2010 (bonus calculated on 12 months of Medicare approved charges)
- 6 month reporting period – July 1 through December 31, 2010 (bonus calculated on 6 months of Medicare approved charges)

There are 2 reporting options

- Claims-based reporting
- Registry-based reporting

In addition to the claims-based reporting mechanism and the registry-based reporting mechanism, CMS is testing electronic health record (EHR) data submission, in cooperation with EHR vendors.

The 2010 PQRI bonus is 2% of Medicare of allowed charges for each physician who successfully reports. This means the physician must report a minimum of three (3) quality measures at least 80% (each measure) of the time the measure is applicable to a given patient. 2010 bonus payments should be received sometime during the third (3rd) quarter 2011. (C = Claims-based reporting; R = Registry-based reporting)

Measure #	Description	Reporting Option
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	C, R
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	C, R
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	C, R
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care	C, R
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	C, R
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	C, R
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	C, R
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	C, R

Ophthalmologists using electronic health records (EHR) may also consider the following measure

Measure #	Description	Reporting Option
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	C, R

There are two (2) new ophthalmology measures for 2010, but these measures may only be submitted via **registry-based reporting:**

- Measure #191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
- Measure #192: Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

New for 2010, under the Group Practice Reporting Option (GPRO), a group practice may potentially qualify to earn PQRI incentive payment equal to 2% of the group practice's total allowed charges

> A "group practice" under the 2010 PQRI GPRO consists of a physician group practice, as defined by a single Tax Identification Number (TIN), with at least 200 or more individual eligible professionals (EP) (as identified by Individual NPIs) who have reassigned their billing rights to the TIN.
>
> Group practices participating in the Physician Group Practice (PGP) and Medicare Care Management Performance (MCMP) demonstration in 2010 will not be allowed to participate in GPRO for the 2010 PQRI.
>
> To participate in the 2010 PQRI GPRO, a group practice must submit a self-nomination letter to CMS and be selected to participate in the 2010 PQRI GPRO.

2010 - Claims-Based Reporting Principles for Electronic Prescribing (eRx) Incentive Program

Big changes have been made to report the 2010 E-Prescribing Measure. A successful individual eRx prescriber, eligible to receive the 2% incentive payment must generate and report one or more eRxs associated with a patient visit at a minimum of 25 unique visits per year. Each visit must be accompanied by the eRx G-code attesting that during the patient visit at least one prescription was electronically prescribed. 2010 bonus payment will be sent sometime in the third (3^{rd}) quarter 2011. CMS instructions included below.

> **2010 REPORTING OPTIONS FOR THE ELECTRONIC PRESCRIBING MEASURE: ONLY FOR INDIVIDUAL CLAIMS-BASED AND REGISTRY-BASED REPORTING**
>
> (These specifications do not apply to the following reporting options: EHR-based submission or group practice reporting option [GPRO].)
>
> in order to report this measure, a qualified electronic prescribing (eRx) system must have been adopted

DESCRIPTION:
Documents whether the eligible professional has adopted a qualified electronic prescribing (eRx) system and the extent of use in the ambulatory setting. A qualified eRx system is one that is capable of ALL of the following:

- Generate a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs) if available
- Select medications, print prescriptions, electronically transmit prescriptions, and conduct all alerts (defined below)
- Provide information related to lower cost, therapeutically appropriate alternatives (if any). (The availability of an eRx system to receive tiered formulary information, if available, would meet this requirement for 2010)
- Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available)

The system must employ, for the capabilities listed, the eRx standards adopted by the Secretary for Part D by virtue of the 2003 Medicare Modernization Act (MMA).

INSTRUCTIONS:
In order to report this measure, a qualified eRx system that meets the above requirements must have been adopted. The measure is to be reported for those patient visits that meet the denominator coding criteria for which an individual eligible professional has electronically prescribed at least one prescription for a patient with Medicare Part B. Denominator coding criteria for this measure includes various ambulatory care settings.

There is no specific diagnosis required for this measure. The diagnosis associated with the patient encounter that requires the eRx may be used to report the eRx G-code. The individual eligible professional who generates at least one eRx associated with a patient visit on 25 or more unique events during the reporting period will be eligible for incentive payment.

Measure Reporting via Claims:
Submit both a denominator *CPT* code and the numerator G-code on the claim. All measure-specific coding should be reported ON THE SAME CLAIM (Faxes do not qualify as electronic prescribing).

Measure Reporting via Registry:
A denominator CPT code and an electronically generated and transmitted prescription (not faxed) are required to report the measure.

REPORTING NUMERATOR:
A qualified eRx system (as specified above) has been adopted and the following G-code applies to the patient visit

G8553 At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system

REPORTING DENOMINATOR:
Any patient visit for which one (or more) of the following denominator codes applies and is included on the claim

Patient visit during the reporting period (*CPT* or *HCPCS*): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862; (eye codes) 92002, 92004, 92012, 92014; 96150, 96151, 96152;

(office and other outpatient codes) 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215; (nursing facility codes) 99304, 99305, 99306, 99307, 99308, 99309, 99310 99315, 99316; (domiciliary/assisted living codes) 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347; (Home visits) 99348, 99349, 99350; G0101, G0108, G0109

DEFINITIONS:

Electronic Prescribing (eRx) – The transmission, using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or health plan either directly or through an intermediary, including an eRx network. Electronic prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser. (Faxes do not qualify as electronic prescribing).

Electronic Prescribing Event – For the purposes of this measure, an electronic prescribing event includes all prescriptions electronically prescribed during a patient visit.

Successful Individual Electronic Prescriber - Incentive Eligible – A successful individual eRx prescriber, eligible to receive an incentive payment, must generate and report one or more eRxs associated with a patient visit, a minimum of 25 unique visits per year. Each visit must be accompanied by the eRx G-code attesting that during the patient visit at least one prescription was electronically prescribed. Electronically generated prescriptions not associated with a denominator eligible patient visit do not count towards the minimum of 25 different eRx events. Additionally, 10% of an eligible professional's Medicare Part B charges must be comprised of the codes in the denominator of the measure to be incentive eligible.