**2011 Melanoma Physician Quality Reporting (PQRS): FREQUENTLY ASKED QUESTIONS**

**Q:** What is the Physician Quality Reporting System?

**A:** The Physician Quality Reporting System, formerly known as PQRI, is a program developed by the Centers for Medicare and Medicaid Services (CMS) to provide a financial incentive bonus to physicians who volunteer to report on best practice quality measures for the Medicare patients they treat.

**Q:** The physician I work for told me that I need to submit his/her information through a registry. What does that mean?

**A:** A registry is an electronic system that is built by an outside company (vendor) that allows physician practices to enter quality information online. All vendors have to be registered on a qualified list with CMS.

**Q:** Does the AAD have a registry for members to use?

**A:** Yes, the AAD’s registry is called the Quality Reporting System. This module is just for Physician Quality Reporting System submissions and is only open to AAD members at this time. The AAD’s registry is a web-based system – all you need is an internet connection to use it. No software will be downloaded on to your computer.

**Q:** I participated in this program in the past using my claims forms; am I able to do that this year?

**A:** No, CMS determined that measures #137, #138, and #224 can only be answered through an electronic registry in 2011.

**Q:** More than one AAD member practices in the office I work for. Can I purchase the product for the whole practice to use?

**A:** No, each AAD member physician must purchase the module individually through his/her respective AAD member ID and password.

**Q:** If I have to buy one for each member in the practice, do I have to pay full price for each one?

**A:** Yes, the registry will be $249 per physician. If the physician has purchased another module from the Academy (e.g. a CPAT module), then the price will be $229.

**Q:** I have a non-AAD member who practices with an AAD dermatologist (example: a plastic surgeon) who is also interested in participating in the Physician Quality Reporting System. Can he/she use the Academy’s registry as well?

**A:** No, this registry is only open to AAD members at this time and purchases must be made through a member’s AAD member ID and password.

**Q:** Are my office’s Nurse Practitioners (NPs) and/or Physician Assistants (PAs) able to report through the AAD’s registry?

**A:** No, the 2011 Quality Reporting System module is only open for AAD members to purchase.

**Q:** Sometimes, multiple different providers in a practice will treat a single patient. Who should report that patient?

**A:** A physician will report a patient only if that patient is billed under his or her individual NPI. If the physician’s individual NPI is not on the Medicare claim, then the patient should not be entered into the registry for that physician.
2011 Melanoma Physician Quality Reporting (PQRS):
FREQUENTLY ASKED QUESTIONS

Q: If I have multiple Tax-ID numbers (TINs) for my practice, under which do I report?
A: CMS analyzes your PQRS data strictly per the Federal Tax ID shown on the Part B claims you are submitting. On the CMS 1500 paper form, that is field 25 where you enter a nine digit number and then check whether it is an SSN (Social Security Number) or EIN (Employee ID Number). In a registry, you will enter whatever number is on your Part B claims.

Q: How many “best practice quality measures” are there for dermatologists?
A: There are three melanoma measures for the 2011 Physician Quality Reporting System.

Measure #137 - Melanoma: Continuity of Care – Recall System
Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes:
• A target date for the next complete physical skin exam, AND
• A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

Measure #138 - Melanoma: Coordination of Care
Percentage of patient visits, regardless of patient age, with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.

Measure #224 - Melanoma: Overutilization of Imaging Studies in Stage 0-IA Melanoma
Percentage of patients, regardless of age, with Stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies have been ordered related to the melanoma diagnosis.

Q: How many measures do I have to report?
A: Providers must report a minimum of three measures. You do not have to meet the requirements of three measures for every patient, but you must report on at least three measures. However, you must have greater than a 0% performance rate for all reported measures in order to qualify for the incentive payment. In addition, each of the quality measures must have at least one eligible instance in order for you to qualify for the incentive. Since the only applicable diagnosis for measure 138 is a new diagnosis of melanoma, you must see at least one patient with a new diagnosis of melanoma (that is also a Medicare patient) to report measure 138 successfully.

Example Scenario: “This year, I saw eleven Medicare patients with a personal history of melanoma (V10.82), and I diagnosed four Medicare patients with a new melanoma (172.X). How many of these patients do I report? How many times should I report each one?”

Answer: You would have to report at least nine of your eleven patients (82%) with a history of melanoma, as well as all four of your new diagnoses (100%). In this way, you are reporting at least 80 percent of the eligible patients and diagnoses. If all of your patients with a history of melanoma returned for follow-up appointments, you only have to input one visit from that patient.
2011 Melanoma Physician Quality Reporting (PQRS): FREQUENTLY ASKED QUESTIONS

Q: What constitutes a complete recall system, with regards to measure 137?
A: A complete recall system must be linked to a process that notifies patients when their next physical exam is due and must follow up with patients who either did not make an appointment within the specified timeframe, or who missed a scheduled appointment. It also must include the following elements at a minimum: the patient identifier, patient contact information, cancer diagnosis(es), date(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam.

Q: To which imaging studies does measure 224 refer?
A: Measure 224 refers to a chest x-ray, CT, ultrasound, MRI, PET, and nuclear medicine scans. If you know that any of these studies were ordered, even if by another physician, you must note this is the reporting.

Q: What signs and/or symptoms should I be watching for, in regards to measure 224?
A: You will report that the patient had signs or symptoms if the patient presented on the visit date with respiratory, neurologic, musculoskeletal, gastrointestinal, skin/lymphatic or other clinical symptoms.

Q: I use the code 238.2, unknown neoplasm when I perform a biopsy. How would I be able to report for measure 138?
A: Upon performing a biopsy on a suspicious lesion, many practices code the office visit with a 238.2, unknown neoplasm. If the pathology report reveals a melanoma, then it is common for the practice to refer it to another physician for excision. In this situation, the original doctor would never code for a 172.x, new occurrence of melanoma – excluding them from reporting measure 138, which is needed to meet the three measure reporting threshold for Medicare.

The referring physician should hold the initial claim until the pathology report has been received if he or she strongly suspects a new occurrence of melanoma. If the patient indeed has a melanoma, then the physician is able to code a 172.x for that patient, thus satisfying the reporting requirement for measure 138.

Q: When should I begin reporting on a patient?
A: Providers should enter a patient only when they have coded for a new melanoma diagnosis (172.x) or a history of melanoma (V10.82) where applicable.

Q: Do I have to submit data for the entire year?
A: Providers choose the reporting period on which they wish to report: January 1 - December 31, 2011 (12 months) or July 1 - December 31, 2011 (6 months). Choosing the 6 month reporting period will mean less chart entry for the practice, but the incentive payment will be smaller. Choosing the 12 month reporting period will equate to a larger bonus check, but will require more chart entry for the practice to complete.

Q: I initially chose the 6-month reporting period, but then changed my mind and wish to submit for the 12-month period instead. Am I able to switch my choice of reporting periods?
A: Yes, you will need to alter your reporting period selection on the “Participant Profile” page within the module.
2011 Melanoma Physician Quality Reporting (PQRS): FREQUENTLY ASKED QUESTIONS

Q: I understand that this program only applies to Medicare patients, but what if Medicare is a secondary or tertiary payer for this patient’s care?
A: Patients who have Medicare as a secondary or tertiary payer should be included in your submission.

Q: Should I include patients covered under Medicare Advantage plans?
A: No, do not include Medicare Advantage patients in your PQRS submission.

Q: Should I include patients covered under Railroad Medicare?
A: Yes, you should include Railroad Medicare patients in your submission.

Q: When can I begin to submit my chart information?
A: The “Initiate Submission” link, located on the module main page after you log in, will become active in mid-December 2011. This will enable you to begin submitting your final chart information to CMS.

Q: When is the deadline to submit all of my chart information?
A: All information must be submitted by January 31, 2012 if using the Academy’s QRS registry.

Q: When can I expect to receive my incentive payment?
A: CMS states that checks will be issued in the fall of 2012.

Q: How much will my incentive payment be?
A: If participants successfully meet the criteria of the Physician Quality Reporting System program and accurately report all applicable measures, they will receive a bonus of 1% of total allowed Medicare Part B charges to CMS for that reporting period (either January 1 – December 31, 2011 or July 1 - December 31, 2011). Although you are reporting only on your melanoma patients, your incentive will be based on all allowed Medicare Part B charges.

Q: Where can I view feedback reports from my past participation in PQRI/PQRS?
A: You may request any feedback report using the CMS Communication Support Page. Reports from 2010 will be available through the portal beginning in the fall. For more information, visit the “Physician and Other Health Care Professionals Quality Reporting Portal” at www.qualitynet.org/pqrs.
2011 Melanoma Physician Quality Reporting (PQRS):
FREQUENTLY ASKED QUESTIONS

Q: What are the applicable codes I should be looking for?
A:

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<th>MEASURE</th>
<th>APPLICABLE CPT CODE</th>
<th>APPLICABLE ICD-9 CODE</th>
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<td>172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, or V10.82</td>
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Q: I use an electronic health record (EHR); can I automatically export my data from the EHR to the registry?
A: For dermatologists using an EHR in their office, the Academy has developed an integration between some EHRs and the QRS registry. Currently, offices that use either NexTech or Encite EHRs can populate the registry directly, without manual entry. Dermatologists would still need to register and purchase the registry through the AAD’s website. The Academy continues to reach out to other EHR vendors to promote this registry integration opportunity.

Q: How will the health care reform bill affect the Physician Quality Reporting System?
A: The Patient Protection and Affordable Care Act will continue to offer incentives for participation through 2014. However, the CMS Physician Fee Schedule final rule released in November 2011 “establish[es] CY 2013 (that is, January 1, 2013 through December 31, 2013) as the reporting period for the 2015 payment adjustment.” Therefore, an eligible professional will have to report for the 2013 reporting period in order to avoid the penalty in 2015.

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<th>Year</th>
<th>Incentive or Penalty</th>
<th>Percentage</th>
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<td>Penalty</td>
<td>- 2%</td>
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For further information or questions, please contact Scott Weinberg at sweinberg@aad.org.