2012 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 (QRS). 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, #224, and #265 can only be answered through an electronic registry in 2012.

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: 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: The 2012 QRS module is only open for AAD members to purchase. However, the QRS registry vendor, NetHealth, is also offering the registry to Society of Dermatology Physician Assistants (SDPA) members to purchase at http://www.dermpa.org/nethealth_information. If the NP or PA is not a member of SDPA and wishes to participate in PQRS, he or she can report through one of the other qualified registries, located here.

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.
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Q: If I have multiple Tax Identification Numbers (TINs) for my practice, under which do I report?
A: CMS analyzes your PQRS data strictly per the TIN 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 a 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 quality measures are there for dermatologists?
A: There are four dermatology-appropriate measures for the 2012 Physician Quality Reporting System, of which you must choose at least three:

- **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 Melanoma**
  Percentage of patients, regardless of age, without signs or symptoms, for whom no diagnostic imaging studies have been ordered related to the melanoma diagnosis.

- **Measure #265 – Biopsy Follow-Up**
  Percentage of patients who are undergoing a biopsy whose biopsy results have been reviewed by the biopsying physician and communicated to the primary care/referring physician and the patient.

Q: How many measures do I have to report?
A: Providers must report a minimum of three measures (therefore, choose three of the four available in the AAD’s registry).

Q: How many measures do I have to meet?
A: You must have greater than a 0% performance rate for all reported measures in order to qualify for the incentive payment. However, not every reported patient needs to meet all three measures. 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?”
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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 patients (100%) with a new diagnosis of melanoma. If all of your patients with a history of melanoma returned for follow-up appointments, you only have to enter one visit for that patient into the registry.

Q: Can I have all exclusions (e.g. “system,” “patient,” or “other”) for a measure and still qualify for the incentive?
A: Yes, you can still qualify for the incentive even if you report every patient as an exclusion for a measure.

Q: What is a complete recall system for 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: What does it mean by “other physicians” in measure 138?
A: “Other physicians” can be a primary care physician (PCP), referring physician, and/or any other physician participating the patient’s care.

Q: What are the imaging studies in measure 224?
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: Measure 224 refers to metastatic signs and/or symptoms. 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: What should be in the tracking log for measure 265?
A: The tracking log should include: initials of biopsying physician; date of biopsy; type of biopsy; biopsy result; and date of biopsy result.

Q: I use the code 238.2, unknown neoplasm when I perform a biopsy. How would I report measure 138?
A: When 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.

Cont.
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), a history of melanoma (V10.82), or any other patient who underwent a biopsy, where applicable.

Q: Do I have to submit data for the entire year?
A: Yes, CMS now requires all PQRS participants to report a full year period.

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 2012. 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: The Academy’s QRS registry requires that all information be submitted by January 31, 2013.

Q: When can I expect to receive my incentive payment?
A: CMS states that checks will be issued in the fall of 2013.

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 0.5% of total allowed Medicare Part B charges to CMS for the calendar year. Although you are reporting only three of four specific measures, 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 2011 will be available through the portal beginning in fall 2012. For more information, visit the "Physician and Other Health Care Professionals Quality Reporting Portal" at www.qualitynet.org/pqrs.

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

<table>
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<tr>
<th>MEASURE</th>
<th>APPLICABLE CPT CODE</th>
<th>APPLICABLE ICD-9 CODE</th>
</tr>
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<tbody>
<tr>
<td>137</td>
<td>99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, or 99215</td>
<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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<td>265</td>
<td>11100, 11755, 19100, 19101, 19102, 19103, 19125, 20200, 20205, 20206, 20220, 20225, 20240, 20245, 20250, 20251, 21550, 21920, 21925, 23065, 23066, 23100, 23101, 24065, 24066, 24100, 24101, 25065, 25066, 25100, 25101, 26100, 26105, 26110, 27040, 27041, 27050, 27052, 27323, 27324, 27330, 27331, 27613, 27614, 27620, 28050, 28052, 28054, 30100, 31050, 31051, 31237, 31510, 31576, 31625, 31628, 31629, 31717, 32100, 32400, 32402, 32405, 37200, 37609, 38221, 38500, 38505, 38510, 38520, 38525, 38530, 38570, 38572, 39400, 40490, 40808, 41100, 41108, 42100, 42400, 42405, 42800, 42802, 42804, 42806, 43202, 43239, 43261, 43605, 44010, 44020, 44025, 44100, 44322, 44361, 44377, 44382, 44389, 45100, 45305, 45331, 45380, 45392, 46606, 47000, 47001, 47100, 47553, 47561, 48100, 48102, 49000, 49010, 49180, 50200, 50205, 50555, 50557, 50574, 50576, 50955, 50957, 50974, 50976, 52007, 52204 52224, 52250, 52354, 53200, 54100, 54105, 54105, 54900,</td>
<td>All patients undergoing a biopsy.</td>
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54500, 54505, 54800, 54865, 55700, 55705, 
55706, 56605, 56821, 57100, 57105, 57421, 
57454, 57455, 57460, 57500, 57520, 58558, 
58900, 59015, 60540, 60545, 61140, 61575, 
61576, 61750, 61751, 62269, 63275, 63276, 
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63290, 63615, 64795, 65410, 67346, 67400, 
67415, 67450, 67810, 68100, 68510, 68525, 
69100, 69105, 75970, 89290, 89291, 93505

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.

<table>
<thead>
<tr>
<th>Year</th>
<th>Incentive or Penalty</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>2011</td>
<td>Incentive</td>
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<tr>
<td>2012</td>
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</tr>
<tr>
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<td>Incentive</td>
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<tr>
<td>2014</td>
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<td>2016 -</td>
<td>Penalty</td>
<td>- 2%</td>
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For further information or questions, please email QRSSupport@nethealthinc.com