PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) Update 2013

James R. Christina, DPM
Director Scientific Affairs
APMA
## Overview of Physician Programs by Year (cont.)

<table>
<thead>
<tr>
<th>Year</th>
<th>Physician Quality Reporting System + MOC Incentive</th>
<th>eRx Incentive Program</th>
<th>EHR Incentive Program</th>
<th>Physician Compare</th>
<th>Physician Feedback Quality Resource Use Reports and Episode Grouper</th>
<th>Value Modifier: Differential Payment Modifier Based on Quality Compared to Cost in Budget-Neutral Manner</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>+ 0.5% incentive payment</td>
<td>+ 0.5% incentive payment</td>
<td>New Medicare EHR Incentive participants limited to $39,000 maximum over 4 years or Medicaid EHR incentive maximum $63,750 over 6 years</td>
<td>By 1/01/2013 implement plan for making performance information on quality and patient experience measures available on web site</td>
<td></td>
<td>Secretary may include completion of MOC and practice assessment as measure for Value Modifier</td>
</tr>
<tr>
<td></td>
<td>+ 0.5% Maintenance of Certification Program Incentive</td>
<td>Last year of eRx incentive payment - 1.5% payment adjustment</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2014</td>
<td>+ 0.5% incentive payment</td>
<td>- 2.0% payment adjustment</td>
<td>Last year to begin to qualify for Medicare EHR incentive. New participants limited to $24,000 maximum over 3 years or Medicaid EHR incentive maximum $63,750 over 6 years</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>+ 0.5% MOC program incentive</td>
<td>Last year of eRx payment adjustment</td>
<td></td>
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<tr>
<td></td>
<td>Final year for PQRS incentive and MOC program incentive</td>
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<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2015</td>
<td>- 1.5% payment adjustment</td>
<td>N/A</td>
<td>2015 Medicare payment adjustment begins for those not Meaningful Users of EHRs - 1%, or -2% if for 2014 subject to eRx payment adjustment</td>
<td>Submit report to Congress on web site</td>
<td>No Medicare EHR incentives for those not Meaningful Users in prior years</td>
<td>Start of value modifier with a phased implementation so that some physicians or groups of physicians paid under the PFS are subject to modifier</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>May begin Medicaid EHR incentive maximum $63,750 over 6 years</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Physician Quality Reporting System</td>
<td>eRx Incentive Program</td>
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<td>-----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>---------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2016</td>
<td>- 2.0% payment adjustment</td>
<td>N/A</td>
<td>Medicare EHR subject to - 2.0% payment adjustment Last year to begin Medicaid EHR incentive maximum $63,750 over 6 years</td>
<td></td>
<td></td>
<td>Value modifier with a phased implementation so that some physicians or groups paid under the PFS are subject to modifier</td>
</tr>
<tr>
<td>2017</td>
<td>- 2.0% payment adjustment</td>
<td>N/A</td>
<td>Medicare EHR subject to - 3.0% payment adjustment</td>
<td></td>
<td></td>
<td>Value modifier with a phased implementation so that all physicians and groups paid under the PFS are subject to modifier Payment modifier may apply to eligible professionals other than physicians</td>
</tr>
</tbody>
</table>
### Overview of Physician Programs by Year (cont.)

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>2018 and beyond</td>
<td>- 2.0% payment adjustment</td>
<td>N/A</td>
<td>For 2018 and beyond subject to additional - 1.0 % per year if proportion of eligible professionals who are meaningful EHR users is less than 75%; Subject to maximum - 5%</td>
<td>N/A</td>
<td>Value modifier applies to all physicians and groups paid under the PFS are subject to modifier. Payment modifier may apply to eligible professionals other than physicians.</td>
<td></td>
</tr>
</tbody>
</table>
Physician Quality Reporting System (PQRS)
UNDERSTANDING A MEASURE

• Each measure is constructed with a numerator and denominator.
• **Denominator:** Identifies who qualifies as an eligible patient for reporting a specific measure. It may contain information such as age, gender, CPT codes, ICD-9 codes, etc.
• **Numerator:** Describes the specific action that was performed (the quality measure) on an eligible patient, e.g. lower extremity neurological exam performed.
• Numerator/Denominator gives you a performance percentage on a particular measure. (This is the essence of the program. You end up with a performance score on each measure.)
REPORTING PQRS MEASURES

There are multiple ways to report PQRS measures:

- Individual Claims
- Group Reporting
- Reporting through registries
- Reporting through electronic health record
- Administrative claims method

In general most podiatrists will utilize the individual claims method and that is the method I will focus on discussing. If you are in a large group or multi-specialty group you may be able to utilize a different reporting option.
REPORTING A MEASURE GROUP

• Currently there are no measure groups that are applicable to the practice of podiatry.
  – What about the Diabetes Measure Group or the Perioperative Care Measure Group?
  • You must report each measure in the group:

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Title</th>
<th>NQF measure number</th>
<th>Measure Developer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus</td>
<td>0059</td>
<td>NCQA</td>
</tr>
<tr>
<td>2</td>
<td>Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus</td>
<td>0064</td>
<td>NCQA</td>
</tr>
<tr>
<td>3</td>
<td>Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus</td>
<td>0061</td>
<td>NCQA</td>
</tr>
<tr>
<td>117</td>
<td>Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient</td>
<td>0055</td>
<td>NCQA</td>
</tr>
<tr>
<td>119</td>
<td>Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients</td>
<td>0062</td>
<td>NCQA</td>
</tr>
<tr>
<td>163</td>
<td>Diabetes Mellitus: Foot Exam</td>
<td>0056</td>
<td>NCQA</td>
</tr>
</tbody>
</table>
Perioperative Care Measure Group

PERIOPERATIVE CARE MEASURES GROUP OVERVIEW

2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2012 PHYSICIAN QUALITY REPORTING MEASURES IN PERIOPERATIVE CARE MEASURES GROUP:

#20. Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician
#21. Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin
#22. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)
#23. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
Perioperative Care Measure Group

Patient sample criteria for the Perioperative Care Measures Group are patients aged 18 years and older that have a specific surgical procedure performed:

One of the following surgical procedure codes:

19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 22558, 22600, 22612, 22630, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27269, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 39545, 39561, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 44005, 44010, 44020, 44021, 44050, 44055, 44120, 44125, 44126, 44127, 44130, 47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47770, 47775, 47800, 47802, 47900, 48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49215, 50320, 50340, 50360, 50365, 50370, 50380, 60521, 60522, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276
The incentive payment is 0.5% of estimated Part B billings for 2013

(Same as in 2012)
What does the future hold

• Beginning in 2015 a payment adjustment will apply under the Physician Quality Reporting System (PQRS). If you do not successfully submit quality data measures the reduction will be:
  • 1.5% in 2015
  • 2.0% in 2016 and each subsequent year

As with the e-prescribing program they will use participation in a prior year’s PQRS program to determine if you will be subject to the payment adjustment (reduction). For 2015 payment adjustment they will evaluate whether you participated in PQRS in 2013.

CMS has determined that participating in PQRS in 2013 for the purpose of avoiding the payment reduction in 2015 means submitting at least one quality measure.
REQUIREMENTS
(individual claims based method)

• Report on at least 3 2013 PQRS measures
• Report each measure for at least 50% of eligible professional’s Medicare Part B fee for service patients for whom services were furnished during the reporting period to which the measure applies. (Both 6 month and 12 month reporting periods are available)
THE MEASURES

• There are a total of 259 individual measures available for claims and/or registry based reporting for the 2013 (and 288 in 2014) Physician Quality Reporting System (PQRS)
In general, **most** podiatric physicians will need to do individual claims based reporting:

From 1/1/2013 through 12/31/2013
How to do it
(the easy method)
PICK YOUR THREE MEASURES

• Measure 126:
  – Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation

• Measure 127:
  – Diabetic Foot and Ankle Care, Ulcer Prevention: Evaluation of Footwear

• Measure 163:
  – Diabetes Mellitus: Foot Exam
WHY THESE THREE MEASURES

• These measures only need to be reported once during the reporting period. Since the majority of patients with DM are seen more than once a year, if you do not report it on a visit you can always report it on a subsequent visit in the same reporting year.

• They are measures we normally do in the course of visits at least once a year for our patients with DM.

• You only report on patients that are eligible according to the measure specifications, so you have already narrowed the eligible patient pool since the patient must have a diagnosis of DM to be eligible for these measures.
Set up a tracking system

• Print a list of all of your patients with diabetes and chart the measures as you report them
• If you are still using charts, put a sticker on the charts of your patients with diabetes and check off the measures as you report them
• If you have an EHR talk to your vendor about a notification system that reminds you when the patient is eligible for the measures you have selected and tracks when the patient has had all eligible measures submitted for the year
THE STRUCTURE OF A MEASURE

- Each measure has a numerator and a denominator
  - **Denominator**: Tells you who is an eligible patient to report a particular measure. It will usually contain (but does not have to) a CPT procedure code and an ICD-9 diagnosis code. It will also usually contain some demographic information: age range, sex, etc.
  - **Numerator**: Represents the number of eligible patients that you performed a specific quality measure.

THE MEASURE DEFINES THE ELIGIBLE PATIENT!!!
Definition: A lower extremity neurological exam consists of a documented evaluation of motor and sensory abilities including reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection. (It is generally recommended that at least two of the tests be performed)
DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetes mellitus

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter

AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

AND
Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who had a lower extremity neurological exam performed at least once within 12 months

Definition:
Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities and may include: reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection. The components listed are consistent with the neurological assessment recommended by the Task Force of the Foot Care Interest Group of the American Diabetes Association. They generally recommend at least two of the listed tests be performed when evaluating for loss of protective sensation; however, the clinician should perform all necessary tests to make the proper evaluation.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Lower Extremity Neurological Exam Performed
G8404: Lower extremity neurological exam performed and documented

OR

Lower Extremity Neurological Exam not Performed for Documented Reasons
G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure

OR

Lower Extremity Neurological Exam not Performed
G8405: Lower extremity neurological exam not performed
Definition: Evaluation for proper footwear includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device and counseling on appropriate footwear should be based on risk categorization.
DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetes mellitus

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter

AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

AND
Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who were evaluated for proper footwear and sizing at least once within 12 months

Definition:
Evaluation for Proper Footwear — Includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device and counseling on appropriate footwear should be based on risk categorization.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Footwear Evaluation Performed
G8410: Footwear evaluation performed and documented

OR

Footwear Evaluation not Performed for Documented Reasons
G8416: Clinician documented that patient was not an eligible candidate for footwear evaluation measure

OR

Footwear Evaluation not Performed
G8415: Footwear evaluation was not performed
Here is the only tricky part:

**Measure 163**

Age range: 18-75

Qualifying CPT codes: Essentially just E/M

Reports using a CPT Category II code (not a G code)
Measure #163: Diabetes Mellitus: Foot Exam

2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:
The percentage of patients aged 18 through 75 years with diabetes who had a foot examination

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. The performance period for this measure is 12 months. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure’s denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.
DENOMINATOR:
Patients aged 18 through 75 years with a diagnosis of diabetes

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter

AND

Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

AND

Patient encounter during the reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

NUMERATOR:
Patients who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam)

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Foot Exam Performed
CPT II 2028F: Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when any of the three components are completed)

OR

Foot Exam not Performed for Medical Reason
Append a modifier (1P) to CPT Category II code 2028F to report documented circumstances that appropriately exclude patients from the denominator.
2028F with 1P: Documentation of medical reason for not performing foot exam (i.e., patient with bilateral foot/leg amputation)

OR

Foot Exam not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 2028F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2028F with 8P: Foot exam was not performed, reason not otherwise specified
Patient with diagnosis of diabetes mellitus

18 years of age or older

18-75 years of age

Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Patient encounter during the reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

Perform and report measures 126 and 127

Perform and report measure 163
CLAIM SUBMISSION DETAILS:

Quality Data Codes (QDCs) must be submitted with a line item charge of zero dollars ($0.00) at the time the associated covered service is performed.

The submitted charge field cannot be blank.

The line item charge should be $0.00.

If a system does not allow a $0.00 line item charge, use a small amount such as $0.01.

Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)
EXAMPLE OF HOW IT IS DONE

• You see a 68 year old male with NIDDM as a new patient with the chief complaint of “heel pain.”

• You do an H & P including in your physical exam a vascular, neurological, biomechanical, and dermatological exam. You evaluate the patient’s current footwear.
• Documentation in the note of the patient visit of each quality measure being performed (neurological exam, evaluation for footwear and diabetic foot exam) must be present along with your normal documentation for the patient visit (in this case heel pain).
CLINICAL FINDINGS

- Your diagnosis is plantar fasciitis, NIDDM with peripheral neuropathy and loss of protective sensation.

- You counsel the patient regarding diabetic foot care and risks of LOPS.

- You advise the patient about proper shoe gear—patient is eligible for therapeutic shoes.

- You treat the patient for the plantar fasciitis.
CODING

• Diagnosis (ICD-9): 250.60, 727.1
• Procedure (CPT): 99203
• Quality Codes:
  – G8404 (Neurological Exam Performed)
  – G8410 (Footwear Evaluation Performed)
  – 2028F: (Foot Examination Performed)
Please note place of service is incorrect, this example is just to demonstrate reporting of G and HCPCS II.

<table>
<thead>
<tr>
<th>Date of Current Illness/Injury</th>
<th>Dates Patient Unable to Work</th>
<th>Hospitalization Dates Related to Current Services</th>
<th>Number of Referring Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/20/2009</td>
<td></td>
<td></td>
<td>000000</td>
</tr>
</tbody>
</table>

**Diagnosis or Nature of Illness or Injury:**

1. 727.1
2. 250.60

**Physician or Supplier Information:**

<table>
<thead>
<tr>
<th>Date(s) of Service</th>
<th>Place of Service</th>
<th>Procedure, Service, or Supplies</th>
<th>Diagnosis Code</th>
<th>Days or Units</th>
<th>Medicare Plan</th>
<th>Cob</th>
<th>Reserved for Local Use</th>
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<tbody>
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<td>99203</td>
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<td>G8404</td>
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<tr>
<td>01/27/09</td>
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<td>G8410</td>
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<tr>
<td>01/27/09</td>
<td></td>
<td>2028F</td>
<td>2</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Information:**

- **Federal Tax I.D. Number:** 00-00000000
- **Patient's Account No.:** 
- **Accept Assignment?** Yes
- **Total Charge:** $125.00
- **Amount Paid:** $125.00
- **Balance Due:** $125.00

**Signature:**

John Doe, DPM
OTHER MEASURES

• There is no limitation on the measures that you choose to report or the number of measures you report (as long as you report at least 3), just remember that they need to be within the scope of practice of your license.

• Just remember to check the denominator of the measures that you choose for the specifics of patient eligibility, i.e. age range, CPT codes, ICD-9 codes, etc.
• There is a 0.5% additional incentive payment available for participation in a Maintenance of Certification (MOC) program. Currently ABPM and ABPS have developed such a program, so if you are a Diplomate of either board, you should check with them how to achieve MOC.
QUESTIONS

Resources:

CMS PQRS Website
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS

PQRS Frequently Asked Questions (FAQs)
https://questions.cms.gov/