PQRS made easy

Now that the Medicare Physician Quality Reporting System (PQRS) has moved away from incentive payments to potential downward payment adjustments, registered dietitian nutritionists (RDNs) will want to be sure they don’t leave money on the table when it comes to their Medicare patients. Mastering the PQRS involves learning a new language and developing some new habits within your practice. By investing a little bit of time, RDNs can ensure that they receive from Medicare the full payments that they deserve for their services. Armed with the information in this article plus resources on the Academy website, you can easily become a PQRS pro.

What is PQRS?
The Physician Quality Reporting System (PQRS) is a Centers for Medicare & Medicaid Services (CMS) program that uses a combination of incentive payments and negative payment adjustments to promote the reporting of data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries. Currently, payments for these services are not based on the quality of care revealed by PQRS reporting. Instead, payments depend on whether or not the RDN has met the reporting requirements (number of measures, number of domains).

Who participates in PQRS?
PQRS data are collected from eligible professionals (EPs), including some RDNs. To determine whether you are an EP, see the text box “Am I eligible to participate in PQRS?”

Three Easy Steps
Now that you’ve determined you are eligible to participate in PQRS, follow these simple steps to get you on the road to avoiding a downward payment adjustment:

Step 1: Select a reporting method
Technically, there are multiple methods available for reporting PQRS data. However, as an RDN, you will most likely either use claims-based or electronic health record (EHR) reporting if you are reporting as an individual or part of a RDN-group practice. If you are an RDN working in a physician office or other multidisciplinary physician group practice, you may also have the option of registry-based reporting.
• For claims-based reporting, you add specific data to section 24 of the CMS-1500 claim form. (See case study and sample completed form on page 3.)
• There are two forms of EHR reporting. Data may be directly extracted from your EHR and submitted by your practice to CMS, or data may be extracted from your EHR by what is known as a data submission vendor, which then submits the data on behalf of your practice. In either case, the EHR must be considered certified EHR technology (CEHRT). (To learn whether your EHR is considered CEHRT, visit: http://oncchpl.force.com/ehrcert/ehrproductsearch. Click “Download CHPL Product Information.” You can then search the Excel spreadsheet for your EHR product.)
• If you use a billing service, check

Am I eligible to participate in PQRS?
To be eligible to participate in PQRS, an RDN must be paid under the Medicare Physician Fee Schedule, bill Medicare using a CMS-1500 claim form and meet one of the following criteria:
• Practices in a private practice (single or group practice)
• Is part of a multi-specialty group practice
• Reassigns benefits to a Critical Access Hospital (CAH) that bills professional services at a facility level, such as CAH Method II billing

RDNs who practice in the following settings are not eligible to participate in PQRS:
• Hospital outpatient clinics that bill Medicare Part B on the UB-04 form
• Federally Qualified Health Centers
• Rural Health Clinics

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www.eatright.org/mntprovider
Step 2: Select measures to report
The rules for PQRS reporting indicate that RDNs must report on nine measures, and the reported measures must cover at least three of the National Quality Strategy (NQS) domains. RDNs who do not meet the requirements face a 2% downward adjustment in payment for services rendered in 2017. In addition, beginning in January 2015, RDNs must also report on at least one “cross-cutting” measure. However, these rules seem to put RDNs, as well as many other types of Medicare providers, in a bind because, in fact, there are only 4 or 7 measures applicable to RDNs in the PQRS measures set depending on the reporting method used. (See “PQRS measures applicable to RDNs” chart on page 4.) So, how is this problem resolved? RDNs need to report on all applicable measures. Then CMS will use a process called the Measure-Applicability Validation process to determine whether the provider should have reported more measures. This process should prevent any negative consequences for RDNs who report on all the measures that are applicable to their services. The good news is that, no matter the reporting method selected, the measures applicable to RDNs meet the requirements related to NQS domains and cross-cutting measures.

Step 3: Report
The reporting step is often the most intimidating one for RDNs, but it need not be. Once you understand some reporting basics, you’ll find it is not too difficult. Potentially the most difficult piece of this step is setting up your office procedures to support PQRS reporting.

For RDNs reporting via a claim form, PQRS measures are submitted by adding Quality-Data codes (QDCs) to the claim form. (See sample completed claim form on page 3.) QDCs are nonpayable, alpha-numeric codes used solely for the purposes of reporting PQRS data via claims-based and registry-based reporting. For each PQRS measure, there is an associated list of QDCs, each one specifying a level of performance on that measure. A modifier may also be added to the QDC to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. For more information about QDC measures applicable to RDNs as well as PQRS fact sheets, visit: www.eatright.org/Members/content.aspx?id=6442478742.

For RDNs reporting measures via an EHR, care related to the PQRS measures will be documented in the EHR and then the data will be extracted by either the practice or the data submission vendor and submitted to CMS via a special web-based portal.

That was easy!
While the PQRS process may take some getting used to, it isn’t too complicated. Now that you have become familiar with PQRS and are ready to avoid a downward payment adjustment in 2017, take a look at the sample case study and completed CMS 1500 form on page 3. You may also wish to listen to the webinar “The Ins and Outs of the Physician Quality Reporting System (PQRS) for Registered Dietitian.” Although this webinar was recorded in 2014, the recording and accompanying handouts contain useful and practical information that is still relevant for 2015. The webinar and additional detailed information on PQRS, including the measures applicable to RDNs, can be found on the Academy website at: www.eatright.org/Members/content.aspx?id=6442478742.

Tips for PQRS reporting
- Know your timeline. Eligible providers have until Feb. 26, 2016, to submit claims with PQRS codes reported for services rendered in 2015.
- Include PQRS codes when you first submit a claim. (You cannot resubmit a claim solely for the purposes of adding PQRS codes.)
- Beginning Oct. 1, 2015, use ICD-10-CM codes on all Medicare claims.
- If you use claims-based reporting, use the latest version of the CMS-1500 form (2/12), which went into effect on April 1, 2014.
- If the patient’s body mass index (BMI) is outside of normal parameters, have a documented follow-up plan.
- Know how to screen for unhealthy alcohol use and elder maltreatment. Easy-to-administer, standardized screening tools are available. For more details, refer to the 2014 PQRS Implement Guide available at: www.eatright.org/Members/content.aspx?id=6442478742.
- If the patient screens positive for elder maltreatment, have a documented follow-up plan (e.g., referral to appropriate social services agency).
- When available, utilize laboratory data obtained from the patient’s physician for reporting.
PQRS compliance case study

Karen Smith (DOB 05/01/1939) with type 2 diabetes mellitus (250.00), was referred by Dr. Jeffrey Jones. You met with her on 01/14/2015 for initial MNT appointment lasting 60 minutes.

Patient data: Ht 66"; Wt 200 lb.; BMI 32.3; A1c 7.5%.

You have a documented follow-up plan in place to address her above-normal BMI. You have documented all current medications, vitamins/minerals/herbs/supplements with product name, dosage, frequency and route of administration. Elder maltreatment screen was negative. Here’s how you would complete the CMS-1500 claim form and report the data for PQRS compliance.

- Insert referring physician’s name and NPI.
- Insert ICD-9 Code 250.00 (Type 2 diabetes mellitus).
- (Lines 1 to 6) Insert date of service (01/14/15), place of service (11 = office), diagnosis pointer (A), charges, units (4) and your NPI.
- (Line 1) Insert CPT code (97802).
- (Line 2) For CPT/HCPCS, include G8417 with a charge of $0.01 and unit = 1 to indicate BMI was greater than normal and a follow-up plan was documented. (PQRS #128)
- (Line 3) Insert G8427 for CPT/HCPCS to indicate a list of current medications was documented in the medical record. (PQRS #130)
- (Line 4) Insert 3045F for CPT/HCPCS to indicate the patient’s A1c was in the 7.0%–9.0% range. (PQRS #1)
- (Line 5) Insert G8734 for CPT/HCPCS to indicate that completion of an elder maltreatment screen is documented and there is no follow-up plan because the screen was negative. (PQRS #181)
- Total all charges. Do not include the $0.01 PQRS "charges" in this total.

Adult Weight Management Evidence-Based Nutrition Practice Guideline available

The Academy of Nutrition and Dietetics Evidence Analysis Library (EAL) has recently published a new Adult Weight Management Evidence-Based Nutrition Practice Guideline. The guideline recommendations are based on a systematic review of the literature and the work performed by the Academy of Nutrition and Dietetics Expert Working Group on Adult Weight Management; the United States Preventive Services Task Force (USPSTF); the United States Department of Agriculture (USDA) Nutrition Evidence Library (NEL); and the American Heart Association (AHA), American College of Cardiology (ACC), and the Obesity Society (TOS). The guideline, free to all Academy members and EAL subscribers, is available at: www.anddeal.org.
### PQRS measures applicable to RDNs

<table>
<thead>
<tr>
<th>PQRS measure</th>
<th>Claims</th>
<th>EHR</th>
<th>Registry</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS#1: Diabetes: Hemoglobin A1c Poor Control (NQS Domain: Effective Clinical Care)</td>
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<td>X</td>
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<tr>
<td>PQRS#2: Diabetes: Low Density Lipoprotein Cholesterol (LDL-C) Control (&lt;100 mg/dL) (NQS Domain: Effective Clinical Care)</td>
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<tr>
<td>PQRS#126: Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation (NQS Domain: Effective Clinical Care)</td>
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<tr>
<td>PQRS#127: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention, Evaluation of Footwear (NQS Domain: Effective Clinical Care)</td>
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<td>X</td>
</tr>
<tr>
<td>PQRS#128*: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up (NQS Domain: Community/Population Health)</td>
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<tr>
<td>PQRS#130*: Documentation of Current Medications in the Medical Record (NQS Domain: Patient Safety)</td>
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<tr>
<td>PQRS#173: Preventive Care and Screening: Unhealthy Alcohol Use – Screening (NQS Domain: Community/Population Health)</td>
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</tr>
<tr>
<td>PQRS#181: Elder Maltreatment Screen and Follow-up Plan (NQS Domain: Patient Safety)</td>
<td></td>
<td></td>
<td>X</td>
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</tbody>
</table>

*Denotes cross-cutting measure

### QUESTION CORNER

**Q**: Do I need to report to PQRS on all of my Medicare patients?

**A**: Technically, eligible providers (EPs) must report measures for at least 50% of all Medicare Part B patients seen during the 2015 reporting period. In practice, it is probably easiest for registered dietitian nutritionists (RDNs) to report on all of their Medicare patients seen in 2015 rather than trying to estimate the 50% minimum threshold.

**Q**: Do I need to report all PQRS measures for all Medicare patient encounters?

**A**: No. Most measures need to be reported a minimum of once per calendar year. The only exception is PQRS#130 (Documentation of Current Medications in the Medical Record), which should be reported for each visit. For the measures that need to be reported only once per year, the Centers for Medicare & Medicaid Services (CMS) will use the most recently reported data. RDNs will therefore want to develop a system to track that the PQRS measures have been reported at least once in the calendar year. More information on PQRS measures applicable to RDNs can be found at: www.eatright.org/Members/content.aspx?id=6442478745.

**Q**: How will I know if CMS received my PQRS data?

**A**: RDNs should check their Remittance Advice/EOB for denial code N620, accompanied by the message, “Alert: This procedure code is for quality reporting/informational purposes only.” This code indicates that the PQRS codes were received into the CMS National Claims History (NCH) database. Claims submitted with a quality data code (QDC) line-item charge of $0.01 or more will also generate claim adjustment reason code (CARC) 246 with an accompanying message, “This non-payable code is for required reporting only,” indicating the data have been received. For more information on Physician Quality Reporting System, visit: www.eatright.org/Members/content.aspx?id=6442478742.

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