2016 Quality Measures FAQs

Do I have to still report PQRS?

- No, GPRO takes the place of reporting PQRS.

Do I still need to report meaningful use?

- Yes, meaningful use is a requirement.

What is the point of billing the CPT codes/G-codes if Premier already has the claims data?

- CPT codes are not necessary, however, the CPT codes enables the 360 Analytics website to show your practice quality data. This allows Premier Management team to be able to see the clinical status of your patients. Think of them as reporting codes when you previously used them for PQRS.
- The use of CPT codes has the additional benefit of reducing the reporting burden during the annual CMS audit, better known as the Group Reporting Option (GPRO). Please note that when it is time to report for GPRO, we will ask you to provide evidence from the patient's chart of the completed measures.

Do I have to use the CPT codes?

- It is highly preferred that you use the CPT codes to ease the minds of Premier Quality and Leadership teams so they know you are completing all measures accurately. If you do not use the CPT codes, when it comes time for GPRO reporting period (January-March), Premier will ask you to manually report the measures.

How often can I bill for these codes?

- Please find attached a document attached which includes the frequency in which each code may be billed.

Do I have to bill two CPT codes for the Clinical Depression Measure?

- Yes, you must bill the G0444 (confirms that the annual depression screening was complete) code, and either G8431 (positive for depression) or G8510 (negative for depression)

If a patient is currently seeing a Cardiologist that manages their CAD, HF, or IVD, or an Ophthalmologist for the diabetes eye exam, do I still have to report these measures?

- Yes, all supporting documents (echocardiograms, eye exam) must be in the Primary Care physician's records in order to satisfy the measure.

Do these measures have to be completed during an AWV?

- No, it is only a suggestion that you complete all of these measures during an AWV. As long as the measures are completed during the measurement period (January-December) and follow up visits are scheduled during the measurement period, Medicare and Premier will be happy.

How often can an AWV be billed to Medicare?

- Medicare covers an AWV for all beneficiaries who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not gotten either an IPPE or an AWV within the past 12 months (that is, at least 11 months have passed following the month in which the IPPE or the last AWV was performed). Medicare pays for only one first AWV per beneficiary per lifetime and pays for one subsequent AWV per year thereafter. **Annual Wellness Visits (AWVs) are covered by Medicare at 12 month intervals.** This means that 11 full calendar months must pass after the month in which a beneficiary had received an AWV. Therefore 365 days would not need to elapse between visits, provided that 11 full months had passed since the last visit.

What conditions constitute an IVD diagnoses?

Ischemic Vascular Disease (IVD)			
Atherosclerosis or Atherosclerotic disease (any type)	Myocardial Infarction (MI or heart attack)	Peripheral Ischemia	Cerebral vascular disease
Infarction (any type)	ST elevation myocardial infarction (STEMI)	Renal artery disease (stenosi	Cerebral embolism
Ischemic or Ischemia (any type)	Ischemic Cardiomyopathy	Atherosclerosis renal artery	Transient ischemic attack (TIA)
Coronary artery disease (CAD)	Coronary Artery Bypass Graft (CABG)	Carotid artery disease	Limb ischemia
Coronary Stenosis	Percutaneous Coronary Intervention (PCI/angioplasty/stents)	Cerebral ischemia	
	Peripheral Artery disease (PAD)		

Best Practices

- The recommended use for the checklist is for the provider to create a "2016 GPRO or Premier Quality Measures" file in the patient chart. Each time the patient comes in for an office visit, pull out the checklist and check off the measures completed in that visit. Then provide the billing individual with the checklist so the CPT codes can be billed. Return the checklist to the patient chart for the next office visit.

- Please be sure to document patient exclusions every year for every measure in the patient's chart.

- The ICD-10 codes on the checklist are recommendations of generic codes that coincide with the CPT codes listed. They are not the only codes that could apply to the CPT codes.

- Be sure to counsel and document a follow up plan for patients with a below normal BMI

- **Mental Health** – Please provide the severity of the depression based on a numerical value from a PHQ-9 test. Also suitable is describing the depression as mild, moderate, or severe.

- **Medication Documentation** – Documenting the medication a patient takes must be performed at every visit. *Must include all known Rx meds, OTC, herbals, and vitamins/minerals/dietary supplements and must contain name, dosage, frequency and route of administration.*

- **Influenza Vaccine** – Must include a receipt if administered by a third party. It is also important to note that if the vaccine is administered in your office, it must have taken place during Oct 1, 2015 and March 31, 2016 or the measure is not satisfied.

- **Colorectal Screening** – If patient refuses all 3 types of appropriate screening, please document. The measure is not satisfied unless one of the three screenings are complete or documented that the patient refused all 3 types of screening.

- **Diabetes Eye Exam** – Patient must have retinal or dilated eye exam by eye care professional. A copy of this exam must be reviewed and kept in the Primary Care Physician's chart.