PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) and e-Prescribing Update 2013

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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 the 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.
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.
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 with one reporting period available for 2013.

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, 99234, 99235, 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
G8405: 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, 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/mechanical 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,
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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, 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

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

Age

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, 99338, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

Perform and report measures 126 and 127

(any of codes in yellow)

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 codes.

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</table>

Signed: John Doe, DPM

[Approved by AMA Council on Medical Service 8/88]
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 programs, so if you are a Diplomate of either board, you should check with them how to achieve MOC.
The Electronic Prescribing (eRx) Incentive Program
Most of the requirements for the eRx Incentive Program were established in the CY 2012 Medicare PFS final rule.

**Updates to the eRx Incentive Program:**

- New Criteria for the eRx group practice reporting option (eRx GPRO)
  - Since, accordingly with PQRS, we expanded definition of group practice to include groups of 2-24 eligible professionals, we finalized new criteria for becoming a successful electronic prescriber under the eRx GPRO:
    - Report the electronic prescribing measure for at least 75 instances during the applicable 2013 eRx incentive or 2014 eRx payment adjustment reporting period
E-Prescribing
(eRx incentive program)

In 2013 you can earn an incentive payment equal to 0.5% percent of the total estimated allowed charges for all covered professional services furnished during the 2013 reporting period (1/1/2013 through 12/31/2013).

(Was 1% in 2012)
FUTURE PAYMENTS AND ADJUSTMENTS

• Incentive payment: 2013 is last year for eRx incentive payments

• Payment adjustments:
  • 1.5 percent in 2013 (currently in effect)
  • 2.0 percent in 2014

No eRx incentive payments or payment adjustments are authorized beyond 2014, however, the meaningful use penalty for 2015 will be an additional 1% if you do not eRx in 2014.
THE PENALTY PHASE  
(Payment Adjustment)

• 2012 and 2013 will be used to determine if you will be penalized in 2014.
• If you are not deemed a successful e-prescriber for the first six months of 2013 (you must submit 10 unique electronic prescriptions*), you will receive 98% of ALL your Medicare Part B FFS payments in 2014 (2% penalty) unless:
  – You are deemed a successful e-prescriber for the entire year of 2012 (you must submit 25 unique electronic prescriptions), you will be exempt from the 2014 penalty or
  – You qualify for one of the exemptions (some you must file for and some are automatic)

*There is a change in requirements to avoid the penalty
ELIGIBILITY

As some individuals (identified by NPIs) may be associated with more than one practice or Tax Identification Number (TIN), for the 2013 incentive payments and 2013 and 2014 payment adjustments the determination of whether an eligible professional is a successful electronic prescriber will continue to be made for each unique TIN/NPI combination.
THERE ARE SOME EXCEPTIONS

- You do not qualify for eRx incentive because fewer than 10% of your total Medicare Part B FFS payments are represented by the CPT codes in the eRx denominator (for the January 1, 2013—June 30, 2013 reporting period).

- An eligible professional does not have at least 100 cases (that is, claims for patient services) containing an encounter code that falls within the denominator of the electronic prescribing measure for dates of service during: the 6-month reporting period (January 1, 2013 through June 30, 2013) for the 2014 payment adjustment. If an eligible professional has fewer than 100 denominator-eligible instances in a 6-month period, this will be an indicator that the professional likely has a small Medicare patient population.
CMS may, on a case-by-case basis, exempt an eligible professional from the application of the eRx payment adjustment if compliance with the requirement for being a successful e-prescriber would result in a significant hardship.

This exemption is subject to annual renewal.

For the 2014 eRx payment adjustment, the following circumstances would constitute a hardship:

• The eligible professional or group practice practices in a rural area with limited high speed Internet access (report G-code G9642).
• The eligible professional or group practice practices in an area with limited available pharmacies for electronic prescribing (report G-code G8643).
• Inability to electronically prescribe due to local, state, or federal law or regulation.
• Eligible professionals who prescribe fewer than 100 prescriptions during a 6-month payment adjustment reporting period.
New Significant Hardship Exemption Categories for the 2013 and 2014 eRx payment adjustments:

- Eligible professionals or group practices who achieve meaningful use during certain eRx payment adjustment reporting period

- Eligible professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology

Eligible professionals or group practices will not need to affirmatively request an exemption for these categories. Rather, CMS will use the information provided in the EHR Incentive Program’s Registration and Attestation page to determine whether the exemption applies.
HARDSHIP EXEMPTIONS

To request exemptions:

https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234

*You must make your exemption request by June 30 of the preceding year
(Although this year they re-opened the exemption request period and to avoid the 2013 penalty you can still request an exemption until January 31, 2013)
How to Request an eRx Informal Review for the 2013 or 2014 eRx Payment Adjustments:

- Informal Review Request Method: email
- Deadline:
  - For the 2013 eRx payment adjustment: February 28, 2013
  - For the 2014 eRx payment adjustment: February 28, 2014
DEFINITION: E-Prescribing

• The transmission, using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or health plan either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser.
REQUIREMENTS

• IN ORDER TO BE A SUCCESSFUL E-PRESCRIBER, YOU MUST ADOPT AND UTILIZE A QUALIFIED* ELECTRONIC PRESCRIBING SYSTEM

*CMS has expanded the definition of a qualified e-prescribing system to include any e-prescribing system contained in a certified EHR
COMPONENTS OF A “QUALIFIED” E-PRESCRIBING SYSTEM
1. Generate a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs) if available.
2. Select medications, print prescriptions, electronically transmit prescriptions, and conduct all alerts (defined below)

**Alerts** – Written or acoustic signals to warn prescriber of possible undesirable or unsafe situations, including potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions
3. Provide information related to lower cost, therapeutically appropriate alternatives (if any)

(The availability of an e-prescribing system to receive tiered formulary information, if available, would meet this requirement for 2011.)
4. Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient’s drug plan (if available)
This information must be conveyed using the standards in effect for the Part D e-prescribing program

HOW TO REPORT

• **G8553**: At least one prescription created during the encounter was generated using a qualified e-prescribing system
TO BE SUCCESSFUL

• You must report **G8553** on at least 25 unique patient visits during 2013

• The eligible procedure codes in the denominator must represent at least 10% of your total estimated Part B billings for 2013
Denominator Criteria (Eligible Cases):

Patient encounter during the reporting period (CPT or HCPCS):

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109
Remember the eligibility of a visit is determined by the CPT or HCPCS code that is billed. Just because you e-prescribe during a visit, it does not necessarily mean it is an eligible visit.

- For example, you see a patient with an abscess and you perform an I & D billing CPT code 10060 and e-prescribe an oral antibiotic. Because 10060 is not in the denominator of the measure (remember codes listed on previous slide), this is not an eligible visit to report.
HOW THIS WORKS IN THE REAL WORLD
A 72-year-old female presents to your office as a new patient with the chief complaint of “thick discolored nails.” After performing an appropriate history and physical exam, you make a diagnosis of onychomycosis. After discussion with the patient, the determination is made to start the patient on oral Lamisil.
Diagnosis: Onychomycosis 110.1

CPT Code billed: 99203 (New patient E&M)

You generate a prescription for Lamisil through a qualified e-prescribing system.
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</table>

31. Signature of Physician or Supplier including degrees or credentials:
   (I certify that the statements on the reverse apply to the bill and are made a part thereof.)

32. Name and address of facility where services were rendered (if other than home or office).

33. Physician’s, supplier’s billing name, address, zip code & phone #

Signed: Joe Doe, DPM Date: 2/17/10

PLEASE PRINT OR TYPE
IN SUMMARY:

• Must use qualified e-prescribing system

• Must e-prescribe on at least 25 eligible patient encounters (eligibility determined by denominator codes) during 2013

• Denominator codes must represent at least 10% of your total billings for 2013

• Penalty phase for 2014 will be based on first six months of 2013: You must submit 10 unique e-prescribing visits (*but do not have to be associated with a denominator code) or

• Penalty phase for 2014 will be based on the entire 2012 year: You must be a successful e-prescriber (successfully submit 25 unique e-prescribing visits)
Frequently Asked Questions

• No, you do not have to do three measures on each patient with diabetes if you are reporting measures 126, 127 and 163.

• No you cannot bring patients into the office just to do the quality measures.

• Yes, as part of measure 127 you are supposed to measure the foot, however, the intent of the measure is to be sure that the patient is wearing shoes that fit their feet appropriately.
RESOURCES

There are free eRx programs available:


- [www.practicefusion.com](http://www.practicefusion.com)
RESOURCES

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

• CMS eRx Incentive Program Website
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive

• 2013 PFS Final Rule
  http://www.ofr.gov/(X(1)S(vp32o25ckyhpvspfpzx3owe4))/OFRUpload/OFRData/2012-26900_PI.pdf

• PQRS Frequently Asked Questions (FAQs)
  https://questions.cms.gov/
• QualityNet Help Desk:
  866-288-8912 (TTY 877-715-6222)
  7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@sdps.org
  You will be asked to provide basic information such as name, practice, address, phone, and e-mail

• Provider Contact Center:
Thank you

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