

## **Physician Quality Reporting Initiative (PQRI) 2009**

Once again Medicare is making available to PT Providers in Private Practice who bill their Medicare on HCFA 1500's as an opportunity to participate in Pay for Performance measures. Here are tips for your clinic/facility

The reporting is to be done with Medicare Primary and on the first patient submission. Do not report to other primary payers unless notified or approved to do so. On Medicare Secondary Claims, place PQRI codes on the claims on the first patient submission.

When using the measures, these are items of importance:

1. All ICD-9's are acceptable except for Diabetes diagnosis which requires a 250 series code
2. Quality measure codes must be billed with an eligible CPT Code
3. Must report on 3 of the 7 measures for all applicable Medicare patients.
5. Medicare will calculate acceptable performance based on 80% reporting on applicable measures.

Providers may want to create a simple one page form including the PQRI Measures their clinic selects to be used by therapists at intake & with results submitted to bill with the Evals or Re-Evals as appropriate.

The following 4 asterisked\* measures appear to be ones that you might find easiest to operationalize in an outpatient setting!

### **\*Measure #124: Health Information Technology**

- Patient must be 18 years or older
- Needs to be reported with specific CPT codes such as 97001, 97002, 97750, 97003 or 97004.
- Report one of these codes based on the outcome for this quality measure:  
G8447 — CCHIT (Commission of Certified Healthcare Information Technology) certified EMR used  
G8448 — Non-CCHIT certified EMR used  
G8449- Not documented with EMR at this time. (e.g., system inoperable at the time of the visit), document reason here and in medical chart.

Is your EMR CCHIT certified? Does it manage a medication list; manage a problem list; have manually entering or electronically receiving capabilities, store and display laboratory results as discrete searchable data elements; meeting basic privacy and security elements?

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

- Patient must be 18 years or older and have diagnosis of diabetes mellitus (ICD-9 code in 250s)
- Needs to be reported with specific CPT codes such as 97001, 97002.
- Report one of these codes based on the patient outcome for this quality measure:  
G8404- Lower extremity neurological exam performed  
G8406- Lower extremity neurological exam not performed (e.g. patient was not eligible candidate for lower extremity neurological exam, document reason)  
G8405- Lower extremity neurological exam not performed and no documented reason

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

- Patient must be 18 years or older and have diagnosis of diabetes mellitus (ICD-9 code in 250s)
- Needs to be reported with specific CPT codes such as 97001, 97002.
- Report one of these codes based on the patient outcome for this quality measure:  
G8410- Footwear Evaluation performed  
G8415: Footwear evaluation was not performed  
G8416- Footwear Evaluation not performed (document why evaluation was not performed)

### **\*Measure #128: Body Mass Index Screening and Follow-Up**

- Patient must be 65 years or older and
- Needs to be reported with specific CPT codes such as 97001, 97002.
- Report one of these codes based on the patient outcome for this quality measure:
  - G8417- BMI of greater than or equal to 30 was calculated; follow-up plan documented in the medical record
  - G8418- BMI of less than or equal to 22 was documented and a follow-up plan was documented in the medical record
  - G8419- BMI of less than 22 or greater than 30 was calculated but no follow up plan was documented in the medical record
  - G8420- BMI of less than 30 or greater than or equal to 22 was calculated and documented
  - G8421- BMI not calculated
  - G8422- Patient not eligible for BMI calculation

A height & weight measurement & BMI Calculation can be completed & reported upon evaluation on all patient intake forms along with documenting any proposed follow up to be used for **Medicare Patients  $\geq$  65.**

### **Measure #130: Universal Documentation and Verification of Current Medications in the Medical Record**

- Patient must be 18 years or older
- Needs to be reported with specific CPT codes such as 97001, 97002, 97003, and 97004.
- Current medications with dosages need to be verified with patient and included in the medical record
- Report one of these codes based on the patient outcome for this quality measure:
  - G8427- Written provider verification was obtained confirming current medications with dosages, verified with the patient and included in the medical record.
  - G8428- Current medications with dosages were documented without documented patient verification
  - G8429- Incomplete or no documentation that patient's current medications with dosages were assessed
  - G8430- Documentation that patient is not eligible for medical assessment
  - G8507: Provider documentation that patient is not eligible for patient verification of current medications

### **\*Measure #131: Pain Assessment Prior to Initiation of Patient Therapy**

- Patient must be 18 years or older
- Needs to be reported with specific CPT codes such as 97001, 97003.
- Report one of these codes based on the outcome for this quality measure:
  - G8440- Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of no pain as a result from assessment.
  - G8441- No documentation of pain assessment prior to start of treatment.
  - G8442- Documentation that patient is not eligible for pain assessment
  - G8508: Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, patient not eligible
  - G8509: Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, reason not specified

A Pain Assessment Tool such as the Pain Scale (1-10/10) can easily be added to all patient intake forms to be used for **Medicare Patients  $\geq$  18.**

### **\*Measure #154: Fall Risk Assessment**

- Patient must be 65 years or older
- Needs to be reported with CPT codes such as 97001, 97002, 97003, 97004
- Risk Assessment – Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months.
- Report the following code(s) based on the outcome obtained from applying the measure:
  - 3288F & 1100F: Falls risk assessment documented & patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year
  - 3288F-1P & 1100F Risk Assessment for falls not completed for medical reasons, append a modifier (1P) to 3288F to report documented circumstances that appropriately exclude patients from the denominator.
  - 1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year.
  - 1101F- 8P: No documentation of falls status
  - 3288F-8P & 1100F: Risk Assessment for Falls not Completed, Reason not Specified, append a reporting modifier (8P) to 3288F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
  - 3288F- 8P & 1100F: Falls risk assessment not completed, reason not otherwise specified, and patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

### **\*The Fall Assessment:**

This assessment should be part of an individualized, multifactorial intervention. Multifactorial assessment may include the following: identification of falls history, assessment of gait, balance and mobility, and muscle weakness; assessment of osteoporosis risk; assessment of the older person's perceived functional ability and fear relating to falling; assessment of visual impairment; assessment of cognitive impairment and neurological examination; assessment of urinary incontinence; assessment of home hazards; cardiovascular examination and medication review; review of all medications and doses; evaluation of gait and balance, mobility levels and lower extremity joint function; examination of neurological function, muscle strength, proprioception, reflexes, and tests of cortical, extrapyramidal, and cerebellar function and cognitive evaluation; screening for depression; assessment of postural blood pressure; assessment of heart rate and rhythm, assessment of home environment

The Question: "Have you experienced any problems with falling in the past year?" can easily be added to all patient intake forms.

### **Measure #155: Falls Risk Plan of Care (paired with #154 Screening for Falls when a risk of falls has been identified)**

- This measure *should* be reported if CPT II code 1100F "Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year" is submitted for Measure #154.
- Patient must be 65 years or older
- Needs to be reported with CPT codes such as 97001, 97002, 97003, 97004
- Report the following code(s) based on the outcome obtained from applying the measure:
  - 0518F: Falls plan of care documented
  - 0518F-1P: Documentation of medical reason(s) for no plan of care for falls
  - 0518F-8P: Plan of care not documented, reason not otherwise specified

**Plan of Care** – Must include consideration of appropriate assistance device and balance, strength, and gait training. Medical record must include documentation that an assistive device was provided or considered OR referral for evaluation for an appropriate assistance device.

### **Reference & Resources:**

**Physician Quality Reporting Initiative (PQRI)**  
[www.cms.hhs.gov/PQRI/31\\_PQRIToolKit.asp](http://www.cms.hhs.gov/PQRI/31_PQRIToolKit.asp)

[www.apta.org/pqri](http://www.apta.org/pqri)

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