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2010 E-Prescribing (eRx) Update

By Diane Krier-Morrow

Diane Krier-Morrow MBA, MPH, CCS-P

2010 brought a number of changes in CMS policy for physicians. However, there are a few potentially positive policies to which practices should pay attention. Physicians should consider active participation in PQRI, as participants could realize a two-percent bonus payment on all Medicare allowables reported in 2010, not just the claims that include the PQRI code(s). There is an additional two-percent bonus payment for practices participating in electronic prescribing. If you do both, that is a four-percent increase.

Claims-Based Reporting eRx

Electronic prescribing (eRx) had been part of PQRI (**#125**). It is now unnumbered and stands as its own Medicare benefit. The CMS Web site (**www.cms.hhs.gov/ERxIncentive**) reveals that reporting requirements are simplified. Measures are reported only through individual claims-based and registries.

- To report electronic prescribing, a qualified eRx system must have been adopted. No provider enrollment is required. A qualified eRx system is capable of:
  - generating a complete active medication list;
  - selecting medications, print prescriptions, electronically transmit prescriptions and conduct alerts (e.g., inappropriate dose, route of administration, drug-drug interactions, allergy concerns, or warnings and caution);
  - electronically transmitting prescriptions and conduct alerts (e.g., inappropriate dose, route of administration, drug-drug interactions, allergy concerns, or warnings and caution);
  - providing information on lower cost, therapeutically appropriate alternatives (if any); and
  - providing information on formulary or tiered formulary medications, patient eligibility and authorization requirements received electronically from the patient's drug plan (if available).
- For prescription(s) generated and transmitted via qualified eRx systems, report HCPCS code **G8553—At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.**
- Code **G8553** (called the numerator) must be reported on the same claim form as the denominator codes, for the same beneficiary, same date of service, by the same individual NPI who performed the covered service.
- Denominator codes are reporting any ICD-9-CM diagnosis codes, and must include one of the following CPT Category I or HCPCS codes relevant to pulmonary medicine: New and established office/outpatients **99201-99215**; Nursing facility care, **99304-99316**, Domiciliary, rest home or custodial care, **99324-99337**, Home services, **99341-99350** and Health and behavior assessment, **96150-96152**, on the same claim form.
- Code **G8553** must be submitted with a line-item charge of zero dollars ($0.00). The charge field cannot be blank. If the system doesn't allow zeroes in the charge field, use $0.01.
- On the remittance advice notice, a standard remark code (**N365**) reads: "This procedure code is not payable. It is for reporting/information purposes only." **N365** indicates that the eRx G-code passed into the National Claims History database.
- Claims may not be resubmitted for the sole purpose of adding or correcting an eRx code. Faxes do not qualify as electronic prescribing. CMS includes a sample completed claim on its Web site.
- The individual eligible professional who generates at least one eRx associated with a patient visit on 25 or more unique events during the reporting period (January 1 through December 31, 2010) will be eligible for a two-percent incentive payment on all Medicare allowed charges—only if 10 percent of the eligible professional's Medicare Part B charges are comprised of the denominator codes.

Q&A

Fibrinolysis

Q. When billing the new fibrinolysis codes with a hospital follow-up evaluation and management service, should the E/M be appended with a modifier?

A. Yes. For example, **99232-25** and **32561** is the appropriate way to report fibrinolysis on the same day with an Evaluation and Management Service.

Physician Supervision Requirements for PFTs

Q. I have a question regarding Pulmonary Function Tests when the physician owns the equipment. After reading the physician supervision requirements for level 2 supervision, I understand that there is a requirement of the presence of a physician in the office when any inhaled medication is administered by a non-physician. In the CMS LCD L29382, under indications, it states: "All pulmonary diagnostic studies must be: (1) performed by a qualified physician, or (2) performed under the general supervision of a qualified physician by a technologist who has demonstrated minimum entry level competency by being credentialed by a recognized national credentialing body such as the National Board for Respiratory Care (NBRC). In addition to receiving credentialing by a recognized national credentialing body, qualified technologists must have a state license."

There is no mention of the administration of medication. So I am a little confused as to whether the physician needs to be in the office or not. Would you please clarify?

(**Q&A** *continued on page 6*)

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Is PQRI Right for You?

This article contains valuable information on how physicians can report PQRI measures to take advantage of Medicare's payment bonus in 2010. From what we know about the program, it is clear that practices should become knowledgeable about PQRI and consider whether their participation makes sense. Additional individual and group measures directly applicable to the pulmonary, critical care and sleep communities will be developed that will make the program more attractive over time. Below are questions to consider if PQRI is right for your practice.

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Q. Do I have enough patient volume?

A. While most physicians see plenty of patients to keep them busy, you must ask yourself: does your practice see the appropriate volume of patients needed for PQRI? For example, the CMS recently added a PQRI measures group for community-acquired pneumonia or CAP. Unlike the individual measures that require you to report the PQRI measures on 80 percent of the patients you see with the appropriate diagnosis code and E/M code, the CAP PQRI group measure requires you to report a minimum of 30 patients during one year (or 15 patients over a period of six months if you begin participating in July).

For those physicians who see 30 CAP patients each year, reporting the PQRI CAP group measure is very doable. However, if you see fewer CAP patients, reporting this measure won't result in a Medicare bonus payment.

Q. Do I have the right systems in place to report on PQRI measures?

A. Reporting PQRI measures does require additional coding work on the part of physicians and their staffs. Electronic medical records can facilitate the PQRI reporting process and many electronic medical record venders offer automated PQRI reporting systems. Some vendors have also developed standalone software to assist physician offices in reporting PQRI measures.

Whether your practice has an electronic medical record system in place, you plan on purchasing PQRI reporting software or you report codes manually, offices should evaluate their current systems before embarking on PQRI.

Q. Are the existing PQRI measures applicable to my practice?

A. Currently, there are a number of individual measures that are applicable to the pulmonary community: physicians can report on pneumonia, asthma, smoking cessation and COPD. Currently, there is only one measure for critical care and none specific to sleep. To receive the PQRI bonus, physicians must report on at least three or more measures for 80 percent of all patients who are 18 or older. For asthma, measures apply to patients from the ages of five to 40.

An easier approach is to report group measures, which require a minimum of reporting on only 30 patients (as opposed to 80 percent of all adult patients for three or more individual measures). For physicians who see 30 or more CAP patients in a year, PQRI is probably an attractive way to enhance all other Medicare payments. While there is a preventive care group measure on which a few pulmonary practices could report—because you need to perform all component parts of a group measure—the CAP measure is the only group directly applicable to the pulmonary community.

Q. Does the PQRI payment justify the cost of collecting the data?

A. Is the payment worth the effort? For successful PQRI reporters, Medicare pays a two-percent bonus on the total Medicare reimbursement for providers in the calendar year. Two-percent could be a nominal or substantial number, depending on your practice. In 2008, the most recent year from which data is available, the CMS reported that more than 153,000 providers reported PQRI data. Of those, over 85,000 received PQRI bonus payments totaling $92 million. The average PQRI physician payment bonus was just over $1,000 in 2008.

Whether it's worth the effort will depend on the volume of Medicare patients your practice sees, the billing systems you have in place and whether you keep medical records electronically. Other factors include the efficiency of your staff and your practice's motivation.

Q. What does the future hold?

A. Most observers believe that the current voluntary PQRI reporting program will become mandatory at some point. Legislation before Congress would make the program mandatory for physicians who accept Medicare reimbursements. Practices may want to weigh the advantages of being an early adopter of PQRI, rather than waiting until reporting is a Medicare requirement.

If PQRI is a good fit for you and your practice, the following information focuses on the technical details regarding what measures are available and the mechanics of how to report them. As always, if you have questions or need more information about PQRI, e-mail us at **CodingQuestions@thoracic.org**.

2010 Pulmonary PQRI Performance Measures

New for 2010: Pneumonia Measures Group

CMS released the PQRI specifications for 2010 reporting through both claims-based and registry reporting. One of the 13 measures groups is for CAP, which bundles **#56** Vital Signs, **#57** Assessment of Oxygen, **#58** Assessment of Mental Status, **#59** Empiric Antibiotic Prescribed. In 2008, all four individual pneumonia measures were on the top 10 list for highest reporting. Remember, this measure requires you to either report on 80 percent of the patients you see with the appropriate diagnosis code and E/M code—or on 30 patients during one year (or 15 patients over a period of six months, if you begin participating in July). These need not be consecutive patients, which was a previous reporting criteria for measures groups. It is important to note that claims cannot be resubmitted just to add a quality measure code.

How to Report CAP Measures

For patients 18 years and older, report **G8546** (I intend to report the CAP Measures Group) on **ONLY the first claim** form with an ICD-9-CM pneumonia diagnosis codes **481-483.8**, **486**, **487.0**, where the following office or other outpatient procedure was performed:

New Patient **99201-99205**;
Established Patient **99212-99215**;
Emergency Department **99281-99285**;
Critical Care **99291** (you must report ED place of service 23 on the Part B claim form only for **99291**);
Domiciliary, Rest Home, Custodial Care; **99324-99337**, Home Services **99341-99350**, on the same claim form.

If all of the quality actions for the patient have been performed for all measures within the group (**#56-#59**), the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. The CAP Measures Group Composite G code needs to be reported for every claim during each occurrence of CAP:

G8550: All quality actions for the applicable measures in the CAP Measures Group have been performed for this patient. This CAP measures code is reported once during each occurrence (i.e., during the 45-day period from the onset of CAP).

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Report **0.00** in the payment field. For claims-based submissions, the carrier/MAC remittance advice notice sent to the practice will show a denial remark code **N365** for the line item on the claim containing quality codes, indicating that the code is not payable and should be used for reporting/information purposes only. Other codes reported on the claim will not be affected by the data code reporting. The **N365** code indicates that the quality code was processed and transmitted.

Additional information on specifications is available at **www.cms.hhs.gov/pqri** in the "Code Measures" section of the site.

Individual Performance Measures

Pay For Performance Initiatives are developed in nearly all sites of service to focus on the performance of quality medicine. In December 2009, the CMS finalized the list of performance measure specifications for its 2010 PQRI initiative, which began January 1, 2010 (or for physicians reporting for six months, the initiative begins July 1, 2010).

All 175 measures have been reviewed, and the eight specific measures relevant to the pulmonary and critical care communities—two for COPD, four for pneumonia and two for asthma—are the same since inception of the PQRI program on July 1, 2007. The only addition in 2010 is the CAP measures group described above. The CMS has removed **#125** (e-prescribing) from the list of PQRI measures and now handles it separately.

Select a Reporting Option

In 2010, there are five reporting options: claims-based, qualified registry, measures groups, qualified electronic health reporting (for individual measures only) and group practice (for practices with more than 200 physicians). Most pulmonary and critical care practices will be reporting measures related to COPD, pneumonia, asthma and other disorders. For the COPD and pneumonia measures, the patient must be at least 18 years old. For the central venous catheter insertion protocol measure (**#76**), there are no age requirements. Asthma measures **#53** and **#64** are limited to patients from the ages of five to 40. And remember, physicians can only report COPD and asthma measures once per reporting period, while pneumonia measures can be reported with each occurrence.

Specifications of these measures are detailed on the CMS Web site and are available at **www.cms.hhs.gov/pqri** in the "Measures Codes" section of the site. Denominator codes are the universe of eligible cases and are listed below as the ICD-9-CM diagnoses and the CPT Evaluation and Management codes, or CMS G-codes. The numerator quality-data codes (QDC) are the CPT Category-II codes listed below. Review closely the appropriate modifiers specific to PQRI reporting. The only change from 2009 on the list below is the deletion of the consultation codes, **99241-99245**. For the measure **#75** for VAP, head elevation was deleted for 2009. Note the STS measure **#157** for thoracic surgery: recording of clinical stage for lung cancer and esophageal cancer resection. In 2010, there is a new group practice reporting option for practices with more than 200 eligible providers identified by individual NPIs, who have reassigned billing rights to the tax identification number or TIN. Large group practices should have sent a self-nomination letter to the CMS by January 31, 2010. So watch this reporting method for 2011 if the practice qualifies by size.

Both the 2010 PQRI Quality Measure Specifications Manual and Release Notes and 2010 PQRI Measures Groups Specifications Manual are posted online at **www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage**.

The following performance measures are of interest to pulmonologists; five general performance measures listed below are clinical performance measures and the last one is a structural performance measure. Details on the modifiers follow later in this article.

PM#	Descriptor	CPT II Code	Appropriate Modifiers	ICD-9-CM	CPT E/M Codes
	COPD				
51	COPD: Spirometry Evaluation (aged 18 and older)	**3023F**	**1P, 2P, 3P, 8P**	**491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496**	**99201-99205, 99212-99215**
52	COPD: Bronchodilator Rx (aged 18 and older)	**4025F + 3025F or 3027F**	**1P, 2P, 3P, 8P to 4025F + 3025F or 3025F-8P + 3027F**	**491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496**	**99201-99205, 99212-99215**
	Pneumonia				
56	Community-Acquired Bacterial Pneumonia: Vital Signs (aged 18 and older)	**2010F**	**8P**	**481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0**	**99201-99205, 99212-99215, 99281-99285, 99291** (99291 requires POS 23, performed in ED) **99324-99350**
57	Community-Acquired Bacterial Pneumonia: Assessment of Oxygen Saturation (aged 18 and older)	**3028F**	**1P, 2P, 3P, 8P**	**481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0**	**99201-99205, 99212-99215, 99281-99285, 99291** (99291 requires POS 23, performed in ED) **99324-99350**
58	Community-Acquired Bacterial Pneumonia: Assessment of Mental Status (aged 18 and older)	**2014F**	**8P**	**481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0**	**99201-99205, 99212-99215, 99281-99285, 99291** (99291 requires POS 23, performed in ED) **99324-99350**
59	Community-Acquired Bacterial Pneumonia: Empiric Antibiotic (aged 18 and older)	**4045F**	**1P, 2P, 3P, 8P**	**481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0**	**99201-99205, 99212-99215, 99281-99285, 99291** (99291 requires POS 23, performed in ED) **99324-99350**

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Pulmonary Performance Measures Description

Chronic Obstructive Pulmonary Disease

#51 COPD: Spirometry Evaluation:

Percentage of patients **aged 18 years and older** with a diagnosis of COPD who had spirometry evaluation results documented. Report a minimum of **once per reporting period**. Do not limit the search for spirometry results to the reporting period.

CPT II **3023F** Spirometry results documented and reviewed.

#52 COPD: Bronchodilator Therapy:

Percentage of patients **aged 18 years and older** with a diagnosis of COPD and who have an FEV_1/FVC less than 70 percent and who have symptoms and were prescribed an inhaled bronchodilator. Report a minimum of **once per reporting period** for all COPD patients seen during the reporting period.

CPT II **4025F** Inhaled bronchodilator prescribed **AND**

CPT II **3025F** Spirometry test results demonstrate FEV_1/FVC less than 70 percent with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing) **OR**

CPT II **3027F** Spirometry test results demonstrate FEV_1/FVC greater than or equal to 70 percent or patient does not have COPD symptoms.

Pneumonia

#56 Vital Signs for Community-Acquired Bacterial Pneumonia:

Percentage of patients **aged 18 years and older** with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed. Report once for **each occurrence** of CAP during the reporting period.

CPT II **2010F** Vital signs (temperature, pulse, respiratory rate and blood pressure) documented and reviewed.

#57 Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia:

Percentage of patients **aged 18 years and older** with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed. Report once for **each occurrence** of CAP during the reporting period.

CPT II **3028F** Oxygen saturation results documented and reviewed (includes assessment through pulse oximetry or arterial blood gas measurement).

#58 Assessment of Mental Status for Community-Acquired Bacterial Pneumonia:

Percentage of patients **aged 18 years and older** with a diagnosis of community-acquired bacterial pneumonia with mental status assessed. Report once for **each occurrence** of CAP during the reporting period.

CPT II **2014F** Mental status assessed.

#59 Empiric Antibiotic for Community-Acquired Bacterial Pneumonia:

Percentage of patients **aged 18 years and older** with a diagnosis of community-acquired bacterial pneumonia with appropriate empiric antibiotic prescribed. Report once for **each occurrence** of CAP during the reporting period.

CPT II **4045F** Appropriate empiric antibiotic prescribed.

Asthma

#53 Asthma: Pharmacologic Therapy:

Percentage of patients **aged five through 40 years** with a diagnosis of mild, moderate or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment. Report a minimum of **once per reporting period** for all asthma patients seen during the reporting period.

CPT II **4015F** Persistent asthma, preferred long-term control medication or acceptable alternative treatment prescribed **AND**

CPT II **1038F** Persistent asthma (mild, moderate or severe).

#64 Asthma Assessment:

Percentage of patients **aged five through 40 years** with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms. Report a minimum of **once per reporting period**.

CPT II **1005F** Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire).

Catheter-related Bloodstream Infections (CRBSI)

#76: Prevention of Catheter-Related Bloodstream Infections (CRBSI)—Central Venous Catheter Insertion Protocol

Percentage of patients, **regardless of age**, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique (cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine or cutaneous antisepsis, or acceptable alternative antiseptics, per current guideline) followed. Report **each time** a CVC insertion is performed during the reporting period.

CPT II **6030F** All elements of maximal sterile barrier technique (including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis, or acceptable alternative antiseptics, per current guideline) followed (only use modifiers 1P or 8P).

Smoking Cessation

#114: Inquiry Regarding Tobacco Use:

Percentage of patients **aged 18 years or older** who were queried about tobacco use one or more times within 24 months prior to the date of service. Report a minimum of **once per reporting period** for all patients seen during the reporting period.

CPT II **1000F** Tobacco use assessed (only modifier **8P**) **AND**

CPT II **1034F** Current tobacco smoker **OR**

CPT II **1035F** Current smokeless tobacco user (e.g., chew or snuff) **OR**

CPT II **1036F** Current tobacco non-user.

#115: Advising Smokers and Tobacco Users to Quit:

Percentage of patients **aged 18 years and older** and are smokers or tobacco users who received advice to quit smoking. Report a minimum of **once per reporting period** for all patients (whether or not they use tobacco) seen during the reporting period.

CPT II **G8455** Current tobacco smoker **OR**

CPT II **G8456** Current smokeless tobacco user (e.g., chew or snuff) **AND**

CPT II **4000F** Tobacco use cessation intervention, counseling **OR**

CPT II **4001F** Tobacco use cessation intervention, pharmacologic therapy **OR**

CPT II **G8457** Current tobacco non-user.

Thoracic Surgery - Lung Cancer Staging

#157: Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection:

Percentage of surgical patients **aged 18 years and older** undergoing resection for lung or esophageal cancer who had clinical TNM staging provided prior to surgery. Report **each time** a major cancer resection of the lung or esophagus is performed.

CPT II **3323F** Clinical tumor, node and metastases (TNM) staging provided prior to surgery.

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General Clinical Performance Measures

#46 Medication Reconciliation: Reconciliation after Discharge from an Inpatient Facility

Percentage of patients **aged 65 years and older** discharged from any inpatient facility (e.g., hospital, skilled nursing facility or rehabilitation facility) and seen within 60 days following discharge in the office by the physicians providing ongoing care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.

CPT II **1111F** Discharge medications reconciled with the current medication list in outpatient medical record (only modifier **8P** allowed) **AND**

CPT II **1110F** Patient discharged from an inpatient facility (e.g., hospital, skilled nursing facility or rehabilitation facility, such as LTACH) within the last 60 days.

#47 Advance Care Plan:

Percentage of patients **aged 65 years and older** who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan in the medical record. Report **once per reporting period**.

CPT II **1123F** Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record (only modifier **8P** allowed) **OR**

CPT II **1124F** Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

#110: Preventive Care and Screening: Influenza Vaccination for Patients Aged 50 Years or Older:

Percentage of patients **aged 50 years and older** who received an influenza immunization during the flu season (September through February). Report **once per reporting period**.

CPT II **G8482** Influenza immunization was ordered or administered **OR**

CPT II **G8483** Influenza immunization was not ordered or administered for reasons documented by clinician.

CPT II **G8484** Influenza immunization was not ordered or administered, reason not specified.

#111 Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older:

Percentage of patients **aged 65 years and older** who have ever received a pneumococcal vaccine. Report **once per reporting period**.

CPT II **4040F** Pneumococcal vaccine administered or previously received (only **1P**, **8P** modifiers).

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

Percentage of patients **aged 18 years and older** with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative is documented by the provider. Report at **each visit** during the reporting period.

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Quality measures for 2010 PQRI are listed below. A sample pulmonary PQRI encounter form, including four PQRI measures, is also provided.

Sample Quality Reporting for Physicians

Patient Name: Acct #: DOB: Age: DOS: Last Dx Codes:

Measure #51: Spirometry	Measure #52 – Bronchodilator Therapy	Measure #114 – Inquiry Regarding Tobacco Use	Measure #115 – Advising Smokers to Quit
Age: $\geq$ 18 Y N	Age: $\geq$ 18 Y N	Age: $\geq$ 18 Y N	Age: $\geq$ 18 Y N
Dx: **491.0 491.8** Y N **491.1 491.9** **491.20 492.0** **491.21 492.8** **491.22 496**	Dx: **491.0 491.8** Y N **491.1 491.9** **491.20 492.0** **491.21 492.8** **491.22 496**	No specific Dx required	No specific Dx required
E/M: New **99201 99202 99203 99204 99205** Est **99212 99213 99214 99215**	E/M: New **99201 99202 99203 99204 99205** Est **99212 99213 99214 99215**	E/M: New **99201 99202 99203 99204 99205** Est **99212 99213 99214 99215**	E/M: New **99201 99202 99203 99204 99205** Est **99212 99213 99214 99215**
Report on Same Claim Form	Report on Same Claim Form	Report on Same Claim Form	Report on Same Claim Form
Spirometry results doc & rev **3023F**	Patient has COPD symptoms, spiro test results = FEV/FVC $< 70\%$ **3025F**	Tobacco use assessed **1000F**	Pt does not use tobacco **G8457**
OR	Inhaled bronchodilator prescribed **3025F & 4025F**	Pt does not use tobacco **1000F & 1036F**	Current smokeless tobacco user **G8456**
Not reviewed and documented for one of the following reasons:	**OR** Bronchodilator not prescribed	Smokeless tobacco user **1000F & 1035F**	Current tobacco smoker **G8455**
Medical reason **3023F-1P**	Medical reason **4025F-1P**	Current tobacco smoker **1000F & 1034F**	**AND**
Patient reason **3023F-2P**	Patient reason **4025F-2P**		Counseling **4000F**
System reason **3023F-3P**	System reason **4025F-3P**		**OR**
OR Not doc or rev, no reason **3023F-8P**	**OR** Not prescribed, not doc **4025F-8P**	**OR** Tobacco use not assessed **1000F-8P**	Pharmacologic Intervention **4001F**
	OR Patient has no COPD symptoms, spirometry test results = FEV/FVC $\geq 70\%$ **3027F**		**PHYSICIAN SIGNATURE**
	OR Spirometry not performed, or doc **3025F-8P**		

If age, diagnosis or CPT code is not as indicated above, do not report performance measure code(s). Report on each of the four measures above once per reporting period (i.e., report only once between January 1 and December 31, 2010, or if you plan to participate for a six-month period, between July 1 and December 31, 2010).

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PM#	Descriptor	CPT II Code	Appropriate Modifiers	ICD-9-CM	CPT E/M Codes
	Asthma (note age requirement)				
53	Asthma: Pharmacologic Therapy (aged five to 40)	**4015F + 1038F or 1039F**	**4015F-2P or -8P+ 1038F or 1039F**	**493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92**	**99201-99205, 99212-99215**
64	Asthma Assessment (aged five to 40)	**1005F**	**8P**	**493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92**	**99201-99205, 99212-99215**
	CVS Protocol				
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI)—Central Venous Catheter (CVC) Insertion Protocol	**6030F**	**1P, 8P**	Any diagnosis with a CVC inserted	**36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 93503 SWAN GANZ**
	Smoking				
114	Inquiry Regarding Tobacco Use	**1000F + 1034F, 1035F or 1036F**	**8P**	Any diagnosis	**99201-99205, 99212-99215**
115	Advising Smokers to Quit	**G8455 or G8456 + 4000F or 4001F** [or **G8457** non-user]	**4000F-8P + G8455**	Any diagnosis	**99201-99205, 99212-99215**
	Thoracic Surgery				
157	Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection	**3323F**	**1P, 8P**	**150.3, 150.4, 150.5, 162.2, 162.3, 162.4, 162.5**	**32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32500, 32503, 32504, 32657, 32663, 43107, 43108, 43112, 43113, 43117, 43118, 43121, 43122, 43123**

*Note that **99211** is not included as any of the denominator codes above. For 2010 reporting, all 175 performance individual measure specifications are available on the CMS Web site.

Q&A *(continued from page 1)*

A. The physician needs to be in the office when medication is administered in case anything goes wrong. I checked with one of the respiratory therapists from the AARC who said: "Under Part B coverage rules, respiratory therapists need 'direct supervision' from a physician. This means the physician must be nearby, in the building, but not necessarily in the room. This comes from Title 18 & 19 of the 1965 Social Security Act. As you probably know 'general supervision' means the physician is accessible by phone or pager and does not need to be in the building. When giving treatments to inpatients, physician supervision requirement does not apply. Except that everything RTs do is based on a physician or physician extender's orders".

Pulmonary Performance Measures Description *(continued from page 5)*

CPT II **G8427** List of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative is documented by the provider.

CPT II **G8428** Provider documentation of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) without documented patient verification.

CPT II **G8429** Incomplete or no provider documentation that the patient's current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were assessed.

CPT II **G8430** Provider documentation that patient is not eligible for medication assessment (e.g., refuses, urgent or emergent medical situation, cognitively impaired and no authorized representative available).

CPT II **G8507** Provider documentation that patient is not eligible for patient verification of current medications.

Cross-references and origins of Category II performance measures are listed in the Index of Clinical Alphabetical Topics for CPT 2010, which is available online at **www.ama-assn.org/ama1/pub/upload/mm/362/cptcat2-alpha-measures-index.pdf**.

Structural Measure

#124: HIT - Adoption/Use of Electronic Health Records (EHR):
CPT II **G8447** Patient encounter was documented using a CCHIT certified EMR **OR**

CPT II **G8448** Patient encounter was documented using a qualified (non-CCHIT certified) EMR.

PQRI Modifiers

1P Performance Measure Exclusion Modifier due to Medical Reasons (eg, not indicated (absence of organ/limb, already received/performed); contraindicated (patient allergic history, potential adverse drug reaction)

2P Performance Measure Exclusion Modifier due to Patient Reasons (eg, patient declined; economic, social, or religious reasons)

3P Performance Measure Exclusion Modifier due to System Reasons (eg, resources to perform the services not available; insurance or coverage/payer-related limitations)

Reporting Modifier

8P Report appended to CPT Category II code to report circumstances when the action described in the performance measure is not performed and the reason is not otherwise specified

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