

# Physician Quality Reporting System (PQRS): Updates for 2013

## Purpose

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This fact sheet includes important information about changes to the Physician Quality Reporting System (PQRS) for 2013. A web page dedicated to providing all the latest news on PQRS is available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS> on the Centers for Medicare & Medicaid Services (CMS) website.

## Important Changes for 2013 PQRS

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The following are key changes to the 2013 PQRS:

- 2015 PQRS payment adjustment will be based on 2013 program year data
  - Addition of administrative claims reporting method for purposes of avoiding the 2015 PQRS payment adjustment
- Addition and deletion of quality measures for a total of 203 measures available for claims and/or registry-based reporting (number does not include measures available for EHR reporting)
- Addition of one new PQRS measures group and retirement of one measures group for a total of 22
- Revisions to reporting requirements, including:
  - Deletion of the 50% reporting option for claims-based reporting of measures groups
  - Deletion of the 80% reporting option for registry-based reporting of measures groups
  - 30-patient sample option changed to 20-patient sample for claims- and registry-based reporting of measures groups
  - Registry-based reporting of measures groups may include Medicare Part B and non-Medicare patients (the majority [11 out of 20] must be Medicare Part B)
  - Group Practice Reporting Option (GPRO) expanded to include groups of 2 or more eligible professionals
  - Expanded use of the registry-based reporting mechanism to group practices participating in the GPRO

## PQRS Payment Adjustments

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Beginning in 2015, if an eligible professional or group practice does not satisfactorily submit data on PQRS quality measures, a 1.5% payment adjustment will apply. The adjustment (98.5% of the fee schedule amount that would otherwise apply to such services) applies to covered professional services furnished by an eligible professional or group practice during 2015.

- There are 3 ways an individual eligible professional or a group practice participating in the GPRO may meet the criteria for avoiding the 2015 PQRS payment adjustment (refer to **Appendix 3**):
  1. Meet the criteria for satisfactory reporting for the 2013 PQRS Incentive
  2. Report 1 valid measure or measures group using the claims, registry, or EHR-based reporting mechanisms (measures groups are not reportable via EHR)
  3. Elect to be analyzed under the administrative claims-based reporting mechanism
    - ◆ The election period will be available via web beginning summer 2013 and will end October 15, 2013 – CMS will distribute the URL for this website when it becomes available

## Administrative Claims

Administrative claims is a new reporting mechanism to avoid the 2015 PQRS payment adjustment. Under this option, CMS will analyze claims data to determine which measures were satisfactorily reported for the 2013 program year. More information regarding administrative claims and how eligible professionals can elect this option will be posted on the CMS website as it becomes available.

Additional information on the PQRS payment adjustment can be found on the CMS PQRS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>.

## 2013 PQRS – Individual Measures

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Several new quality measures reportable via claims and registry were added for the 2013 program year. Fifteen individual measures were retired and 9 measures were added, totaling 259 quality measures for 2013 PQRS.

- **Appendix 1** lists the 15 2012 measures that were retired for 2013. Please see the 2013 measures documents at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS> for specifics.

**NOTE:** The 2013 PQRS measure specifications for any given individual quality measure may be different from specifications for the same quality measure used for 2012. **Eligible professionals should ensure that they are using the most current version of the 2013 PQRS measure specifications.**

## 2013 PQRS – Measures Groups

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For 2013, there are a total of 22 measures groups. Twenty-one measures groups were retained from 2012 and one new measures group was added for 2013. The new measures group is Oncology. For specific measures groups changes from 2012 to 2013, please reference the *2013 Physician Quality Reporting System (PQRS) Measures Groups Release Notes* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>.

**NOTE:** The specifications for measures groups differ from those provided for individual reporting; therefore, the specifications and instructions for measures groups are separate from the specifications and instructions for the 2013 individual measures. The *2013 Physician Quality Reporting System (PQRS) Measures Groups Specifications* for any given measures group may be different from specifications for the same measures group used for 2012. **Eligible professionals should ensure that they are using the most current version of the 2013 measures group specifications.**

## Satisfactory Reporting Criteria for Incentive Purposes – Individual Eligible Professionals

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Changes to the reporting requirements for individual eligible professionals include:

- Changes to the criteria for satisfactory reporting of individual measures by individual eligible professionals
- Minor changes to the criteria for satisfactory reporting for individual eligible professionals who choose to report measures groups (Refer to Tables 2 and 4 in **Appendix 2**).

As in previous years, an eligible professional who reports on fewer than three individual measures via claims may also be subject to the Measure-Applicability Validation (MAV) process to make certain there are no additional measures on which the eligible professional could have reported.

- The criteria used to determine whether an eligible professional satisfactorily reports for the 2013 PQRS are summarized in Tables 1 through 5 in **Appendix 2**.

## International Classification of Diseases-Tenth Revision (ICD-10-CM) Implementation

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CMS will be aligning PQRS with the implementation of ICD-10-CM codes as follows:

- *2013 PQRS Claims/Registry Measures Specifications* include ICD-10-CM codes as a reference only, and will not be accepted for 2013 PQRS measure reporting. Eligible professionals should continue to use the ICD-9-CM codes for 2013 PQRS reporting.
- *2014 PQRS Claims/Registry Measures Specifications* will provide ICD-10-CM codes for reporting purposes during the 2014 PQRS program year.
- For 2013 EHR, ICD-10-CM codes are included in the *2013 EHR Downloadable Resource Table* as a reference (and will be accepted by the system if submitted) but will not be used for measure calculations since the ICD-10-CM implementation date has been extended to 2014.
- For 2014 EHR, ICD-10-CM codes are included in the *2014 EHR Downloadable Resource Table* and will be accepted by the system and used for measure calculations starting in 2014.

## Physician Quality Reporting System – Medicare EHR Incentive Pilot

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CMS has continued the PQRS – Medicare EHR Incentive Pilot for the 2013 program year.

- Successful participation in the pilot will allow receipt of the 2013 PQRS incentive and demonstrate meaningful use of the clinical quality measure (CQM) component of the EHR Incentive Program.
- For additional details on the Physician Quality Reporting System-Medicare EHR Incentive Pilot, please see the *2013 Physician Quality Reporting System-Medicare EHR Incentive Pilot Quick-Reference Guide* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Electronic-Health-Record-Reporting.html>.

## PQRS Group Practice Reporting Option (GPRO)

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2013 PQRS GPRO has expanded to include groups of 2 or more individual eligible professionals.

Also new for 2013 GPRO is the option for groups of all sizes to report via registry.

- Group practices must self-nominate using the Quality Reporting Communication Support Page (Communication Support Page) before January 31, 2012.
- Group practices who do not self-nominate will have an additional opportunity to elect to report as a GPRO beginning summer 2013 and ending October 15, 2013. Those who previously self-nominated may change their selected reporting option during this timeframe.
- 2013 self-nomination and reporting requirements can be found at [http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMS-Selected-Group\\_Practice\\_Reporting\\_Option.htm/](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMS-Selected-Group_Practice_Reporting_Option.htm/).
- Group sizes, reporting mechanisms, and reporting criteria under the GPRO are summarized in Table 7 in **Appendix A**.

**Note:** Group practices of 100 or more eligible professionals may be subject to the Value-Based Payment Modifier. More information can be found at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>.

### Aligning with Medicare Shared Savings Program

2013 PQRS GPRO has adopted the Medicare Shared Savings Program method of assignment and sampling for those group practices who choose to report via the GPRO Web Interface.

## Appendix 1: 2012 PQRS Measures Retired for 2013

Measure Number	Measure Title
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports
57	Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation
58	Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status
92	Acute Otitis Externa (AOE): Pain Assessment
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)
158	Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy
186	Chronic Wound Care: Use of Compression System in Patients with Venous Ulcers
189	Referral for Otologic Evaluation for Patients with a History of Active Drainage from the Ear Within the Previous 90 Days
190	Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss
196	Coronary Artery Disease (CAD): Symptom and Activity Assessment
206	HIV/AIDS: Screening for High Risk Sexual Behaviors
207	HIV/AIDS: Screening for Injection Drug Use
235	Hypertension (HTN): Plan of Care
253	Pregnancy Test for Female Abdominal Pain Patients

## Appendix 2: 2013 Reporting Requirements for Incentive

**Table 1: Criteria for Claims-based Reporting of Individual Measures**

Reporting Criteria	Reporting Period
At least 3 PQRS measures, or 1-2 measures if less than 3 apply to the eligible professional, for at least 50% of applicable Medicare Part B Fee-for-Service (FFS) patients of each eligible professional. Measures with a 0% performance rate will be considered in analysis but will not be considered satisfactorily reported for incentive eligibility.	January 1, 2013 – December 31, 2013

**Table 2: Criteria for Claims-based Reporting of Measures Groups**

Reporting Criteria	Reporting Period
One measures group for 20 applicable Medicare Part B FFS patients of each eligible professional. Measures Groups containing a measure with a 0% performance rate will not be counted.	January 1, 2013 – December 31, 2013

**Table 3: Criteria for Registry-based Reporting of Individual Measures**

Reporting Criteria	Reporting Period
At least 3 PQRS measures for 80% of applicable Medicare Part B FFS patients of each eligible professional. Measures with a 0% performance rate will not be counted.	January 1, 2013– December 31, 2013

**Table 4: Criteria for Registry-based Reporting of Measures Groups**

Reporting Criteria	Reporting Period
One measures group for 20 applicable patients of each eligible professional. A majority of patients (11 out of 20) must be Medicare Part B FFS patients. Measures Groups containing a measure with a 0% performance rate will not be counted.	January 1, 2013 – December 31, 2013
One measures group for 20 applicable patients of each eligible professional. A majority of patients (11 out of 20) must be Medicare Part B FFS patients. Measures Groups containing a measure with a 0% performance rate will not be counted.	July 1, 2013 – December 31, 2013

**Table 5: Criteria for EHR-based Reporting of Individual Measures**

Reporting Criteria	Reporting Period
At least 3 PQRS measures, for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.	January 1, 2013 – December 31, 2013
Report on ALL 3 Medicare EHR Incentive Program core measures. If denominator for 1 or more of core measures is 0, report on up to 3 Medicare EHR Incentive Program alternate core measures; <b>AND</b> Report on 3 (of the 38) additional measures available for the Medicare EHR Incentive Program.	January 1, 2013 – December 31, 2013

**Table 7: Criteria for the Group Practice Reporting Option**

Reporting Period	Group Practice Size	Reporting Mechanism	Reporting Criteria
January 1, 2013– December 31, 2013	2+ Eligible Professionals	Registry	Report at least 3 measures, AND Report each measure for at least 80% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
January 1, 2013– December 31, 2013	25-99 Eligible Professionals	GPRO Web Interface	Report on all measures included in the Web Interface; <b>AND</b> Populate data field for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 283) for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.
January 1, 2013– December 31, 2013	100+ Eligible Professionals	GPRO Web Interface	Report on all measures included in the Web Interface; <b>AND</b> Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 534) for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.

## Appendix 3: 2013 Reporting Requirements for Avoiding the 2015 PQRS Payment Adjustment

**Table 1: Criteria for Avoiding the 2015 PQRS Payment Adjustment**

Individual Eligible Providers	Registered Groups (ACO/PQRS GPRO)
Meet the requirements for satisfactorily reporting for incentive eligibility as defined in the <i>2013 PQRS Measure Specifications</i> (same criteria as 2013 PQRS incentive eligibility)	Meet the requirements for satisfactorily reporting for incentive eligibility as defined in the applicable 2013 measure specification (same criteria as 2013 PQRS incentive eligibility) <ul style="list-style-type: none"> <li>• Report specific ACO/PQRS GPRO measures through the Web Interface based on a pre-populated patient sample, reference the <i>2013 ACO or PQRS GPRO Web Interface Specification (only available to group practices of 25 or more eligible professionals)</i>, <b>OR</b></li> <li>• Report at least 3 registry measures for the PQRS GPRO, reference the <i>2013 PQRS Measure Specification for Claims/Registry Reporting of Individual Measures (available to all group practices participating in PQRS GPRO, not applicable to ACO GPRO)</i></li> </ul>
Report at least 1 <b>valid</b> measure via claims, registry, or qualified EHR (including data submission vendors and direct EHRs) <b>OR</b> Report at least 1 <b>valid</b> measures group via claims or registry	Report at least 1 <b>valid</b> measure via: <ul style="list-style-type: none"> <li>• Web Interface (<i>only available to group practices of 25 or more eligible professionals</i>), <b>OR</b></li> <li>• Registry (<i>available to all PQRS GPRO group practices; not available to ACO GPRO</i>)</li> </ul>
Elect to participate in the administrative claims reporting mechanism by <b>October 15, 2013</b>  <i>Details on how to choose this option will be made available in 2013</i>	Elect to participate as a group in the administrative claims-based reporting mechanism by <b>October 15, 2013 (not available to ACO GPRO)</b> <ul style="list-style-type: none"> <li>• Details on how to choose this option will be made available in 2013</li> </ul>

**Note:** CMS will determine whether the group practice (defined by TIN) is subject to the 2015 PQRS payment adjustment. The PQRS 0% performance rule **only** applies to satisfactorily reporting for incentive eligibility. PQRS GPROs are analyzed at the TIN level under the TIN submitted at the time of final self-nomination or registration; therefore, if an organization or eligible professional changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis.