



2015 PQRS Group Practice and ACO GPRO Web Interface Reporting Method



GPRO Web Interface Q&A Session Support Call

Program Year 2015

January 28, 2016

Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Announcements

1. During this support call, Pioneer Model ACOs, Shared Savings Program ACOs, and PQRS group practices will be collectively referred to as organizations, and we will use the term “Web Interface” when referencing the GPRO Web Interface used by PQRS group practices and ACOs to collect clinical measure information.
2. Review the Web Interface measure specifications and supporting documents on the [GPRO Web Interface](#) page of the CMS website.

Reminders

1. Upcoming 2015 Web Interface Support Calls

Date	Time (ET)	Topic
2/4/2016	1:00-2:00 PM	GPRO Web Interface Q&A Session
2/11/2016	1:00-2:00 PM	GPRO Web Interface Q&A Session
2/18/2016	1:00-2:00 PM	GPRO Web Interface Q&A Session
2/25/2016	1:00-2:00 PM	GPRO Web Interface Q&A Session
3/3/2016	1:00-2:00 PM	GPRO Web Interface Q&A Session
3/10/2016	1:00-2:30 PM	GPRO Web Interface Q&A Session
4/7/2016	1:00-2:00 PM	GPRO Web Interface Lessons Learned

Note: Support calls will offer a question and answer session if the title indicates “Q&A Session”

Reminders (cont.)

2. Important Dates for 2015 Web Interface Submission

Date	Important Event
1/18/2016 through 3/11/2016	Web Interface submission period
3/28/2016 through 4/22/2016	Access 2015 Submission reports

Note: The Web Interface will close at **8:00pm ET on 3/11/2016**. CMS encourages organizations to submit data well *before* 8:00pm ET to ensure it is fully submitted before the Web Interface closes.

Reminder (cont.)

- 3. Upcoming planned system outages:** The Physician and Other Health Care Professionals Quality Reporting Portal (Portal) will be unavailable for scheduled maintenance; therefore, the Web Interface will not be accessible during the following periods:
- **Every Tuesday** starting at 8:00pm ET–Wednesday at 6:00am ET (on an as needed basis)
 - **Every Thursday** starting at 8:00pm ET–Friday at 6:00am ET (on an as needed basis)
 - **Upcoming Potential Downtime Dates:**
 - February: 2/26/2016 8:00PM ET – 2/29/2016 6:00AM ET
 - See the Portal website for the complete list of scheduled system outages, at <https://www.qualitynet.org/pqrs>

Reminders (cont.)

- 4. Reporting Requirements:** Organizations must completely report the required number of beneficiaries in order to satisfactorily report:
- Minimum of 248 consecutively ranked beneficiaries in each module; OR
 - 100 percent of beneficiaries if they have fewer than 248 beneficiaries available in the sample

Reminders (cont.)

5. **Avoiding future payment adjustments:** Satisfactorily reporting all 17 Web Interface quality measures will allow PQRS group practices and EPs participating in an ACO to avoid the 2017 PQRS payment adjustment
6. **Alignment with the Medicare EHR Incentive Program:** EPs participating in an ACO or PQRS group practice who meet 2015 Web Interface submission requirements will satisfy their CQM reporting for the Medicare EHR Incentive Program.
 - Organizations are required to use 2014 Edition CEHRT to populate the Web Interface
 - EPs must still individually attest separately to the EHR Incentive Program for other program requirements

Reminders (cont.)

- 7. EIDM Account Setup:** Please be sure you have set up your EIDM account and established the Web Interface submitter role for quality reporting
- “[Quick Reference Guides](#)” provide complete information on EIDM for PQRS group practices
 - The “EIDM Account and Role Set-up” and “Guidance for Checking EIDM Role Status” on the [Shared Savings Program ACO Portlet](#) provide complete information on EIDM for ACOs
 - QualityNet Help Desk supports all questions related to EIDM and accessing the Web Interface
 - Phone: (866) 288-8912
 - Email: qnetsupport@hcqis.org

Presenter: Bill Spencer, CMS Contractor

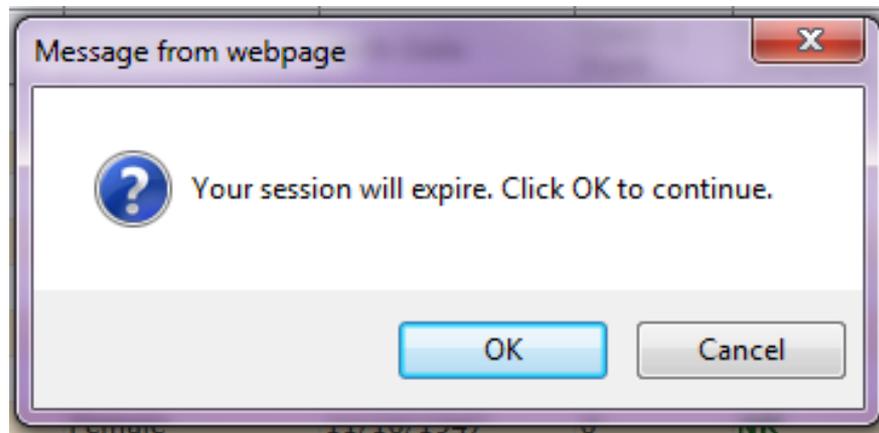
FREQUENT WEB INTERFACE QUESTIONS

Web Interface System Questions

Number	Question	Answer
1	What's the difference between exception and exclusion?	<p>Exception means the patient is marked as complete for that measure (i.e. included with the other patients meeting the requirement), but is not part of the performance calculations (i.e. not in the denominator). Exceptions are consecutively confirmed and completed, and count towards the minimum 248 patients for the organization.</p> <p>Exclusion means the patient is marked as skipped for completion results (therefore, not included in any calculations) within that measure, so another patient needs to be selected in order to meet the minimum patient requirements. Exclusions are consecutively completed but not confirmed, meaning they are processed as skips.</p>

Timeout for Inactivity

- If the Portal detects that you have been inactive for 15 minutes you will be logged out
 - The 15 minute timeout is set by CMS policy and applies to all applications within the Portal
- If you are inactive in the Web Interface for 10 minutes you will receive a warning

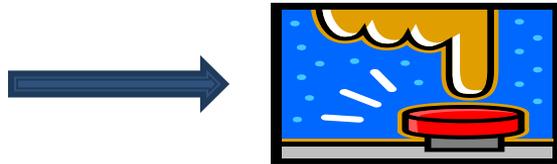


Timeout for Inactivity (cont.)

- If no action is taken for five minutes after the warning is received, you will be logged out
- If you are manually updating patient data and have unsaved data when you are timed out, that data will be lost and the patient's record will remain locked
- If you have uploaded an XML file and the file is still processing when you are timed out, the file will still be processed

Submit Screen

- The **Submit** screen is the final step and notifies CMS that data submission for your PQRS group practice or ACO is complete
- The patient data entered and saved on the **Home** page or uploaded on the **Upload Data** screen is saved to the database, but not sent to CMS until you **Submit**



- **Note:** *Data saved but not submitted will not be counted*
- Each of the 15 modules is listed, with a comment indicating if the module has met the requirements for satisfactory reporting
- You **must Submit again** if you update patient data in order to provide CMS with the most current data

Submit Screen Terms

- When you enter data on the Home page using the measure tabs, you are ***Updating and Saving*** the patient's data to the Web Interface database
- When you use an XML file to update the patient's data you are ***Updating and Saving*** the data to the Web Interface database
 - Both of these actions are ***Collecting*** your data for use in the completeness and performance calculations
- Accessing the **Submit** screen and clicking the **Submit Data to CMS** button calculates your completeness and performance rates and ***submits*** your saved and calculated data to CMS

Submit Screen (cont.)

[Group Name] Accessibility | Help

Home Reports ▾ Export Data Upload Data Add/Edit ▾ Locked Records List Users Submit Preferences

Submit

Before submitting for completion, make sure that:

- The abstractors are done abstracting patient data.
- The totals of modules have met the minimum requirements. Verify this below.
- Multiple submissions are allowed and later submissions override previous submissions.

The data you have submitted **MEETS** the requirements for ACO GPRO Web Interface satisfactory reporting.

See table below for completion details.

Submission agreement: I am fully authorized to submit this data, and I certify that the data submitted is true, accurate, and complete. I understand that submitting false, misleading, or willful omission, misrepresentation, or falsification of any information contained in this submission or any communication supplying information to Medicare may be punished by criminal, civil, or administrative penalties, including fines and imprisonment.

To submit, you **MUST** check the authorization box and click **Submit Data to CMS**.

Submit Data to CMS

Module Completion Status for [Group Name]

Module	Comments
CARE-2: Falls	CARE-2 is complete.
CARE-3: Documentation of Current Medications in the Medical Record	CARE-3 is complete.
CAD: Coronary Artery Disease	CAD is complete.
DM: Diabetes Mellitus	DM is complete.
HF: Heart Failure	HF is complete.
HTN: Hypertension	HTN is complete.
IVD: Ischemic Vascular Disease	IVD is complete.
MH: Mental Health	MH is complete.
PREV-5: Breast Cancer Screening	PREV-5 is complete.
PREV-6: Colorectal Cancer Screening	PREV-6 is complete.
PREV-7: Preventive Care and Screening: Influenza Immunization	PREV-7 is complete.
PREV-8: Pneumonia Vaccination Status for Older Adults	PREV-8 is complete.
PREV-9: BMI Screening and Follow-Up Plan	PREV-9 is complete.
PREV-10: Tobacco Use: Screening and Cessation Intervention	PREV-10 is complete.
PREV-11: Screening for High Blood Pressure and Follow-Up	PREV-11 is complete.
PREV-12: Screening for Clinical Depression and Follow-Up Plan	PREV-12 is complete.

The module meets satisfactory reporting requirements when the comment is "[Module name] is complete."

The module does not meet satisfactory reporting requirements when the comment is "[Module name] IS NOT complete. Please continue updating patients to complete reporting."

[Group Name] Accessibility | Help

Home Reports ▾ Export Data Upload Data Add/Edit ▾ Locked Records List Users Submit Preferences

Submit

Before submitting for completion, make sure that:

- The abstractors are done abstracting patient data.
- The totals of modules have met the minimum requirements. Verify this below.
- Multiple submissions are allowed and later submissions override previous submissions.

The data you have submitted **DOES NOT** meet the requirements for ACO GPRO Web Interface reporting. Please continue updating patients to complete reporting.

See table below for completion details.

Submission agreement: I am fully authorized to submit this data, and I certify that the data submitted is true, accurate, and complete. I understand that submitting false, misleading, or willful omission, misrepresentation, or falsification of any information contained in this submission or any communication supplying information to Medicare may be punished by criminal, civil, or administrative penalties, including fines and imprisonment.

Submit Data to CMS

Module Completion Status for [Group Name]

Module	Comments
CARE-2: Falls	CARE-2 IS NOT complete. Please continue updating patients to complete reporting.
CARE-3: Documentation of Current Medications in the Medical Record	CARE-3 IS NOT complete. Please continue updating patients to complete reporting.
CAD: Coronary Artery Disease	CAD IS NOT complete. Please continue updating patients to complete reporting.
DM: Diabetes Mellitus	DM IS NOT complete. Please continue updating patients to complete reporting.
HF: Heart Failure	HF IS NOT complete. Please continue updating patients to complete reporting.
HTN: Hypertension	HTN IS NOT complete. Please continue updating patients to complete reporting.
IVD: Ischemic Vascular Disease	IVD IS NOT complete. Please continue updating patients to complete reporting.
MH: Mental Health	MH is complete.
PREV-5: Breast Cancer Screening	PREV-5 IS NOT complete. Please continue updating patients to complete reporting.
PREV-6: Colorectal Cancer Screening	PREV-6 IS NOT complete. Please continue updating patients to complete reporting.
PREV-7: Preventive Care and Screening: Influenza Immunization	PREV-7 IS NOT complete. Please continue updating patients to complete reporting.
PREV-8: Pneumonia Vaccination Status for Older Adults	PREV-8 IS NOT complete. Please continue updating patients to complete reporting.
PREV-9: BMI Screening and Follow-Up Plan	PREV-9 IS NOT complete. Please continue updating patients to complete reporting.
PREV-10: Tobacco Use: Screening and Cessation Intervention	PREV-10 IS NOT complete. Please continue updating patients to complete reporting.
PREV-11: Screening for High Blood Pressure and Follow-Up	PREV-11 IS NOT complete. Please continue updating patients to complete reporting.
PREV-12: Screening for Clinical Depression and Follow-Up Plan	PREV-12 IS NOT complete. Please continue updating patients to complete reporting.

Submit Status Report

- **The Submit Status Report confirms that your completed submission has been received by CMS**
- The message indicating you have met the reporting requirements is specific to the GPRO or ACO program, but the remainder of the information is the same
- The report displays the **date** and **time** the **Send Data to CMS** button on the **Submit** screen was clicked
 - The comments column indicates if the module meets the minimum requirements
- If the **Send Data to CMS** button was *not* clicked, the report will indicate that **the data has not been submitted**
- If *incomplete* data has been submitted, the report displays a message indicating the **submitted data does not meet the reporting requirements**

Submit Status Report (cont.)

ACO GPRO Web Interface ----- The Submission Period for 2015 ends on March 11, 2016 at 5:00 PM PT

[Group Name] Accessibility | Help

Home Reports ▾ Export Data Upload Data Add/Edit ▾ Locked Records List Users Submit Preferences

Date and time the Submit Data to CMS button (on the Submit screen) was clicked.

Submit Status Report for [Group Name] 01/15/2016 04:40:17 PM [View Printable Report](#)

The data you have submitted has been received by CMS and MEETS the requirements for ACO GPRO Web Interface satisfactory reporting.

Indicator that reporting requirements were met at the time the data was sent to CMS.

See table below for completion details.

[Refresh](#)

Module	Comments
CARE-2: Falls	CARE-2 is complete.
CARE-3: Documentation of Current Medications in the Medical Record	CARE-3 is complete.
CAD: Coronary Artery Disease	CAD is complete.
DM: Diabetes Mellitus	DM is complete.
HF: Heart Failure	
HTN: Hypertension	
IVD: Ischemic Vascular Disease	
MH: Mental Health	
PREV-5: Breast Cancer Screening	
PREV-6: Colorectal Cancer Screening	
PREV-7: Preventive Care and Screening: Influenza Immunization	
PREV-8: Pneumonia Vaccination Status for Older Adults	
PREV-9: BMI Screening and Follow-Up Plan	
PREV-10: Tobacco Use: Screening and Cessation Intervention	
PREV-11: Screening for High Blood Pressure and Follow-Up	
PREV-12: Screening for Clinical Depression and Follow-Up Plan	

[Refresh](#)

The data you have submitted has been received by CMS but DOES NOT meet the requirements for ACO GPRO Web Interface reporting. Please continue updating patients to complete reporting.

See table below for completion details.

[Refresh](#)

Module	Comments
CARE-2: Falls	CARE-2 IS NOT complete. Please continue updating patients to complete reporting.
CARE-3: Documentation of Current Medications in the Medical Record	CARE-3 IS NOT complete. Please continue updating patients to complete reporting.
CAD: Coronary Artery Disease	CAD IS NOT complete. Please continue updating patients to complete reporting.
DM: Diabetes Mellitus	DM IS NOT complete. Please continue updating patients to complete reporting.
HF: Heart Failure	HF IS NOT complete. Please continue updating patients to complete reporting.
HTN: Hypertension	HTN IS NOT complete. Please continue updating patients to complete reporting.
IVD: Ischemic Vascular Disease	IVD IS NOT complete. Please continue updating patients to complete reporting.
MH: Mental Health	MH is complete.
PREV-5: Breast Cancer Screening	PREV-5 IS NOT complete. Please continue updating patients to complete reporting.
PREV-6: Colorectal Cancer Screening	PREV-6 IS NOT complete. Please continue updating patients to complete reporting.
PREV-7: Preventive Care and Screening: Influenza Immunization	PREV-7 IS NOT complete. Please continue updating patients to complete reporting.
PREV-8: Pneumonia Vaccination Status for Older Adults	PREV-8 IS NOT complete. Please continue updating patients to complete reporting.
PREV-9: BMI Screening and Follow-Up Plan	PREV-9 IS NOT complete. Please continue updating patients to complete reporting.
PREV-10: Tobacco Use: Screening and Cessation Intervention	PREV-10 IS NOT complete. Please continue updating patients to complete reporting.
PREV-11: Screening for High Blood Pressure and Follow-Up	PREV-11 IS NOT complete. Please continue updating patients to complete reporting.
PREV-12: Screening for Clinical Depression and Follow-Up Plan	PREV-12 IS NOT complete. Please continue updating patients to complete reporting.

[Refresh](#)

Presenter: Deb Kaldenberg, CMS Contractor

FREQUENT MEASURES QUESTIONS

Web Interface Measure Questions

Number	Question	Answer
1	<p>Other CMS Approved Reason I am receiving a yellow warning when I select Other CMS Approved Reason. Why is that?</p>	<p>Other CMS approved reason is reserved for cases that are unique, unusual, and not covered by any of the skip reasons identified in the Supporting Documents. Though this option is available as a drop down, it may not be used without prior approval from CMS.</p> <p>This information is currently posted within the 2015 GPRO Web Interface Quality Reporting Q & A document on the CMS website at the following url: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/QA_2015DataCollection_Final_psg.pdf</p>
2	<p>Other CMS Approved Reason What do I need to do to select Other CMS Approved Reason in the web interface.</p>	<p>To gain CMS approval, a QualityNet Help Desk ticket should be submitted with the disease module or patient care measure, and beneficiary rank number (never any protected health information, “PHI”), along with an explanation of why you think it is appropriate to skip the beneficiary. CMS will either approve or deny the request and will identify appropriate next steps (if any) that need to be taken. This information will be provided in the resolution of the QualityNet Help Desk ticket. You should retain this documentation and enter the QualityNet Help Desk resolution number in the Web Interface. Refer to Table B-5 for examples.</p> <p>This information is currently posted within the 2015 GPRO Web Interface Quality Reporting Q & A document on the CMS website at the following url: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/QA_2015DataCollection_Final_psg.pdf</p>

Web Interface Measure Questions

Number	Question	Answer
3	<p>MH-1 Can we use other screening tools besides the PHQ-9? How would we include results from screening tools that are not PHQ-9?</p>	<p>The only depression screening tool that can be used for reporting data specific to the MH-1: Depression Remission at Twelve Months measure is the PHQ-9. The use of the PHQ-9 as well as a PHQ-9 result greater than 9 during the denominator assessment period are components of establishing denominator eligibility for MH-1. A visual representation of how performance is calculated for this measure can be found in the posted 2015 GPRO MH Flow: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_GPRO_MH_Flow_v30.zip</p>
4	<p>MH-1 We are receiving a warning regarding the number of skips for MH-1. Do we need to be concerned?</p>	<p>MH-1 has three denominator components, first is that the patient has a newly diagnosed or existing diagnosis of depression or dysthymia. To be considered denominator eligible the diagnosis needs to be present during the denominator identification measurement period; 12/1/2013 - 11/30/2014. The other components of denominator eligibility are the use of the PHQ-9 screening tool and a PHQ-9 screening result greater than 9; also occurring during the denominator identification measurement period. The first PHQ-9 greater than 9 result during the denominator identification measurement period is considered the index date. If any of the 3 denominator criteria are missing the patient would be skipped. As long as you completely report, either 248 patients or 100% of those that can be reported if less than 248, this measure would be considered as being successfully reported.</p>

Web Interface Measure Questions

Number	Question	Answer
5	MH-1 Can diagnosis be confirmed using other coding besides those identified in the MH Supporting Document? For example ICD-9 311 appears to convert to ICD-10 F32.9.	From the measure developer – the diagnosis codes included in the MH Supporting Document are considered all-inclusive. ICD-9 code 311 is not considered applicable for denominator eligible diagnosis of major depression or dysthymia.
6	HF-6 and CAD-7 We are getting a lot of skips for these two measures. Should we be concerned?	<p>For HF-6 and CAD-7, only patients with a diagnosis of CAD are sampled. Both HF-6 and CAD-7 include additional denominator criteria besides confirmation of diagnosis. For HF-6 if LVSD is not confirmed and "No" is selected mark appropriately for completion and stop abstraction. The patient will be removed from the performance calculations for the measure. For CAD-7 if LVSD is not confirmed and diabetes is not confirmed and "No" is selected mark appropriately for completion and stop abstraction. The patient will be removed from the performance calculations for the measure.</p> <p>The requirement for LVEF is part of the denominator criteria for 2015 HF-6 and CAD-7 (for CAD you would also look for diagnosis of diabetes to establish denominator eligibility). If a patient does not have LVEF they are not considered denominator eligible and are therefore 'skipped'. A visual representation of this guidance can be found in the posted 2015 GPRO</p>

Web Interface Measure Questions

Number	Question	Answer
7	PREV-11 If a patient does NOT have an active diagnosis of HTN prior to 01/01/2015 but is diagnosed with HTN (401.1) during 2015, is that patient eligible for the measure?	This would be considered a Denominator Exclusion if the diagnosis is considered an active diagnosis during the measurement period. Active diagnosis is defined as the patient is under medical management for hypertension. Documentation of medical management should be indicated in the medical records during 2015.
8	CARE-3 Are only PCPs responsible for documentation of current medications. We have several prefilled dates where the visits were with specialists. What do we do?	The CARE-3 measure is not intended to be limited to providers listed in NPI1, NPI2, and NPI3, so you should continue abstracting on patients who were seen by other providers. The CARE-3 measure is not limited to primary care providers so you should continue abstracting on patients who were seen by specialists. Additionally, all populated visits were taken from claims billed by one of your ACO's participant TINs (i.e., these visits are considered 'within the ACO') or at your group practice.
9	CARE-3 We have a “mark as reviewed” button that providers click when they review the patients’ medications and perform medication reconciliation for Meaningful Use. Does this mean that we can go by this button being clicked to declare that we are meeting this GPRO measure?	If the standard policy at the group is that by selecting the med rec radio button in an EMR indicates that the eligible professional (EP) attests to documenting, updating or reviewing the patient’s current medications using all immediate resources available on the date of the encounter this would meet the intent of the measure.

Web Interface Measure Questions

Number	Question	Answer
10	CARE-3 For “Vitamin E 400 iu capsule” – does “take 1 capsule daily” satisfy the measure?	To meet the intent of the measure, the eligible professional should make their best effort to review a current, complete, and accurate list of medications at each encounter. The quality action is reviewing the medications. As an example, if the EP is unable to verify a dosage they would still meet performance as long as they use all immediate resources available on the date of the encounter.
11	CARE-3 We have a patient who received Transitional Care Management (TCM) services (CPT 99496) billed on 3/17/2015 which requires a face-to-face office visit within 1-2 weeks of hospital discharge and TCM is billed 30 days post discharge, however, the patient office visit happened about 2 weeks prior to the 3/17 TCM billed date which is 30 days post discharge. The patient also had an office visit on 3/23/15. The patient saw the physician twice within the same 30 day period, however the date range was larger than the ± 2 days from the Care-3 Office Visit date (medication date) that CMS provided.	TCM coding is part of the CARE-3 code set. However, if you cannot confirm a visit on the prefilled visit date (+/- 2 calendar days) select ‘No – Visit Outside Practice’

Presenter: Michael Kerachsky, Contractor

RESOURCES & WHERE TO GO FOR HELP

Educational Resources

- **GPRO Web Interface web page:** http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html
 - 2015 Web Interface XML Specification
 - 2015 Narrative Measure Specification, Supporting Documents, Flows
 - Data Guidance is included in each Supporting Document as a separate tab at the bottom of the Excel workbook
 - 2015 GPRO Web Interface Quality Reporting Q&A document
 - 2015 GPRO Web Interface Assignment Methodology Specification (for PQRS groups)
 - 2015 GPRO Web Interface Sampling Document
 - 2015 PQRS group practice and ACO Web Interface support call presentations
 - Educational Demonstrations
 - 2015 Web Interface Measures Overview
 - 2015 Assignment and Sampling
 - 2015 GPRO Web Interface Overview
 - 2015 Web Interface XML
 - 2015 Web Interface EIDM
- **PQRS Analysis and Payment web page (PQRS group practices only):** <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html>
 - EIDM User Guide
 - EIDM System Toolkit

Educational Resources (cont.)

- **Shared Savings Program web page:**
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html>
 - 2015 Shared Savings Program Shared Savings and Losses and Assignment Methodology
- **Shared Savings Program Portlet:** <https://portal.cms.gov/>
 - 2015 Quality Measurement, Reporting, and Scoring Quick Reference Guides
 - Shared Savings Program ACO EIDM Account and Role Set-up Guide
 - Guidance for Checking EIDM Role Status
- **Pioneer ACO Model web page:**
<http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/>
 - 2015 Pioneer ACO Alignment and Financial Reconciliation Methods
- **Portal:** <https://www.qualitynet.org/pqrs>
 - EIDM Quick Reference Guides
 - Web Interface User Manual
 - “Sign In” button to access the Web Interface system

Portal Resources

The Web Interface User Guide is posted under User Guides

User Guides

- PQRS Portal User Guide
- PQRS SEVT User Guide
- PQRS Submissions User Guide
- PQRS Submission Reports User Guide
- PQRS GPRO Web Interface User Guide**
- PQRS Feedback Report User Guide
- eRx Feedback Report User Guide
- eRx Payment Adjustment Feedback User Guide
- PQRS Feedback Dashboard User Guide
- PQRS Enhanced Feedback Report User Guide

PQRS Verify Report

Enter a TIN or NPI to verify that a feedback report exists for your organization. The TIN or NPI must be one used to submit Medicare claims and valid PQRI quality data codes. PQRS Feedback Reports for program year 2014 and later can be accessed (when available) from the PV-PQRS portal. For instructions on how to access these Feedback Reports, please go to Physician Feedback Program website.

TIN NPI

TIN: e.g. 01-2123234 or 012123234
NPI: e.g. 0121232345

PQRS Look Up

Enter a TIN, TIN/NPI or CPC Practice Site ID to check if your organization has received 2014 PQRS incentive or 2016 PQRS payment adjustment.

PQRS Eligible Professional

TIN: e.g. 012123234

Physician and Other Health Care Professionals Quality Reporting Portal

to your Portal

If you do not have an account, please register.

Forgot your password?

For assistance with new & existing EIDM accounts, review the Quick Reference Guides.

PQRS Feedback Reports for program year 2014 and later can be accessed (when available) from the PV-PQRS portal. For instructions on how to access these Feedback Reports, please go to Physician Feedback Program website.

Notice: If you have not used your EIDM account within the past 60 days or more, your account will be disabled as required by the CMS security policy. You should have received an e-mail at the time of your EIDM account profile instructing you how to get your account re-enabled. If you need further assistance, please contact the QualityNet Help Desk at 1-866-288-8912, or qnetsupport@hcqis.org.

For support, please contact the QualityNet Help Desk at 866-288-8912, TTY 877-715-6222, or via email at qnetsupport@hcqis.org

The PQRS Portal will be unavailable tonight January 5, 2016 from 8:00 PM:ET until 10:00PM:ET, for scheduled maintenance. You may not be able to login to the portal to retrieve reports during this time. We apologize for any inconvenience.

Scheduled System Outages

PQRS Feedback Reports for program year 2014 and later can be accessed (when available) from the PV-PQRS portal. For instructions on how to access these Feedback Reports, please go to Physician Feedback Program website.

PQRS system and applications will be down for maintenance during the following scheduled outages. For more information, please contact the QualityNet Helpdesk.

Every Tuesday starting at 8:00 PM ET through Wednesday
Every Thursday starting at 8:00 PM ET through Friday
Third weekend of each Month starting Friday at 8:00 PM ET

Upcoming Maintenance weekend schedule:

- January (01/23 - 01/25)
- February (02/20 - 02/22)
- March (03/20 - 03/22)
- April (04/17 - 04/19)
- May (05/15 - 05/17)
- June (06/26 - 06/28)
- July (07/17 - 07/19)
- August (08/21 - 08/23)
- September (09/18 - 09/20)

Click "Sign In" to access the Web Interface System

The EIDM Quick Reference Guides are located below the "Sign In" button

The complete list of 2016 scheduled system outages is posted at the bottom of the web page

Where to Go for Help

- **QualityNet Help Desk**
 - Inquiries related to: EIDM, Web Interface Measures, Web Interface system, and PQRS group practice assignment and sampling
 - E-mail: qnetsupport@hcqis.org
 - Phone: (866) 288-8912 (TTY 1-877-715-6222)
 - Fax: (888) 329-7377
- **CAHPS for PQRS Survey Project Team**
 - Inquiries related to: CAHPS for PQRS survey measures, distribution
 - E-mail: pqrscahps@hcqis.org
- **EHR Incentive Program Information Center**
 - Inquiries related to: Meaningful Use, Attestation
 - Phone: (888) 734-6433 (TTY 888-734-6563)
- **Value Modifier Help Desk**
 - Inquiries related to: QRUR, Physician Compare
 - Phone: (888) 734-6433 Option 3 or pvhelpdesk@cms.hhs.gov

Where to Go for Help (cont.)

- **Medicare Shared Savings Program**
 - Inquiries related to: Shared Savings Program Assignment and Sampling, Program Inquiries
 - Email: sharedsavingsprogram@cms.hhs.gov
- **Pioneer ACO**
 - Inquiries related to: Pioneer Assignment and Sampling, Program Inquiries
 - E-mail: PIONEERQUESTIONS@cms.hhs.gov
- **CAHPS Survey for ACOs Project Team**
 - Inquiries related to: CAHPS Survey for ACOs, distribution
 - Phone: (855) 472-4746
 - E-mail: acocahps@HCQIS.org

Acronyms

- **ACO** – Accountable Care Organization
- **CAHPS** – Consumer Assessment of Healthcare Providers and Systems summary surveys
- **CMS** – Centers for Medicare & Medicaid Services
- **CQMs** – Clinical Quality Measures [for attestation]
- **eCQMs** – Electronic Clinical Quality Measures [for electronic reporting]
- **EHR** – Electronic Health Record
- **EP** – Eligible Professional
- **FFS** – Fee-for-Service
- **GPRO** – Group Practice Reporting Option
- **MPFS** – Medicare Physician Fee Schedule
- **NPI** – National Provider Identifier
- **ONC** – Office of the National Coordinator for Health Information Technology
- **PQRS** – Physician Quality Reporting System
- **Value Modifier** – Value-based Payment Modifier

Time for

QUESTIONS & ANSWERS