2016 Physician Quality Reporting System (PQRS): Implementation Guide

2/18/2016; Revised 3/11/2016; Revised 6/28/2016; Revised 7/13/2016

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Introduction

Purpose

The "2016 PQRS Implementation Guide" helps individual eligible professionals (EPs) and group practices participating in PQRS via the group practice reporting option (GPRO) (referred to as PQRS group practices) understand and report for 2016 PQRS. It addresses common PQRS implementation concerns, such as:

- **Program questions:** What is PQRS? Why should I participate?
- **Measures and Analysis questions:** How do I select which measures to report? How does my data get analyzed?
- **Reporting questions:** What are the different ways I can report? When do I need to report and how do I report?

To supplement this guide, EPs may get the latest information about PQRS on the **PQRS website**, via the **PQRS listserv** and also on **Twitter**. Help Desk support is also available Monday – Friday from 7:00 AM-7:00 PM Central Time at 1-866-288-8912 (TTY: 1-877-715-6222) or at Qnetsupport@hcqis.org.

What is PQRS?

PQRS is a quality reporting program that uses negative payment adjustments to promote reporting of quality information by individual EPs and group practices. Those who do not satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (MPFS) services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board, Medicare Secondary Payer, and Critical Access Hospitals [CAH] Method II) will be subject to a negative payment adjustment under PQRS. Medicare Part C–Medicare Advantage beneficiaries are not included. Reporters may choose from the following reporting mechanisms to submit their quality data:

- Reporting electronically using an electronic health record (EHR)
- Qualified Registry
- Qualified Clinical Data Registry (QCDR)
- PQRS group practice via GPRO Web Interface
- CMS-Certified Survey Vendor
- Claims

All EPs who do not meet the criteria for satisfactory reporting or participating for 2016 PQRS will be subject to the 2018 negative payment adjustment with no exceptions.

Who is eligible to participate in PQRS?

Medicare physicians, practitioners, and therapists providing covered professional services paid under or based on the MPFS are considered EPs under PQRS. To the extent that EPs are providing services which get paid under or based on the MPFS, those services **are** eligible for PQRS negative payment adjustments. Individual EPs, EPs in PQRS group practices, Accountable Care Organizations (ACOs) reporting PQRS via the GPRO Web Interface, and Comprehensive Primary Care (CPC) practice sites are eligible to participate in PQRS. View the complete "2016 PQRS List of Eligible Professionals" (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN] combination) on the PQRS How To Get Started webpage.

EPs or PQRS group practices, using their individual rendering NPI or TIN respectively, may report the quality clinical action for measures within PQRS. Individual EPs report data to CMS at the TIN/NPI level, while PQRS group practices report data to CMS at the TIN level. Most services payable under fee schedules or methodologies other than the MPFS are not included in 2016 PQRS (for example, services provided under federally qualified health center (FQHC) or rural health clinic (RHC) methodologies, portable X-ray suppliers, independent laboratories including place-of-service code "81," hospitals, skilled nursing facilities (SNF), ambulance providers, and ambulatory surgery center facilities). Suppliers of durable medical equipment (DME) are not eligible to report measures via PQRS since DME is not paid under the MPFS.

Why should I participate in PQRS?

- **Help improve health care quality.** Driving quality improvement is a core function of CMS. The vision for the CMS Quality Strategy is to optimize health outcomes by leading clinical quality improvement and health system transformation. PQRS plays a crucial role to facilitate physician participation in this process committed to quality improvement.

- **Be a satisfactory reporter and avoid the 2018 PQRS negative payment adjustment.** Additional information on how to avoid the PQRS negative payment adjustment can be found in this guide and supporting documentation on the CMS PQRS website**.**

What are quality measures?

Quality measures are indicators of the quality of care provided by physicians. They are tools that help CMS measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care. Refer to page 7 for more information on quality measures.

It is important to review and understand each measure specification especially as it pertains to a specific reporting mechanism. The measure specification specific to the reporting mechanism will provide definitions and specific instructions for satisfactorily reporting the measure. This guide provides a web address under each reporting mechanism for easy location of the measures specifications. Refer to the next section, "**PQRS Measure Selection Considerations**" for more information about denominators and numerators. Also refer to **Appendix A: Glossary of Terms**, which further defines the terms denominator and numerator as well as other terms commonly used in PQRS.

Disclaimer: *If reporting for PQRS through another CMS program (such as the Medicare Shared Savings Program, Comprehensive Primary Care Initiative, Pioneer Accountable Care Organizations, or other quality reporting program or initiative), please check the program's requirements for information on how to report quality data to avoid the PQRS negative payment adjustment. Please note, although CMS has attempted to align or adopt similar reporting requirements across programs, EPs should look to the respective quality program to ensure they satisfy the PQRS, EHR Incentive Program, Value-Based Payment Modifier (Value Modifier), etc. requirements of each of these programs.*

PQRS Measure Selection Considerations

The 2016 PQRS measures address various aspects of care, such as prevention, chronic- and acute-care management, procedure-related care, resource utilization, and care coordination. EPs and PQRS group practices are not required to report on all of the PQRS measures and must select which measures they would like to report.

How should I determine which measures to report?

Step	Description
Step 1: Review the Measures List	**Review the "2016 Physician Quality Reporting System (PQRS) Measures List"** and the PQRS Web-Based Measure Search Tool, available on the PQRS Measures Codes webpage, to determine which measures, associated domains, and reporting mechanism(s) may be of interest and applicable to the individual EP or group practice participating in PQRS via GPRO. • Not all measures are available under each PQRS reporting mechanism. EPs or PQRS group practices should avoid individual measures that do not or may infrequently apply to the services they provide to Medicare patients. • With alignment of quality measures across CMS quality reporting programs, some measures from the EHR Incentive Program may have been updated or modified during their National Quality Forum endorsement process. This may result in different measurement titles, number versions, or National Quality Strategy (NQS) domains from the corresponding PQRS specification. Please refer to program specific documentation for accurate interpretation of measures and reporting criteria. • The GPRO Web Interface reporting mechanism has set measures, all of which must be reported.
Step 2: Consider important factors	**Consider the following factors** when selecting measures for reporting: • Clinical conditions usually treated. • Types of care typically provided – e.g., preventive, chronic, acute. • Settings where care is usually delivered – e.g., office, emergency department (ED), surgical suite. • Quality improvement goals for 2016. • Other quality reporting programs in use or being considered by the NQS (see further explanation below).
Step 3: Review specifications	After making a selection of potential measures, **review the specifications** for the selected reporting mechanism for each measure under consideration. Select those measures that apply to services most frequently provided to Medicare patients by the EP or PQRS group practice. • EPs or PQRS group practices should review each measure's denominator coding to determine which patients may be eligible for the selected PQRS measure(s). EPs can report individual measures or Measures Groups, while PQRS group practices can only report individual measures or all of the measures within the GPRO Web Interface, if that mechanism is chosen. • Group practices must report using an EHR, registry, QCDR, or via the GPRO Web Interface in order to select their measures.

The National Quality Strategy (NQS)

In 2016, measures are classified according to the 6 NQS domains based on the NQS's priorities. PQRS reporting mechanisms typically require an EP or PQRS group practice to report 9 or more measures covering at least 3 NQS domains, and cross-cutting measures for EPs with billable face-to-face encounters for satisfactory reporting or participation to avoid the 2018 PQRS negative payment adjustment when reporting individual measures.

The Six NQS Domains

Patient Safety	Person and Caregiver-Centered Experience and Outcomes	Communication and Care Coordination
Effective Clinical Care	Community/ Population Health	Efficiency and Cost Reduction

What is a measure?

Measures consist of two major components: denominators and numerators.

PQRS Denominators and Numerators

Numerator

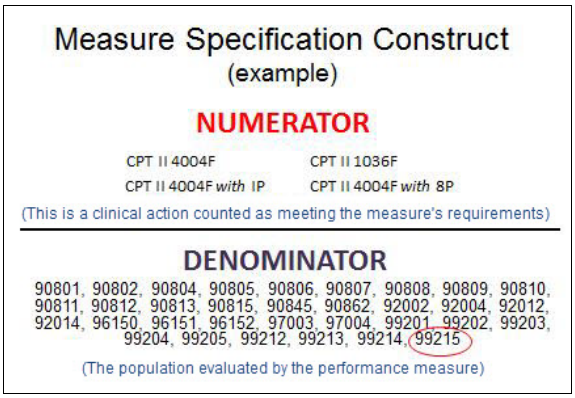
- The upper portion of a fraction used to calculate a rate, proportion, or ratio. The numerator must detail the quality clinical action expected that satisfies the condition(s) and is the focus of the measurement for each patient, procedure, or other unit of measurement established by the denominator (that is, patients who received a particular service or providers that completed a specific outcome/process).

Denominator

- The lower portion of a fraction used to calculate a rate, proportion, or ratio. The denominator must describe the population eligible (or episodes of care) to be evaluated by the measure. This should indicate age, condition, setting, and timeframe (when applicable). For example, "Patients aged 18 through 75 years with a diagnosis of diabetes."

Each component is defined by specific codes described in the respective measure's specification along with the reporting instructions and use of modifiers.

See below for an example of a measurement specification construct:



Measure component #1: Denominator

The first measure component is the denominator, which describes the eligible cases for a measure or the eligible patient population. Physician Quality Reporting measure denominators are identified by ICD-10-CM , ICD-10-PCS, CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc.), and place of service (if applicable). For GPRO Web Interface and electronic reporting using an EHR, other clinical coding sets may be included such as SNOMED, LOINC, or RxNorm.

Measure component #2: Numerator

The second component is the numerator describing the specific clinical action required by the measure for performance. EPs may use the codes present in the numerator to report the outcome of the action as indicated by the measure. PQRS measure numerators are quality-data codes (QDCs) consisting of specified non-payable CPT Category II codes and/or temporary G-codes. For GPRO Web Interface and electronic reporting using an EHR, other clinical coding sets may be included such as SNOMED, LOINC, or RxNorm in order to capture a specific quality action, test, or value.

How is a measure calculated?

Calculating the PQRS reporting rate (dividing the number of reported numerator outcomes by denominator-eligible encounters) identifies the percentage of a defined patient population that was reported for the measure.

For performance rate calculations, some patients may be subtracted from the denominator based on medical, patient, or system performance exclusions/exceptions (depending upon reporting mechanism) allowed by the measure.

The final performance rate calculation represents the eligible population that received a particular process of care or achieved a particular outcome (measure defined performance met outcome). It is important to review and understand each measure's specification, as it contains definitions and specific instructions for reporting the measure.

How do I report PQRS measures?

PQRS offers several reporting mechanisms for reporting measures. There may be different mechanisms available within the specific reporting mechanism to satisfactorily report to avoid the 2018 negative payment adjustment. Refer to **Appendix B: Decision Trees – 2016 PQRS Reporting/Participation for**

Avoiding the 2018 PQRS Negative Payment Adjustment for the *Decision Trees* designed to help participants select among the multiple reporting mechanisms available in PQRS. EPs and PQRS group practices should consider which reporting mechanism best fits their practice and should choose measures within the same option of reporting.

- Please note that PQRS defines a group practice as a single TIN with 2 or more individual EPs (as identified by individual NPI) that have reassigned their billing rights to the TIN.

Determining Group Size

A group practice must have 2 or more EPs who have reassigned their billing rights to the TIN in order to participate via PQRS GPRO. The group practice will determine its size based on the number of EPs billing under the TIN at the *time of registration*. During registration, group size will be categorized as 2-24 EPs, 25-99 EPs and 100 or more EPs. The group practice will need to indicate their group size to CMS by selecting one of these size categories. Reporting requirements and available reporting mechanisms may vary based on the group size. If a group is not able to report on the selected PQRS GPRO reporting mechanism, then it is encouraged to report via another GPRO reporting mechanism or have the eligible professionals in the group participate in the PQRS as individuals in 2016.

- Please note that an individual EP who is a member of a group practice participating in PQRS GPRO is not eligible to separately report under PQRS as an individual EP under that same TIN (that is, for the same TIN/NPI combination).

Reporting Mechanisms Available for 2016

Individual EPs	PQRS Group Practices
• EHR direct product that is Certified Electronic Health Record Technology (CEHRT) • EHR data submission vendor (DSV) that is CEHRT • Qualified PQRS registry • Qualified Clinical Data Registry (QCDR) • Medicare Part B claims submitted to CMS	• EHR direct product that is CEHRT (2+ providers) • EHR DSV that is CEHRT (2+ providers) • Qualified PQRS registry (2+ providers) • QCDR (2+ providers) • GPRO Web Interface (25+ providers) • CAHPS for PQRS using CMS-certified survey vendor (2+ providers) (CAHPS is supplemental to other reporting mechanisms) (required for groups of 100+ providers) • *PQRS group practices must register for the GPRO and select their reporting mechanism by **June 30, 2016**. For more information about reporting PQRS measures as a group, visit the PQRS How to Get Started webpage.*

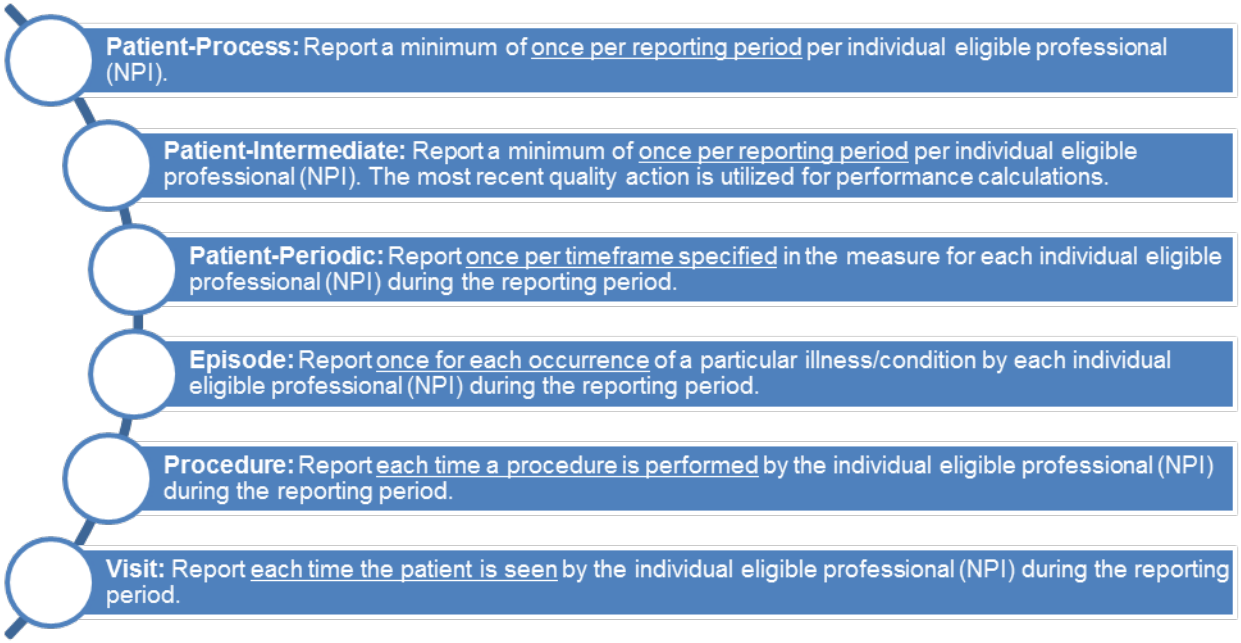
Note: As outlined in the 2016 MPFS final rule, all PQRS quality measure data collected from individual EPs and PQRS group practices via all reporting mechanisms are available for public reporting. In addition, all individual and group-level QCDR measures and CAHPS for PQRS summary survey measures are available for public reporting. All data that meet the public reporting standards will be published on Physician Compare in late 2017. For more information on public reporting, view the CMS Physician Compare Initiative website.

Analysis of PQRS Data: Reporting Frequency and Performance Timeframes

Reporting frequency and performance timeframes are considerations for satisfactorily reporting through the various PQRS reporting mechanisms.

What is "reporting frequency"?

Each measure specification includes a reporting frequency for each denominator-eligible patient (see section on **Measure Selection Considerations**) seen during the reporting period. The reporting frequency described in the measure specification's instructions applies to each individual EP and PQRS group practice submitting individual PQRS measures. The reporting frequency is used in analyzing each measure to help determine satisfactory reporting, according to the reporting frequency in the "Instructions" section of the measure:



What is a performance timeframe?

A measure's performance timeframe is defined in the measure's description and is distinct from the reporting frequency requirement defined in the measure's instructions. The performance timeframe, unique to each measure, outlines the timeframe in which the clinical action described in the numerator may be completed. See **Appendix A: Glossary of Terms****.**

Satisfactorily Report Measures

PQRS EPs and PQRS group practices can refer to the following educational resources, available in 2016:

- "2016 Physician Quality Reporting System (PQRS) Electronic Health Record (EHR) Reporting Made Simple" available on the PQRS Electronic Reporting Using an EHR webpage
- "2016 Physician Quality Reporting System (PQRS) Measures – Registry Reporting Made Simple" available on the PQRS Registry Reporting webpage
- "2016 Physician Quality Reporting System (PQRS) Qualified Clinical Data Registry (QCDR) Participation Made Simple" available on the PQRS Qualified Clinical Data Registry Reporting webpage
- "2016 Physician Quality Reporting System (PQRS) Measures – Claims Reporting Made Simple" available on the PQRS Measures Codes webpage
- "2016 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) Web Interface Reporting Made Simple" available on the PQRS GPRO Web Interface webpage
- "2016 CMS-Certified Survey Vendor Made Simple" available on the PQRS CMS-Certified Survey Vendor webpage
- "2016 Physician Quality Reporting System (PQRS) Getting Started with Measures Groups" available on the PQRS Measures Codes webpage

What's the difference between "satisfactory reporting" vs. "satisfactory participation?"

"**Satisfactory reporting**" refers to participating in 2016 PQRS to avoid the 2018 negative payment adjustment while "**satisfactory participation**" refers to EPs participating in the "qualified clinical data registry (QCDR)" reporting mechanism.

What are the components of a measure?

Please refer to page 7 for more information on measure components.

How should I select which reporting mechanism to use?

Refer to **Appendix B: Decision Trees – 2016 PQRS Reporting/Participation for Avoiding the 2018 PQRS Negative Payment Adjustment** for the *Decision Trees* designed to help participants select among the multiple reporting mechanisms available in PQRS.

Note: For the claims and registry reporting mechanisms, individual EPs and PQRS group practices that report less than 9 measures or less than 3 NQS domains will be subject to Measure-Applicability Validation (MAV). For more information on MAV, please see the PQRS Analysis and Payment webpage.

Appendix A: Glossary of Terms

Terms	Definitions
Base Claim Diagnosis	PQRS refers to all diagnoses listed (Item 21 of the CMS-1500 claim form, field 66 of the CMS-1450 form) associated with physician office, outpatient, and inpatient visits for reporting.
CMS-1450 Form	The CMS-1450 form (UB-04 at present) can be used by an institutional provider to bill a Medicare fiscal intermediary when a provider qualifies for a waiver from the Administrative Simplification Compliance Act requirement for electronic submission of claims. It is also used for billing of institutional charges to most Medicaid State Agencies. Please contact your Medicaid State Agency for more details on their requirements for this paper form. Regardless of the reporting mechanism, CAH II providers will need to continue to add their NPI to the MCS-1450 claim form for analysis of PQRS reporting at the NPI-level. Refer to Appendix E for more information.
CMS-1500 Form	Health Insurance Claim Form CMS-1500 is the standard paper claim form to bill Medicare Fee-For-Service (FFS) Contractors when a paper claim is allowed. Form CMS-1500 may be suitable for billing various government and some private insurers. Refer to Appendix D for more information.
CMS-Certified Survey Vendor	A CMS-certified survey vendor is a reporting mechanism for purposes of reporting CAHPS for PQRS surveys for PQRS group practices. The CMS-certified survey vendor is required to be certified for a particular program year by CMS in order to submit the CAHPS for PQRS survey data.
Claim	For PQRS purposes, one or more claims will be reconnected based on TIN, NPI, beneficiary, and date of service.
Claim Adjustment Reason Code (CARC)	Claim adjustment reason codes (CARC) communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.
CPT Category II Codes or CPT II codes	A set of supplemental CPT codes intended to be used for performance measurement. These codes may be used to facilitate data collection about the quality of care rendered by coding certain services, test results or clinical actions that support nationally established performance measures and that the evidence has demonstrated to contribute to quality patient care.[2] For PQRS, CPT Category II codes are used to report quality measures on a claim for measurement calculation. CPT Category II or CPT II codes were developed through the CPT Editorial Panel for use in performance measurement, encode the clinical action(s) described in a measure's numerator. CPT II codes consist of five alphanumeric characters in a string ending with the letter "F." CPT II codes are not modified or updated during the reporting period and remain valid for the entire program year as published in the measure specifications manuals and related documents for PQRS.

Terms	Definitions
Denominator (Eligible Cases)	The lower portion of a fraction used to calculate a rate, proportion, or ratio. The denominator must describe the population eligible (or episodes of care) to be evaluated by the measure. This should indicate age, condition, setting, and timeframe (when applicable). For example, “Patients aged 18 through 75 years with a diagnosis of diabetes.” **PQRS measure denominators are identified by ICD-10-CM, CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc.), and place of service (if applicable).**
Denominator Exception	The definition included there is 'Those conditions that should remove a patient, procedure, or unit of measurement from the denominator of the performance rate only if the numerator criteria are not met. Denominator exceptions allow for adjustment of the calculated score for those providers with higher risk populations. Denominator exceptions are used only in proportion measures. Denominator exceptions allow for the exercise of clinical judgment and should be specifically defined where capturing the information in a structured manner fits the clinical workflow. These cases are removed from the denominator; however, the number of patients with valid exceptions may still be reported. Exceptions allow for the exercise of clinical judgment. Allowable reasons fall into three general categories: • Medical reasons • Patient reasons • System reasons
Denominator Exclusion	Patients with conditions who should be removed from the measure population and denominator before determining if numerator criteria are met. Patients who should be removed from the measure population and denominator before determining if numerator criteria are met. Denominator exclusions are used in proportion and ratio measures to help narrow the denominator. For example, patients with bilateral lower extremity amputations would be listed as a denominator exclusion for a measure requiring foot exams.
Denominator Statement	A statement that describes the population eligible for the performance measure. For example, “Patients aged 18 through 75 years with a diagnosis of diabetes.”
Diagnosis Pointer	Item 24E of the CMS-1500 claim form or electronic equivalent. For PQRS, the line item containing the quality-data code (QDC) for the measure should point to one diagnosis (from Item 21) per measure-specific denominator coding. To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure’s diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses are considered in PQRS analysis.
Electronic Health Record (EHR)	The Electronic Health Record (EHR) is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter - as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.

Terms	Definitions
Eligible Professional (EP)	Refer to the PQRS How to Get Started webpage for the "2016 PQRS List of Eligible Professionals" Some professionals may be eligible to participate per their specialty, but due to billing method may not be *able* to participate: • Professionals who **do not** bill Medicare at an individual National Provider Identifier (NPI) level, where the rendering provider's individual NPI is entered on CMS-1500 or CMS-1450 type paper or electronic claims billing, associated with specific line-item services. Services payable under fee schedules or methodologies other than the MPFS are not included in PQRS. **Please note:** EPs who render denominator-eligible services under Medicare Part B PFS via CMS-1500 or CMS-1450 claim ***are*** able to participate in PQRS regardless of the organization's participation in other fee schedules or methodologies. For example, an EP who bills under an organization that is registered as a federally qualified health center (FQHC), yet (s)he renders services that are not covered by the FQHC methodology.
Encounter	Encounters with patients during the reporting period which include: CPT Category I E/M service codes, CPT Category I procedure codes, or HCPCS codes found in a PQRS measure's denominator. These codes count as eligible to meet a measure's inclusion requirements when occurring during the reporting period.
G-codes for PQRS	A set of CMS-defined temporary HCPCS codes used to report quality measures on a claim. G-codes are maintained by CMS.
Group Practice Reporting Option (GPRO)	The Group Practice Reporting Option (GPRO) was introduced in 2010 as a reporting mechanism for group practices to participate in PQRS. PQRS defines a group practice as a single TIN with 2 or more individual EPs (as identified by Individual NPI) that have reassigned their billing rights to the TIN.
ICD-10-CM Diagnosis Codes	ICD-10-CM is a clinical modification of the World Health Organization's ICD-10, which consists of a diagnostics classification system. ICD-10-CM includes the level of detail needed for morbidity classification and diagnostics specificity in the United States.[9] For more information on ICD-10 implementation, visit the CMS ICD-10 Website: https://www.cms.gov/Medicare/Coding/ICD10/index.html.
Line-Item Diagnosis	Six service lines are in Section 24 of the CMS-1500 claim form to accommodate submission of the rendering NPI and supplemental information to support the billed service, including the pointed diagnosis from Item 21. QDCs are submitted on the line item in section 24 for PQRS.

Terms	Definitions

Measure	• **Performance Measure**
	  • A quantitative tool (e.g., rate, ratio, index, percentage) that provides an indication of performance in relation to a specified process or outcome.
	  • See also process measure and outcome measure.[1,6]
	• **Measure Types**
	  • **Outcome measure:** A measure that assesses the results of healthcare that are experienced by patients: clinical events, recovery and health status, experiences in the health system, and efficiency/cost.[6]
	  • **Process measure:** A measure that focuses on steps that should be followed to provide good care. There should be a scientific basis for believing that the process, when executed well, will increase the probability of achieving a desired outcome.[6]
	  • **Structural measure:** A measure that assesses features of a healthcare organization or clinician relevant to its capacity to provide healthcare.[6]

Measure Reporting Frequency	• **Patient-Process:** Report a minimum of once per reporting period per individual EP (NPI).
	  • If the measure is reported more than once during the reporting period, performance rates are calculated using the most advantageous QDC submitted.
	  • Reflect quality actions performed throughout the reporting period or other timeframe.
	• **Patient-Intermediate:** Report a minimum of once per reporting period per individual EP (NPI).
	  • If the measure is reported more than once during the reporting period, performance rates are calculated using the most recent QDC submitted.
	  • Often reflects lab or other test value, so the most recent measurement is desired.
	• **Patient-Periodic:** Report once per timeframe specified in the measure for each individual EP (NPI) during the reporting period.
	  • Examples include once per month and three times per year.
	• **Episode:** Report once for each occurrence of a particular illness/condition by each individual EP (NPI) during the reporting period.
	  • Usually reflects a clinical episode, difficult to determine from a single Part B claim.
	  • Requires specialized analytics to determine the episode.
	• **Procedure:** Report each time a procedure is performed by the individual EP (NPI) during the reporting period.
	• **Visit:** Report each time the patient is seen by the individual EP (NPI) during the reporting period.

Terms	Definitions
NPI	National Provider Identifier of the individual EP billing under the Tax ID ("NPI within the Tax ID").
Performance Numerator	The upper portion of a fraction used to calculate a rate, proportion, or ratio. The numerator must detail the quality clinical action expected that satisfies the condition(s) and is the focus of the measurement for each patient, procedure, or other unit of measurement established by the denominator (that is, patients who received a particular service or providers that completed a specific outcome/process)..
Numerator Statement	A statement that describes the clinical action that satisfies the conditions of the performance measure. For example, "Patients that were assessed for the presence or absence of urinary incontinence."
Performance Timeframe	A designated timeframe within which the action described in a performance measure should be completed. This timeframe is generally included in the measure description and may or may not coincide with the measure's data reporting frequency requirement.
Performance Measure Exclusion Modifiers	Modifiers developed exclusively for use with CPT Category II codes to indicate documented medical (1P), patient (2P), or system (3P) reasons for excluding patients from a measure's denominator.[2]
Performance Measure Reporting Modifier 8P	The 8P reporting modifier is intended to be used as a "reporting modifier" to allow the reporting of circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified. 8P performance measure reporting modifier - action not performed, reason not otherwise specified [2]
Place of Service	References Place of Service Codes (POS) from the list provided in section 10.5 of the "Medicare Claims Processing Manual".
Qualified Clinical Data Registry (QCDR)	A CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients.
Quality-Data Code (QDC)	Specified CPT Category II codes with or without modifiers and G-codes used for submission of PQRS data via claims-based or registry reporting mechanisms. The "2016 Physician Quality Reporting System (PQRS) Individual Measure Specifications for Claims and Registry" contains all codes associated with each PQRS measure and instructions for data submission. QDCs are non-payable Healthcare Common Procedure Coding System (HCPCS) codes composed of specified CPT Category II codes and/or G-codes that describe the clinical action required by a measure's numerator. Clinical actions can apply to more than one condition and, therefore, can also apply to more than one measure. For PQRS, where necessary, to avoid shared CPT Category II codes, G-codes are used to distinguish clinical actions across measures. Some measures require more than one clinical action and may have more than one CPT Category II code, G-code, or a combination associated with them. EPs should review numerator reporting instructions for each measure carefully.

Terms	Definitions
Qualified Registry	An entity that collects clinical data from an EP or group practice and submits it to CMS on behalf of the EP or group practice.
Rationale	A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results.[4]
Remittance Advice (RA)	Means utilized by Medicare contractors to communicate to providers, submitting measures through the claims-based reporting mechanism, of processing decisions such as payments, adjustments, and denials.[7]
Remittance Advice Remark Codes (RARC)	Remittance Advice Remark Codes (RARCs) are used to provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC) or to convey information about remittance processing. Each RARC identifies a specific message as shown in the Remittance Advice Remark Code List. There are two types of RARCs, supplemental and informational. The majority of the RARCs are supplemental; these are generally referred to as RARCs without further distinction. Supplemental RARCs provide additional explanation for an adjustment already described by a CARC. The second type of RARC is informational; these RARCs are all prefaced with **Alert:** and are often referred to as Alerts. Alerts are used to convey information about remittance processing and are never related to a specific adjustment or CARC.
Reporting Frequency	The number of times quality-data codes (QDCs) specified for a quality measure must be submitted on claims during the reporting period. The reporting frequency for each measure is described in the "2016 Physician Quality Reporting System (PQRS) Individual Measure Specifications for Claims and Registry" posted on the CMS Web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html
Reporting Mechanisms	2016 reporting mechanisms available for avoiding the payment adjustment: claims-based; registry-based; electronic health record (EHR); participation via QCDR; CAHPS for PQRS, or group practice reporting option (GPRO) Web Interface. Refer to **Appendix B: "Decision Trees – 2016 PQRS Reporting/Participation for Avoiding the 2018 Negative Payment Adjustment"**.
Reporting Period	The period during which PQRS measures are to be reported for covered professional services provided. A 12-month (January 1, 2016 through December 31, 2016) time period is available for the 2016 reporting mechanism the EP selects for submitting PQRS quality data.

Sources

1. Agency for Health Care Research & Quality (AHRQ) National Quality Measures Clearinghouse Glossary

2. IBID, PSNet, Patient Safety Network Glossary

3. American Medical Association (AMA), CPT® Category II Index of Alphabetic Clinical Topics

4. Institute of Medicine (IOM), Performance Measurement Accelerating Improvement, Appendix A Glossary, National Academies Press

5. Joint Commission on Accreditation of Health Care Organizations (JCAHO)

6. CMS Blueprint for the CMS Measures Management System, Version 11, July 2014

7. QualityNet, QMIS Specification Manual for National Hospital Quality Measures, Appendix D-3, Glossary of Terms version 2.3b, 9-28-2007

8. CMS Medicare Learning Network, Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers

9. Medicare Claims Processing Manual: Chapter 26 – Completing and Processing Form CMS – 1500 Data Set

10. American Health Information Management Association (AHIMA), Understanding ICD-10, retrieved from official AHIMA website

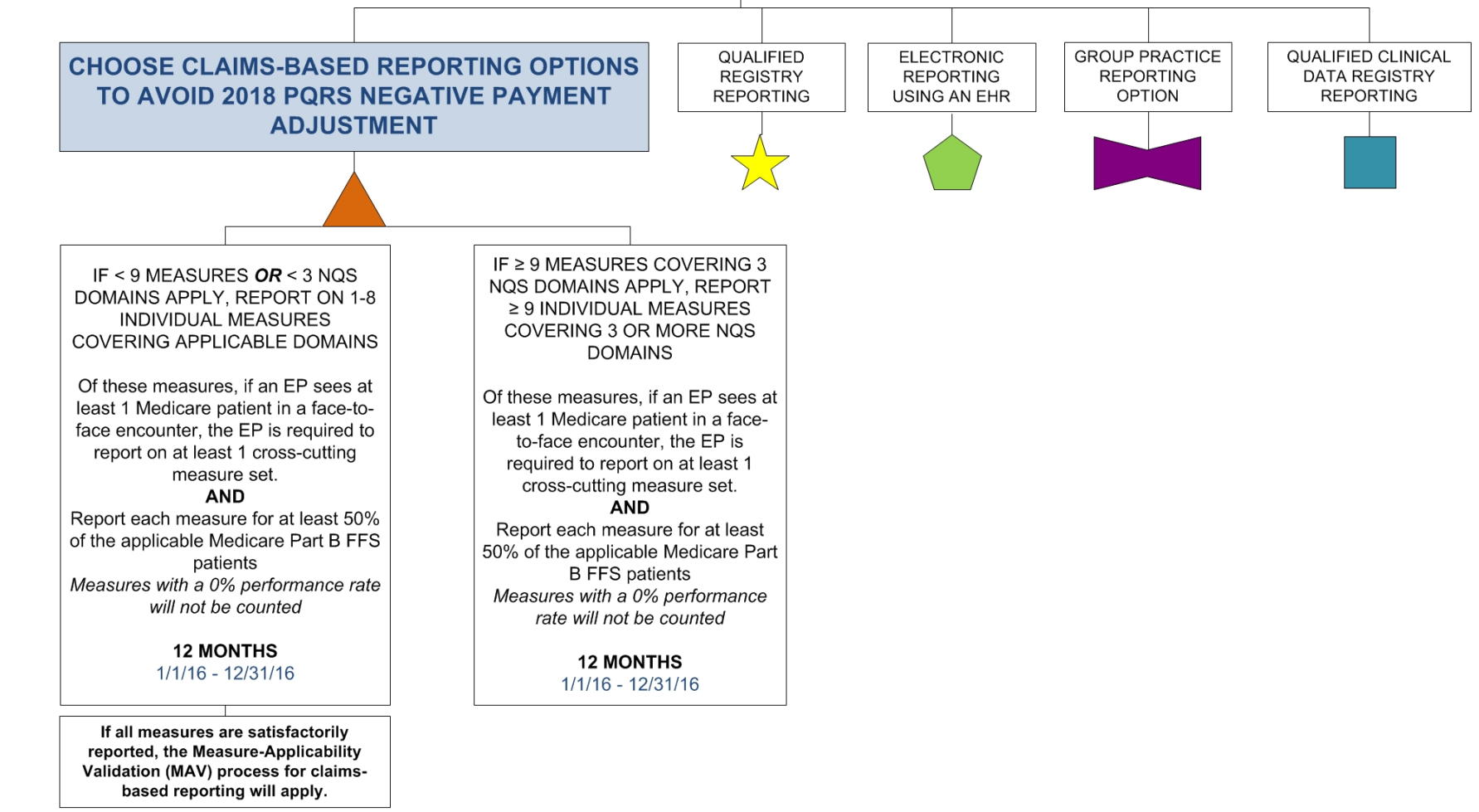
Appendix B: Decision Trees - 2016 PQRS Reporting/Participation for Avoiding the 2018 Negative Payment Adjustment

The individual EP or PQRS group practice will need to determine the best reporting mechanism for participation. PQRS group practices will select their reporting mechanism during registration and the group will need to meet the reporting requirements for the group size selected regardless of changes to the group size after registration. Following are the different reporting mechanisms available for participation in 2016 PQRS as an individual EP or as a PQRS group practice.

I WANT TO PARTICIPATE IN 2016 PQRS TO AVOID THE 2018 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING MECHANISM

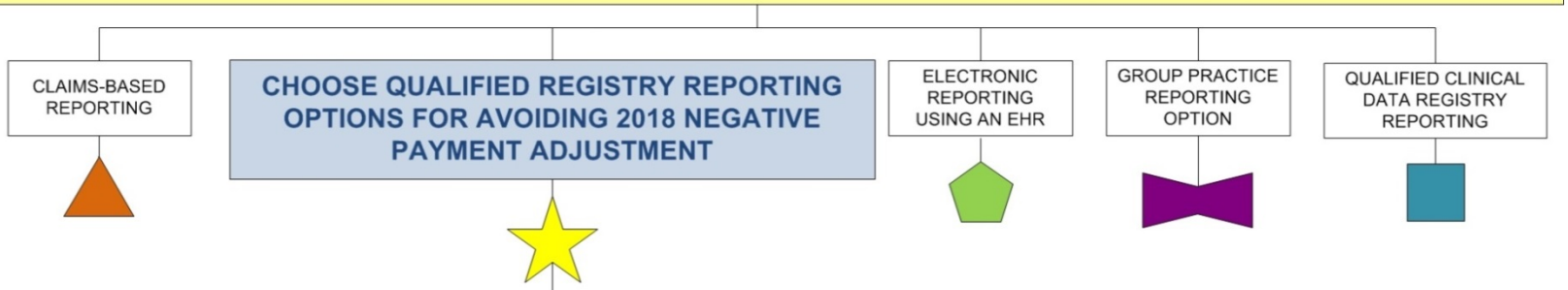
(Refer to the *2016 Physician Quality Reporting System Measures List* for a listing of all 2016 measures and associated NQS domains for a specific reporting mechanism. Also review the appropriate measure specifications for the selected reporting mechanism(s) for 2016 PQRS)



I WANT TO PARTICIPATE IN 2016 PQRS TO AVOID THE 2018 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING MECHANISM

(Refer to the *2016 Physician Quality Reporting System Measures List* for a listing of all 2016 measures and associated NQS domains for a specific reporting mechanism. Also review the appropriate measure specifications for the selected reporting mechanism(s) for 2016 PQRS)



INDIVIDUAL MEASURES

IF < 9 MEASURES ***OR*** < 3 NQS DOMAINS APPLY, REPORT ON 1-8 INDIVIDUAL MEASURES COVERING APPLICABLE DOMAINS

Of these measures, if an EP sees at least 1 Medicare patient in a face-to-face encounter, the EP is required to report on at least 1 cross-cutting measure in the PQRS cross-cutting measures set.

AND

Report each measure for at least 50% of the applicable Medicare Part B FFS patients.

Measures with a 0% performance rate will not be counted

12 MONTHS
1/1/16 - 12/31/16

If all measures are satisfactorily reported, the Measure-Applicability Validation (MAV) process for registry-based reporting will apply.

IF ≥ 9 MEASURES COVERING 3 NQS DOMAINS APPLY, REPORT ≥ 9 INDIVIDUAL MEASURES COVERING 3 OR MORE NQS DOMAINS

Of these measures, if an EP sees at least 1 Medicare patient in a face-to-face encounter, the EP is required to report on at least 1 cross-cutting measure in the PQRS cross-cutting measures set.

AND

Report each measure for at least 50% of the applicable Medicare Part B FFS patients.

Measures with a 0% performance rate will not be counted

12 MONTHS
1/1/16 - 12/31/16

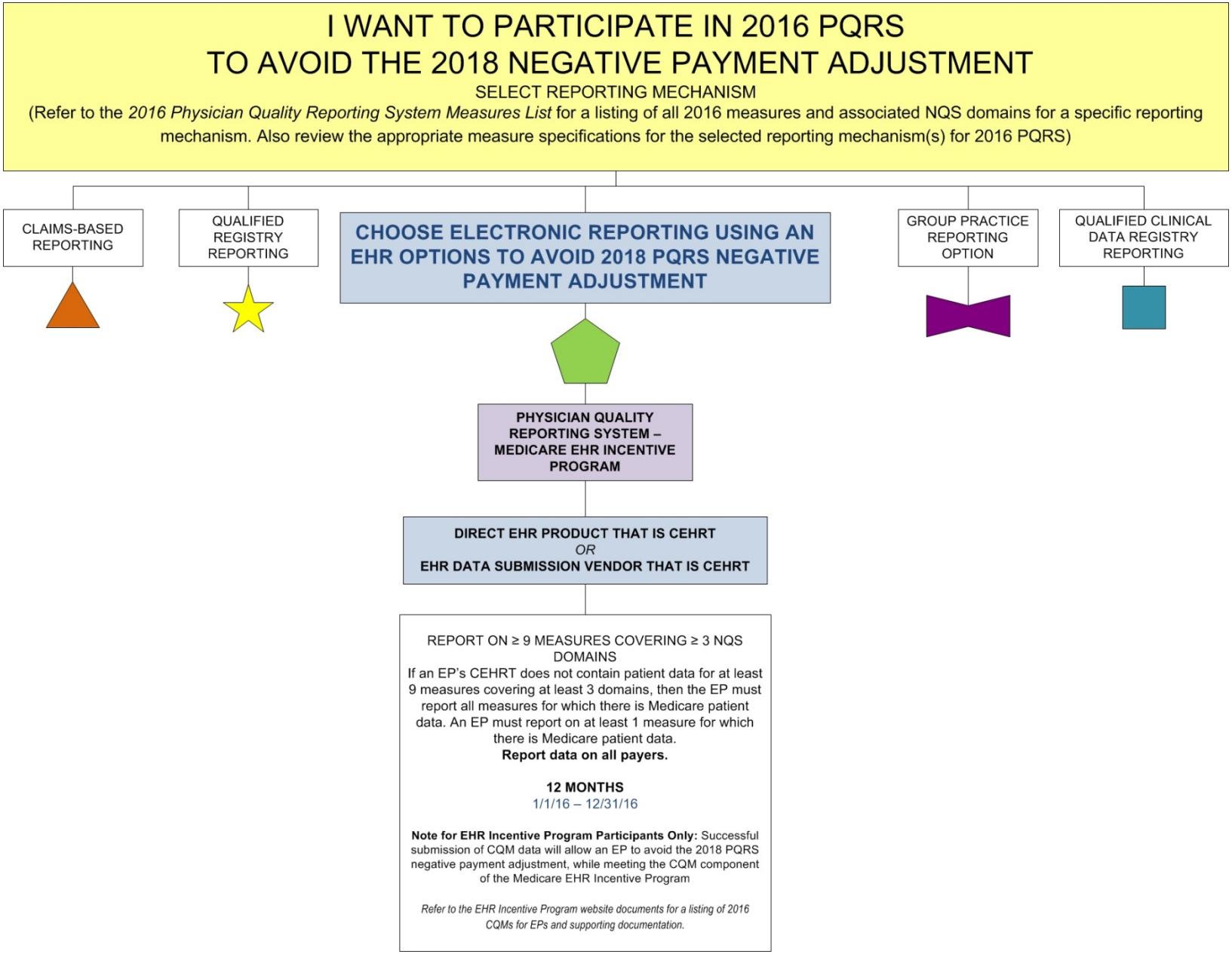
MEASURES GROUP(S)

SUBMIT ≥ 1 MEASURES GROUP FOR

12 MONTHS
1/1/16 – 12/31/16

20 APPLICABLE PATIENTS FOR A MEASURES GROUP (a majority [11] must be Medicare Part B FFS patients)

Measures Groups containing a measure with a 0% performance rate will not be counted



I WANT TO PARTICIPATE IN 2016 PQRS TO AVOID THE 2018 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING MECHANISM

(Refer to the *2016 Physician Quality Reporting System Measures List* for a listing of all 2016 measures and associated NQS domains for a specific reporting mechanism. Also review the appropriate measure specifications for the selected reporting mechanism(s) for 2016 PQRS)

CHOOSE TO PARTICIPATE IN QUALIFIED CLINICAL DATA REGISTRY REPORTING OPTION TO AVOID 2018 NEGATIVE PAYMENT ADJUSTMENT

≥ 9 MEASURES ACROSS 3 NQS DOMAINS APPLY

REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING 3 NQS DOMAINS AND REPORT ≥ **50%** OF APPLICABLE PATIENTS

Of these measures, report on at least 2 outcome measures. If 2 outcome measures are not available, report on at least 1 outcome measure and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.

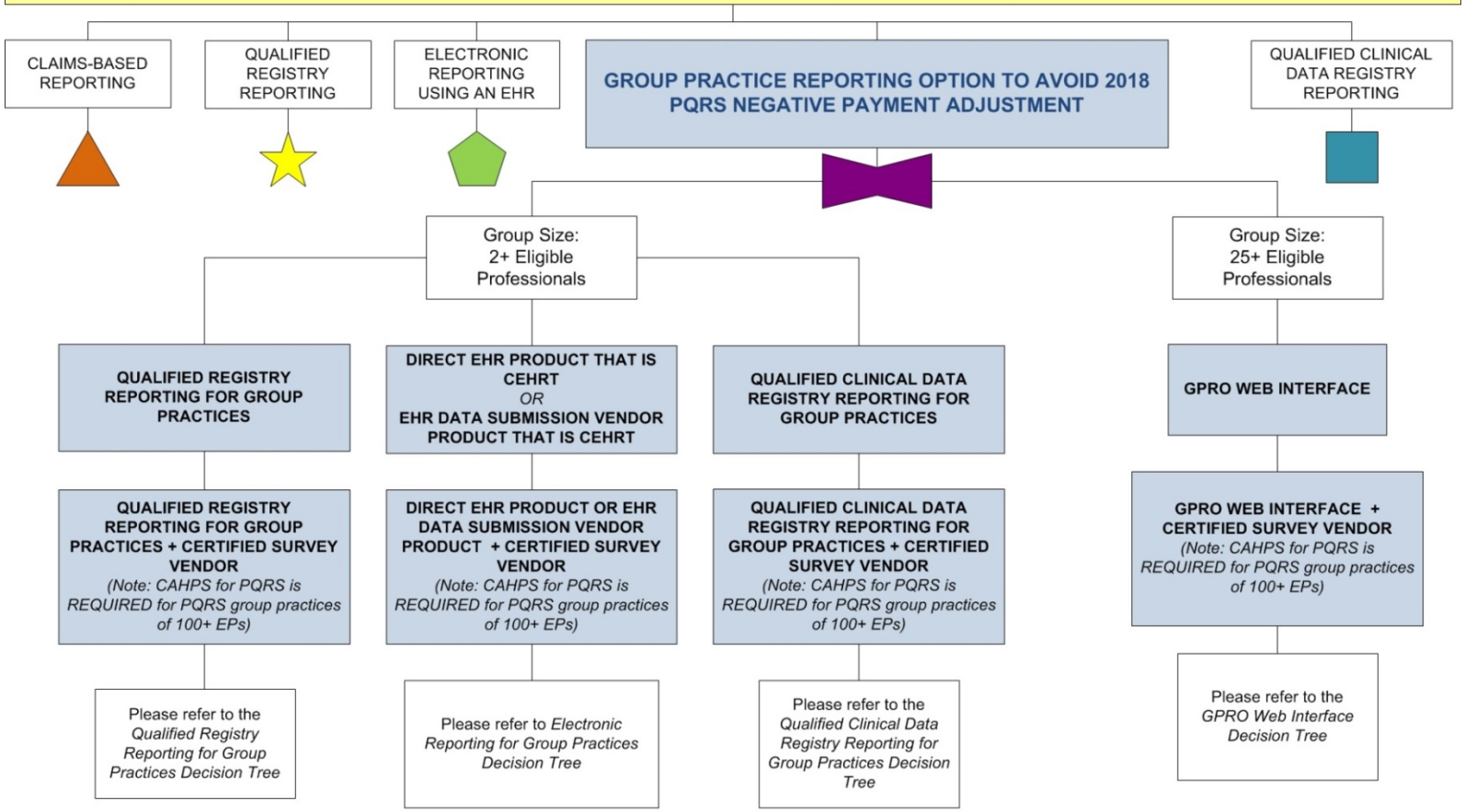
12 MONTHS
1/1/16 - 12/31/16

EPs participating via qualified clinical data registry are not limited to PQRS measures (maximum 30 non-PQRS - all payers)

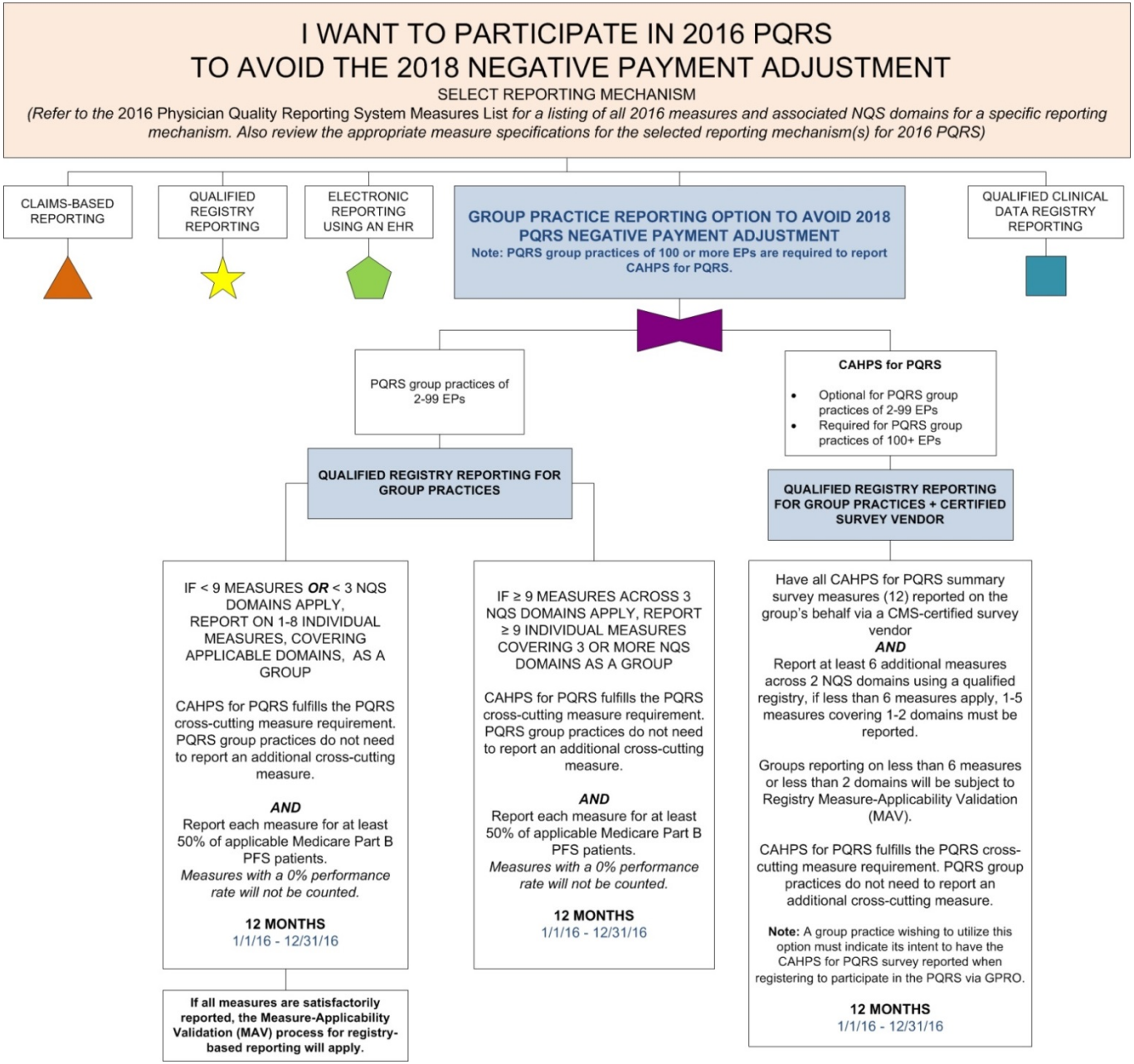
I WANT TO PARTICIPATE IN 2016 PQRS TO AVOID THE 2018 NEGATIVE PAYMENT ADJUSTMENT

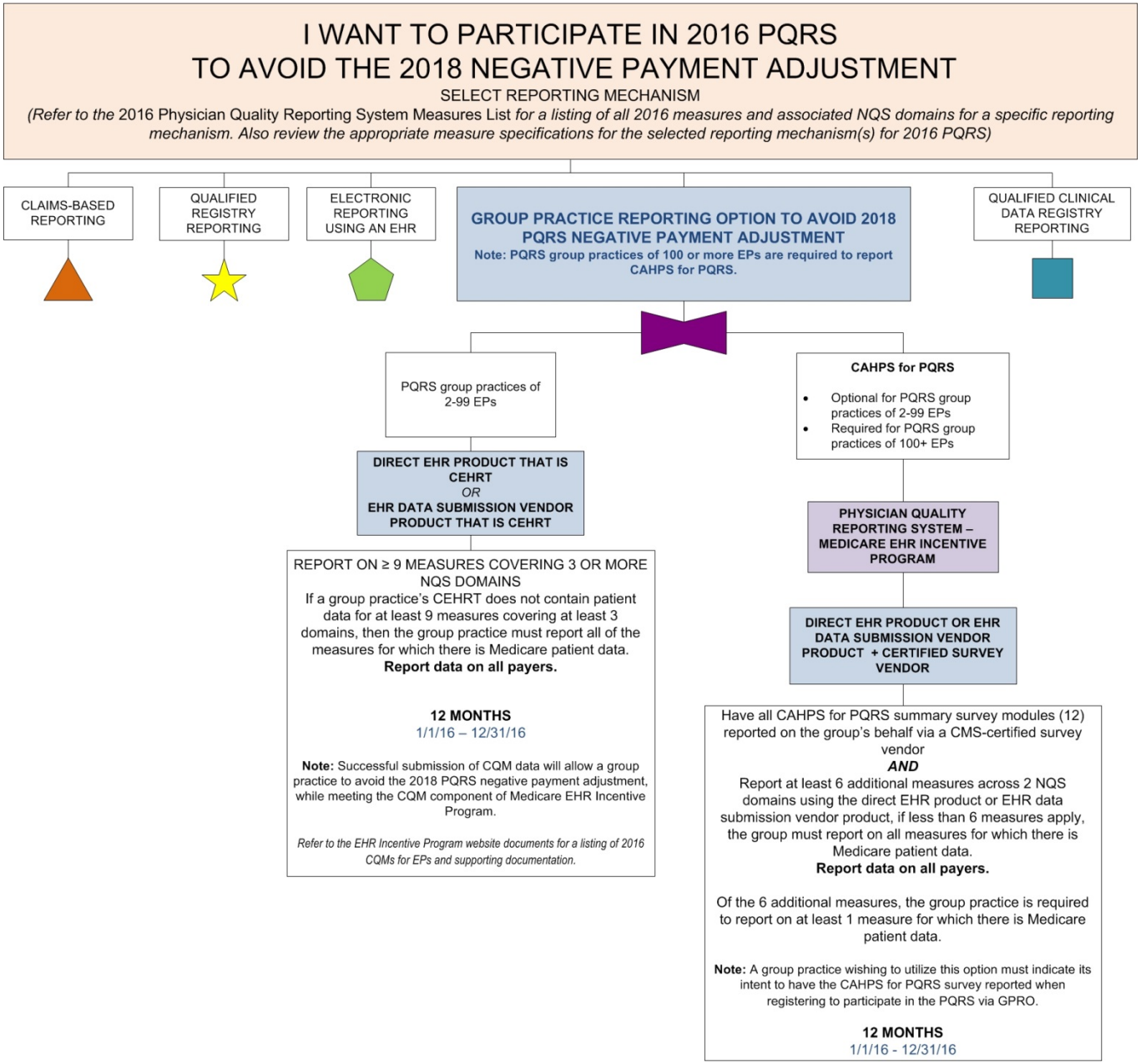
SELECT REPORTING MECHANISM

(Refer to the *2016 Physician Quality Reporting System Measures List* for a listing of all 2016 measures and associated NQS domains for a specific reporting mechanism. Also review the appropriate measure specifications for the selected reporting mechanism(s) 2016 PQRS)



A group practice wishing to participate in PQRS GPRO is required to complete the online registration by **June 30, 2016**.
Note: PQRS group practices must maintain the same TIN throughout the program year.

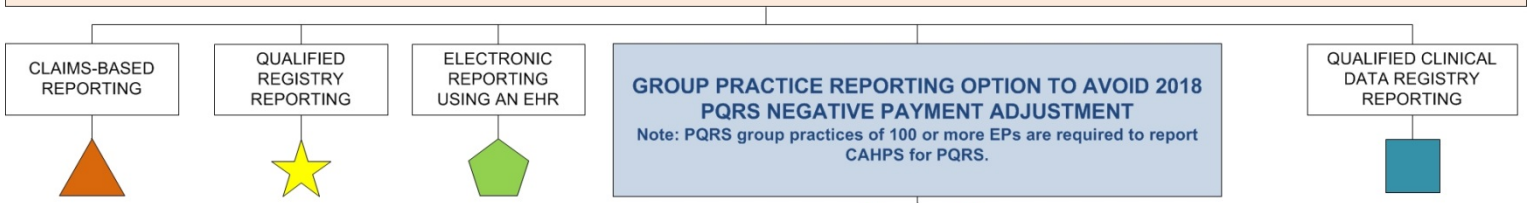




I WANT TO PARTICIPATE IN 2016 PQRS TO AVOID THE 2018 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING MECHANISM

(Refer to the 2016 Physician Quality Reporting System Measures List *for a listing of all 2016 measures and associated NQS domains for a specific reporting mechanism. Also review the appropriate measure specifications for the selected reporting mechanism(s) for 2016 PQRS)*



PQRS group practices of 2-99 EPs

QUALIFIED CLINICAL DATA REGISTRY REPORTING FOR GROUP PRACTICES

≥ 9 MEASURES ACROSS 3 NQS DOMAINS APPLY

REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING 3 NQS DOMAINS AND REPORT ≥ **50%** OF THE GROUP PRACTICE'S PATIENTS

Of these measures, report on at least 2 outcome measures. If 2 outcome measures are not available, report on at least 1 outcome measure and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.

12 MONTHS
1/1/16 - 12/31/16

PQRS group practices participating via qualified clinical data registry are not limited to PQRS measures (maximum 30 non-PQRS - all payers)

CAHPS for PQRS

- Optional for PQRS group practices of 2-99 EPs
- Required for PQRS group practices of 100+ EPs

QUALIFIED CLINICAL DATA REGISTRY REPORTING FOR GROUP PRACTICES + CERTIFIED SURVEY VENDOR

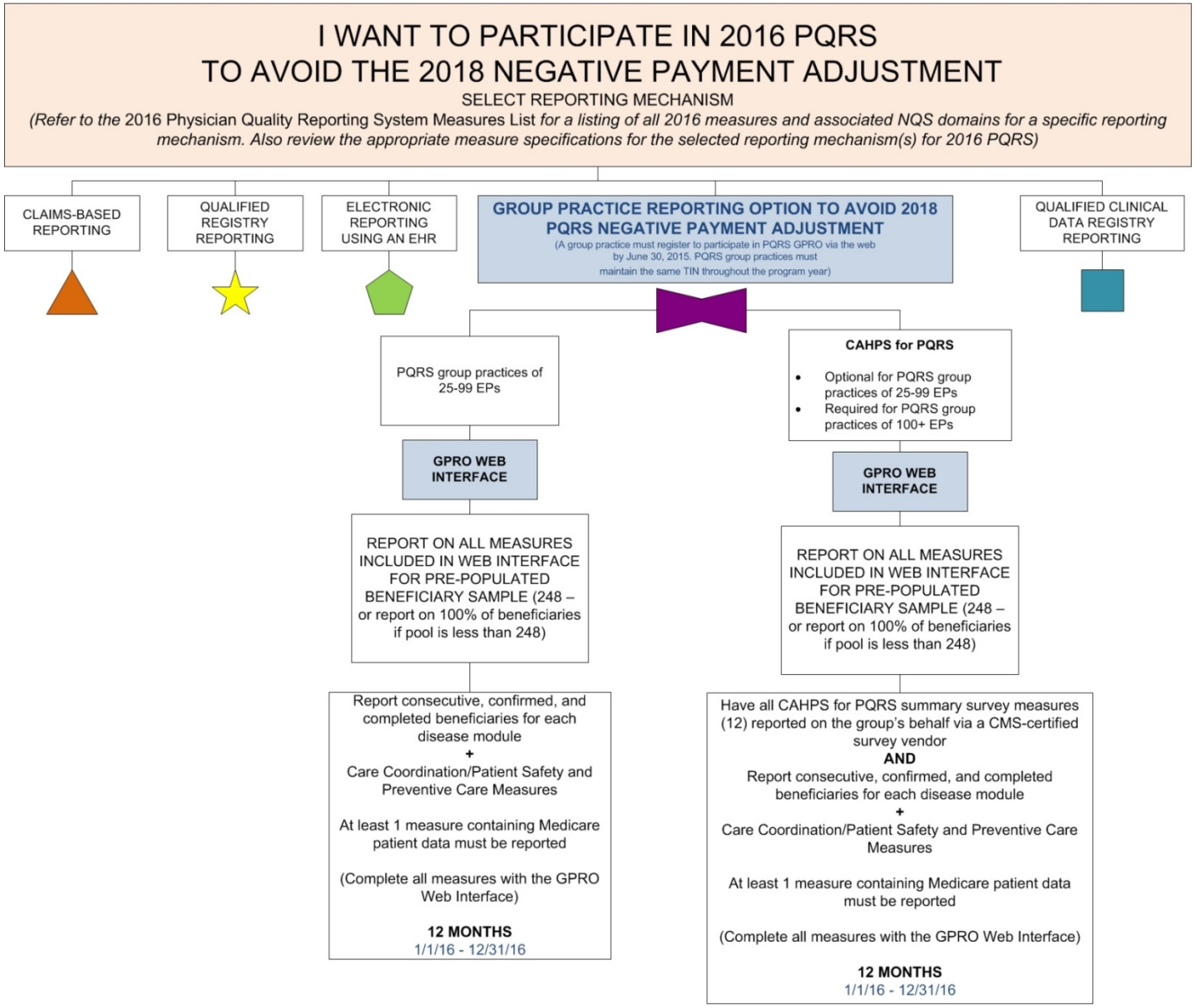
Have all CAHPS for PQRS summary survey measures (12) reported on the group's behalf via a CMS-certified survey vendor

AND

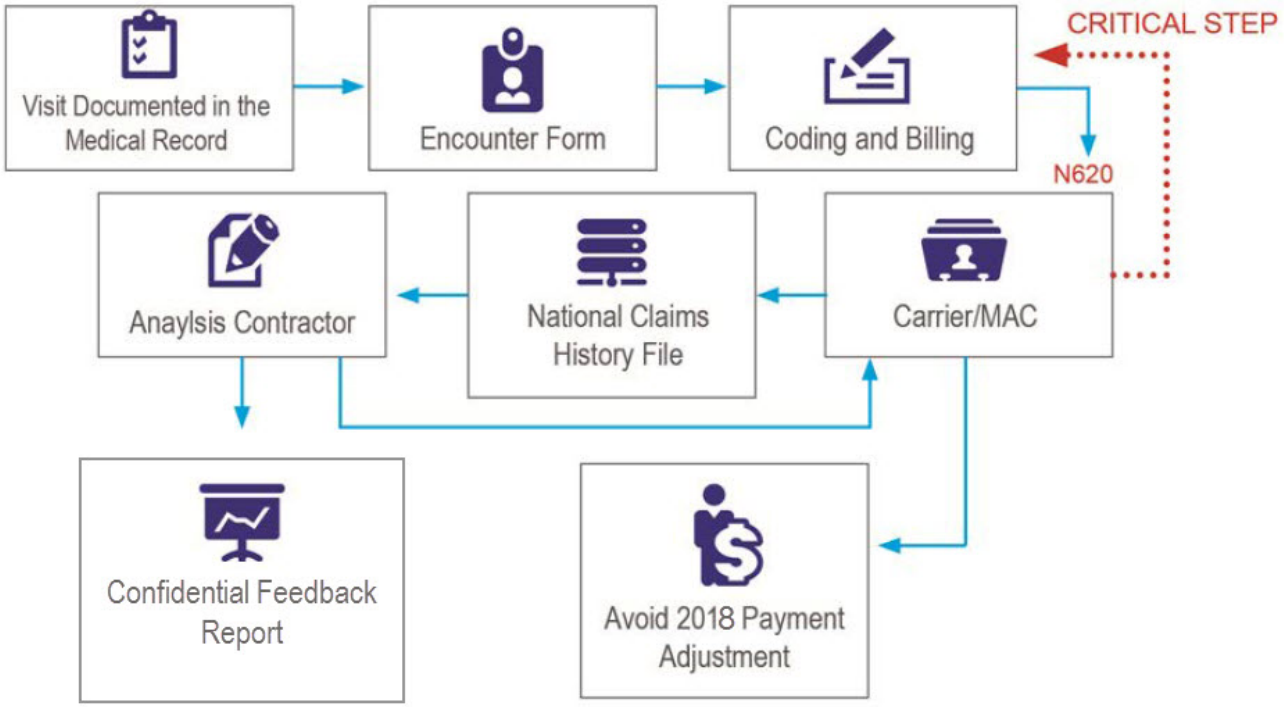
Report at least 6 additional measures across 2 NQS domains using a QCDR. Of the 6 additional measures, the group practice is required to report on at least 1 outcome measure.

Note: A group practice wishing to utilize this option must indicate its intent to have the CAHPS for PQRS survey reported when registering to participate in the PQRS via GPRO.

12 MONTHS
1/1/16 - 12/31/16

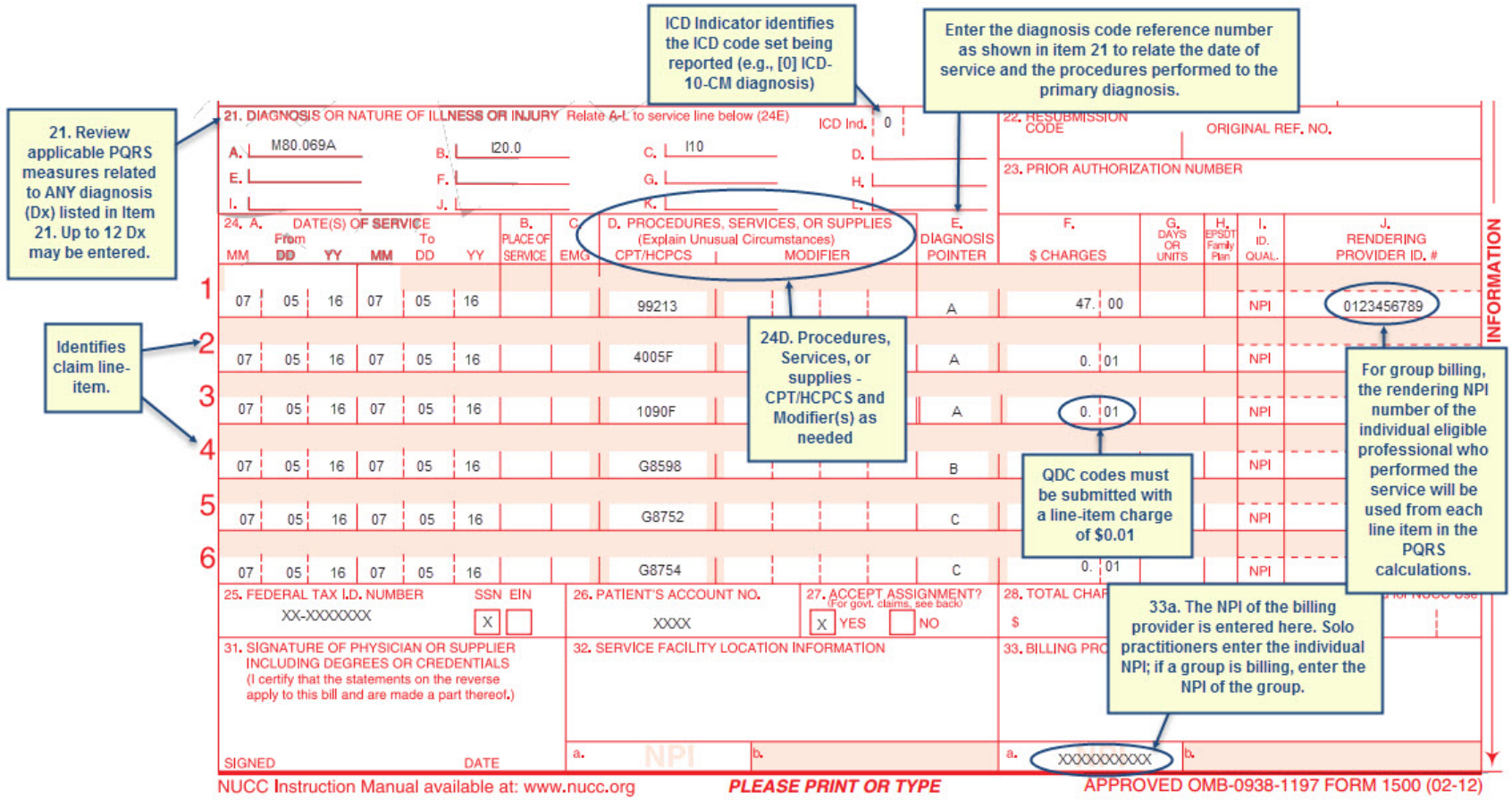


Appendix C: PQRS Claims-Based Process (Data Flow)



Appendix D: CMS-1500 Claim PQRS Example

Below is an example of an individual NPI reporting on a single CMS-1500 claim. See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf for more information and complete billing requirements.



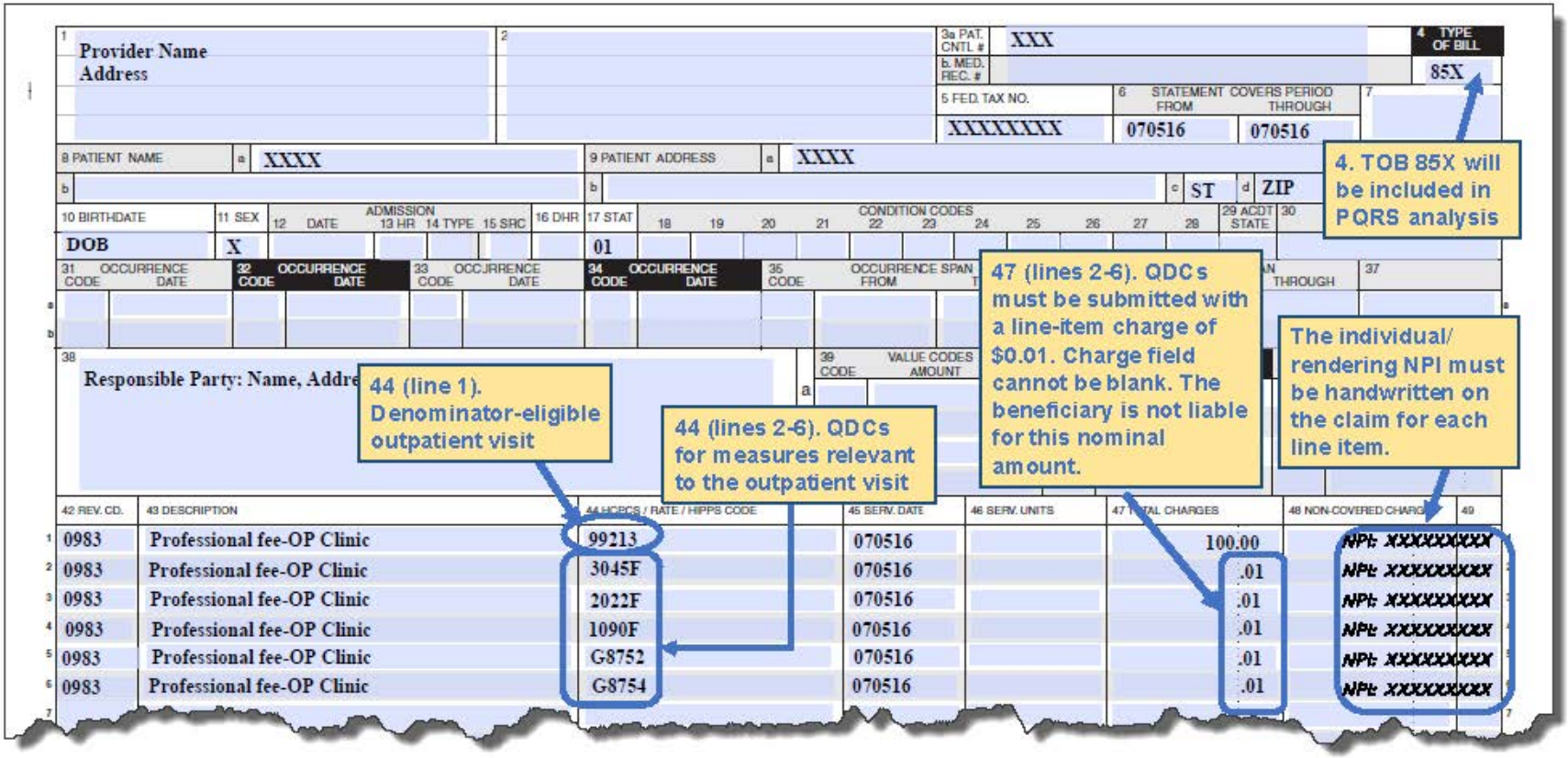
The patient was seen for an **office visit (99213)**. The provider is reporting several measures related to Osteoporosis, ischemic vascular disease (IVD), hypertension and urinary incontinence:

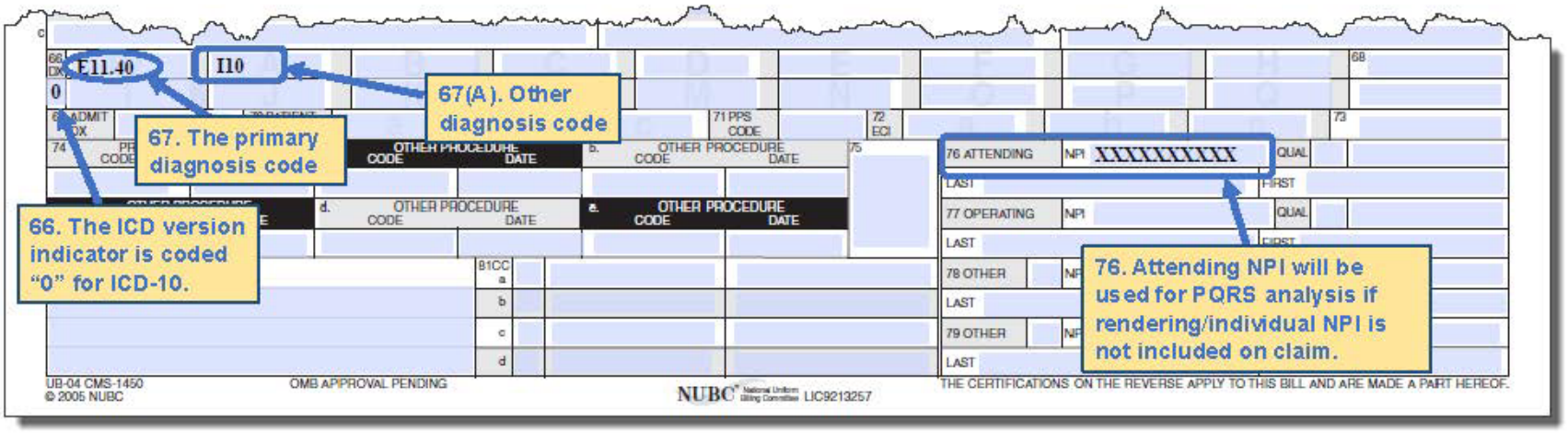
- **Measure #41** (Osteoporosis) with **QDC 4005F** + osteoporosis line-item diagnosis (24E points to DX **M80.069A** in Item 21);
- **Measure #48** (Assessment - Urinary Incontinence) with QDC 1**090F**. For PQRS, there is no specific diagnosis associated with this measure. Point to the appropriate diagnosis for the encounter.

- **Measure #204** (IVD) with QDC **G8598** + IVD line-item diagnosis (24E points to Dx **I20.0** in Item 21); and
- **Measure #236** (Controlling Hypertension) with QDCs **G8752** + **G8754** + Hypertension line-item diagnosis (24E points to Dx **I10** in Item 21).
- **Note:** All diagnoses listed in Item 21 will be used for PQRS analysis. Measures that require the reporting of two or more diagnoses on claim will be analyzed as submitted in Item 21.
- NPI placement: Item 24J must contain the NPI of the individual provider that rendered the service when a group is billing.
- If billing software limits the line items on a claim, you may add a nominal line-item charge of a penny to one of the QDC line items on that second claim. PQRS analysis will subsequently join both claims based on the same beneficiary, for the same date-of-service, for the same TIN/NPI and analyze as one claim.

Appendix E: CMS-1450 Claim PQRS Example

Below is an example of an individual EP under CAH Method II reporting PQRS quality-data codes (QDCs) for 2016 PQRS measures # 1, #117, #48, #236 on a single CMS-1450 claim. See the *Medicare Claims Processing Manual*, Chapter 25, for complete information about billing requirements.



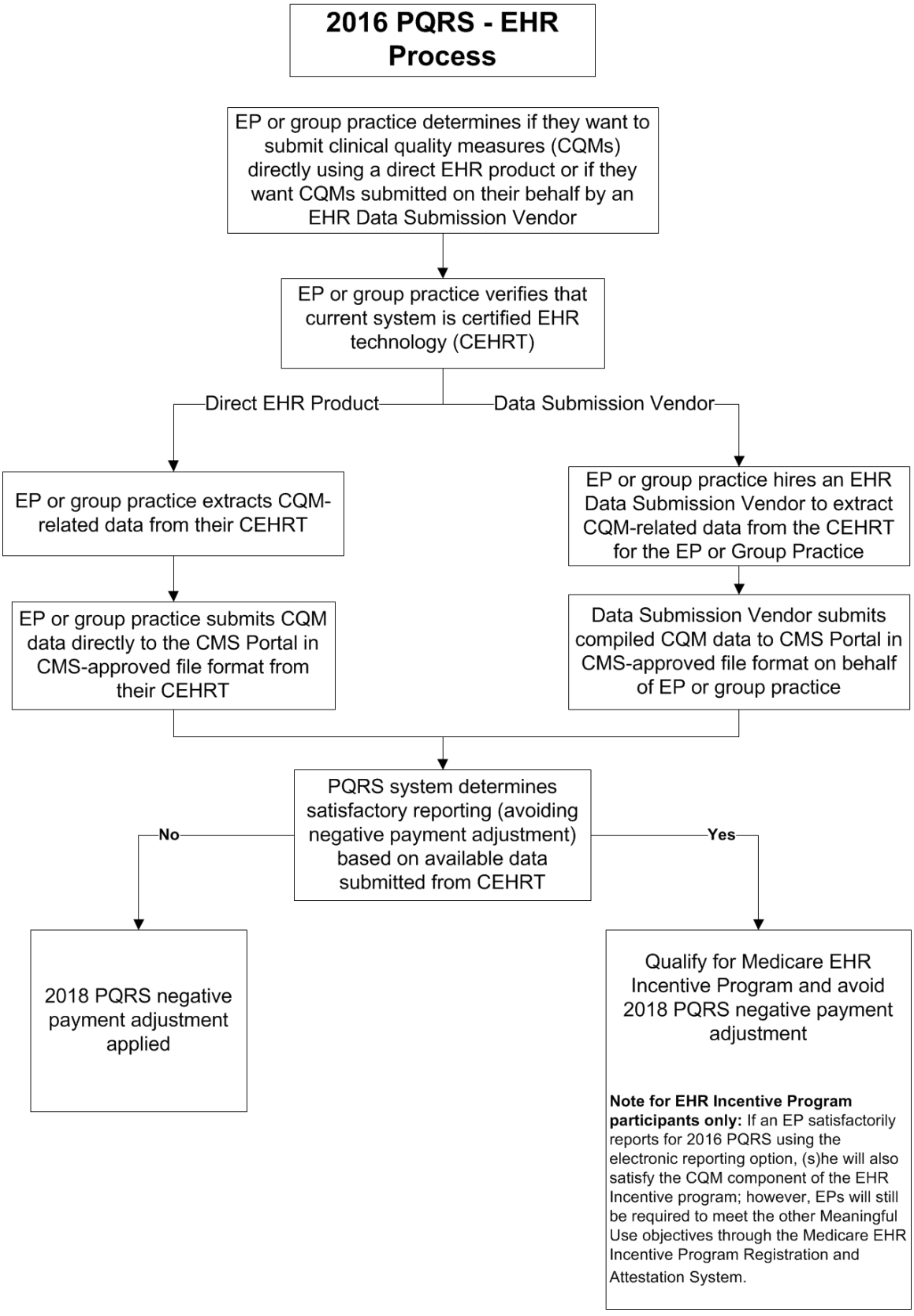


As shown in the above example, the following items are used for PQRS analysis:

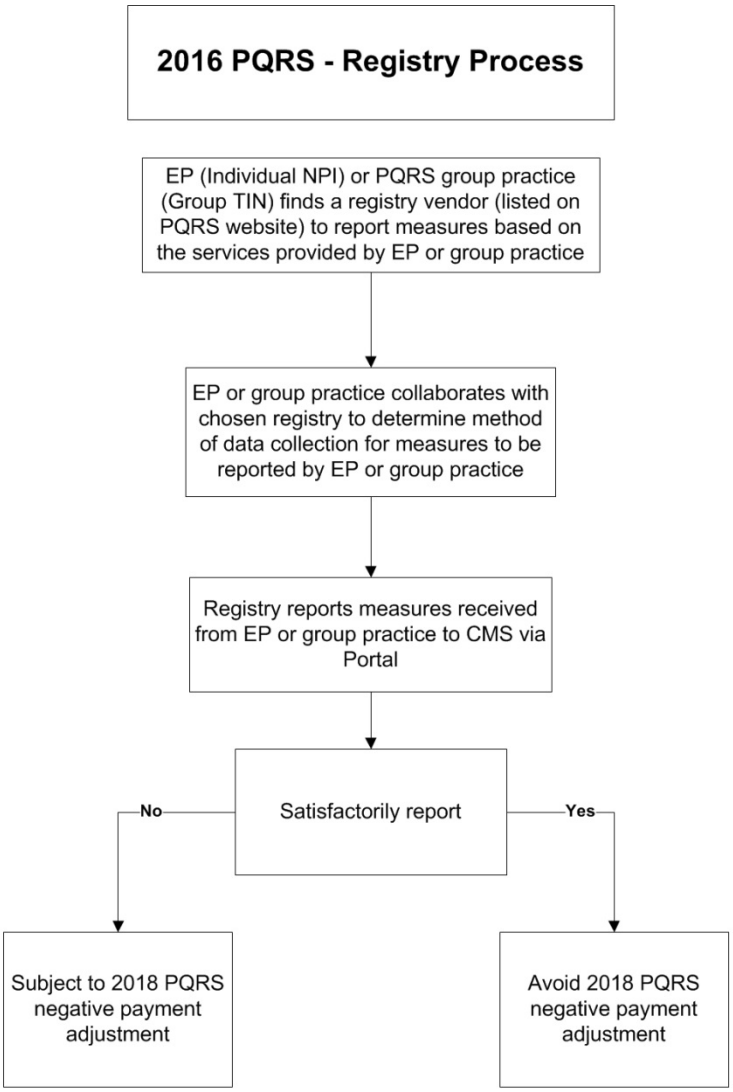
- **4.** PQRS will analyze claims with **85X TOB**, where "X" is any digit between 1 and 9, and **physician supplier revenue codes (RCs) 045x, 096x, 097x and 098x**, which will be paid based on the lesser of the submitted charges or the Medicare Physician Fee Schedule (MPFS).
  Note: The RCs and descriptions will change depending on the service location.
- **44. (line 1) Denominator-eligible office visit:** For this example the patient (age 70) was seen for an **office visit (99213)**, which is entered as the first line item.
- **44. (lines 2-6) Report QDCs:** For this visit, the EP is reporting **several individual PQRS measures related to diabetes, hypertension (HTN),** and **urinary incontinence, including the following:**
  - **Measure #1** (hemoglobin A1c poor control) with **QDC 3045F** + diabetes diagnosis **E11.40** in form locator 67;
  - **Measure #117** (diabetes - eye exam) with **QDCs 2022F** + diabetes diagnosis **E11.40** in form locator 67;
  - **Measure #48** (assessment - urinary incontinence) with **QDC 1090F;**
    *Note: **For PQRS, there is no specific diagnosis associated with this measure.***
  - **Measure #236 (hypertension – controlling)** with **QDC G8752** + **G8754** + HTN diagnosis **I10** in **form locator 67A**; and
- **47. (lines 2-6) Line-item charges:** If billing software limits the line items on a claim, you may add a nominal line-item charge of a penny to one of the QDC line items on the second claim. PQRS analysis will subsequently join claims that have the same beneficiary information, the same date-of-service, and the same CCN/TIN/NPI, and analyze the data as if it was submitted on one claim.

- **67 and 67(A).** The **principle diagnosis code** must be entered in **form locator 67**. **Other diagnosis codes** can be entered in **form locator 67A-Q**. For this example, the principle diagnosis code is E11.40 diabetic neuropathy, which is listed in form locator 67. The other diagnosis code is I10 HTN, which is listed in form locator 67A.
- **NPI placement: For combined claims (containing both professional and technical services), the** rendering/individual NPI must be provided at the line ***level***, such as handwritten next to the line item on the CMS-1450 form or entered in loop 2420A in 837I.

Appendix F: EHR Process (Data Flow)

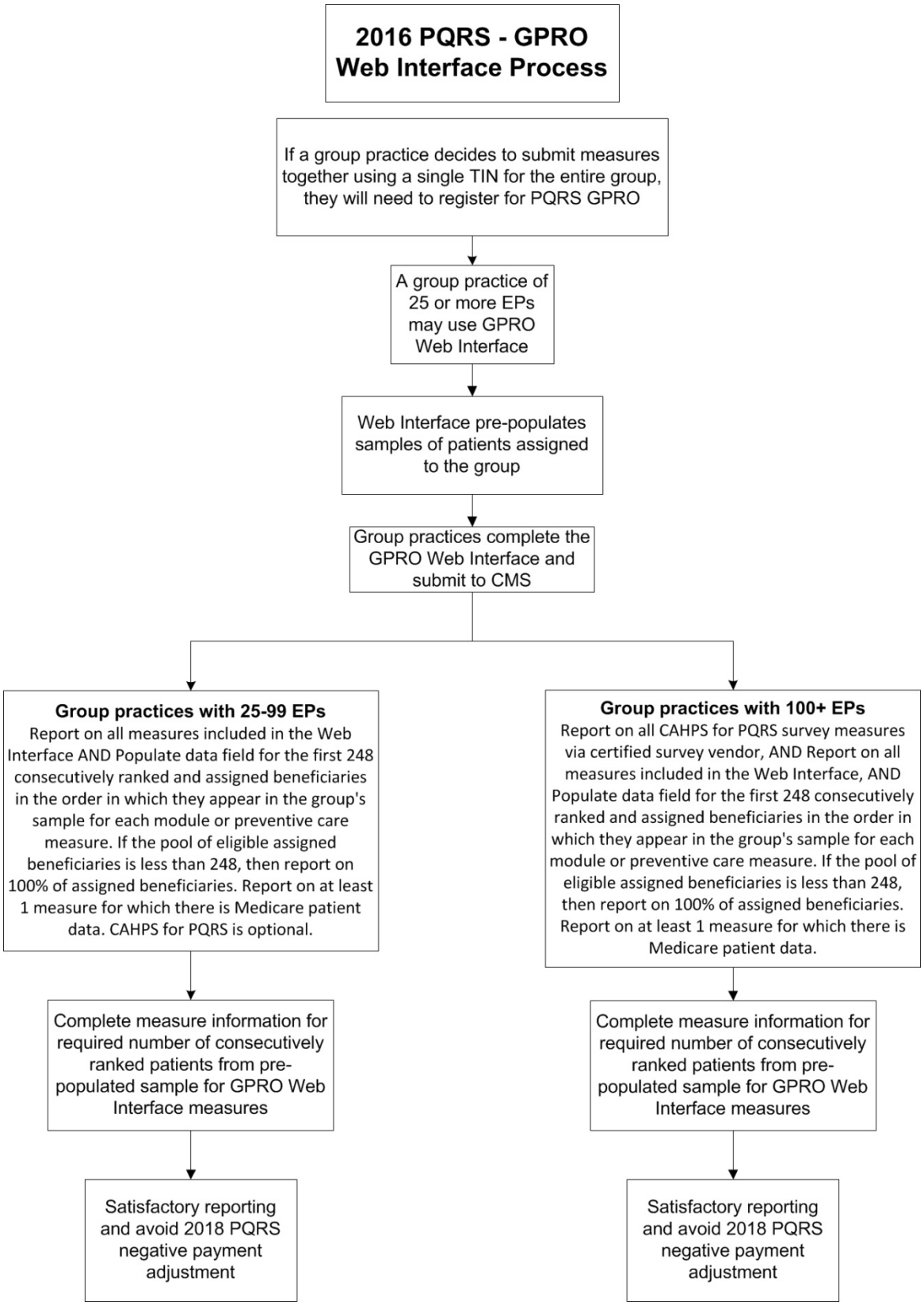


Appendix G: Registry Process (Data Flow)

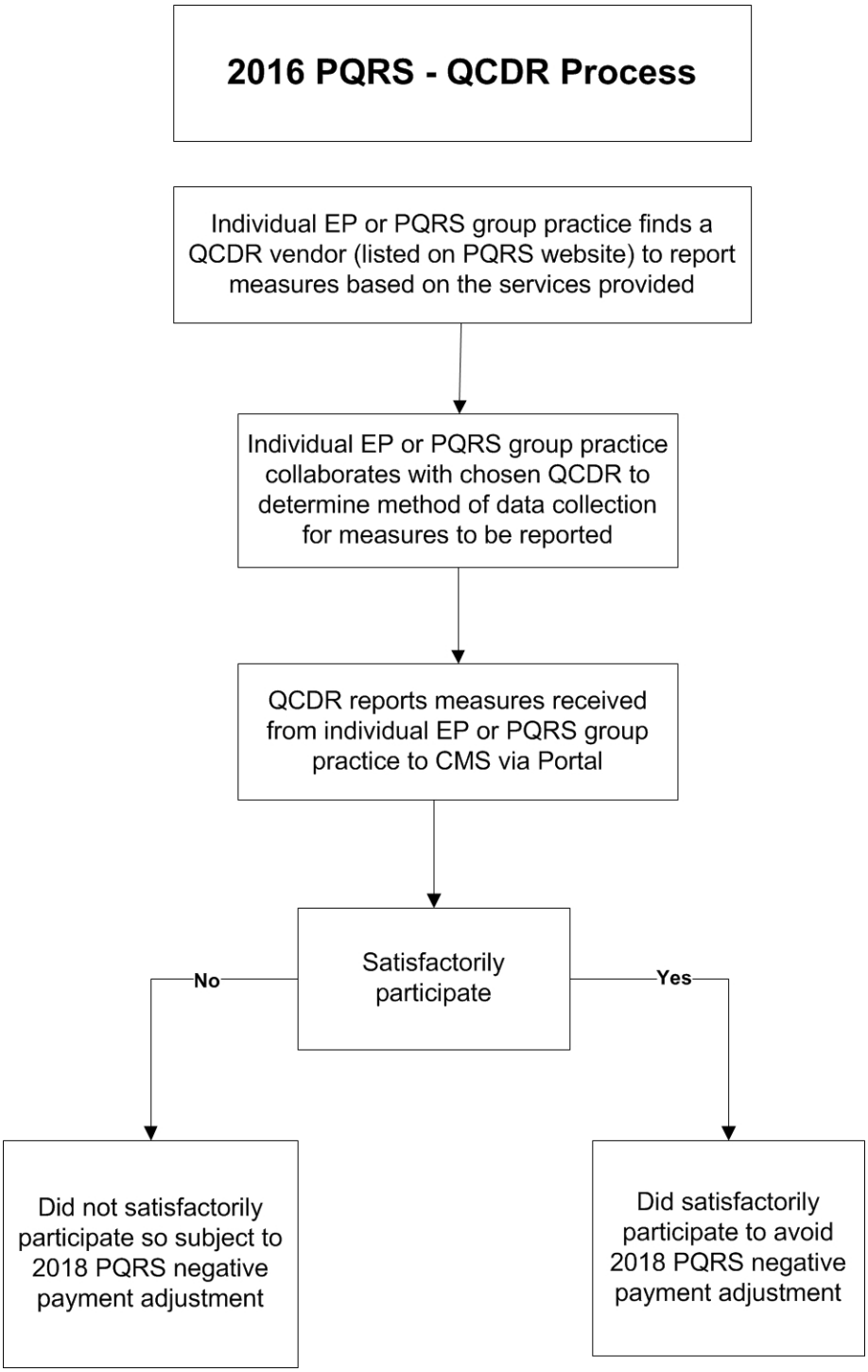


*Note: All qualified registries must be able to submit **ALL** needed data elements and transmit the data to CMS for at least 9 measures covering 3 NQS domains as well as **ALL** data elements for all of the cross-cutting measures.*

Appendix H: PQRS GPRO Web Interface Process (Data Flow)



Appendix I: QCDR Process (Data Flow)



Appendix J: Revision Notes

3/11/2016

- Pg. 29 revised PQRS Claims-Based Process (Data Flow) to reflect payment adjustment information rather than incentive payment.

6/28/2016

- Pg. 9 Clarified GPRO participation language.
- Pg. 33 Added line indicators to the text description to the CMS-1450 Claim PQRS Example.

7/13/2016

- Pg. 23 Updated 50% reporting rule in QCDR Decision Tree for Individual EPs.