2015 Physician Quality Reporting System (PQRS): Implementation Guide

1/15/2015; Revised 2/25/2015

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Introduction

Purpose

The *2015 PQRS Implementation Guide* helps eligible professionals (EPs) and group practices participating in PQRS via the group practice reporting option (GPRO) understand and report for 2015 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 CST 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

Beginning in 2015, CAHs using billing method II may participate in PQRS by all reporting mechanisms including claims-based reporting.

All EPs who do not meet the criteria for satisfactory reporting or participating for 2015 PQRS will be subject to the 2017 negative payment adjustment with no exceptions.

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Who is eligible to participate in PQRS?

Medicare physicians, practitioners, and therapists providing covered professional services paid under or based on the MPFS are 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 group practices participating via GPRO (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 **list of EPs** (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]).

EPs or group practices participating via GPRO, using their individual rendering NPI or TIN, may report the quality clinical action for measures within PQRS. Most services payable under fee schedules or methodologies other than the MPFS are not included in 2015 PQRS (for example, services provided under federally qualified health center or rural health clinics methodologies, portable X-ray suppliers, independent laboratories including place-of-service code "81," hospitals, , skilled nursing facilities, 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 2017 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.**

Note: "Satisfactory reporting" refers to participating in PQRS in 2015 to avoid the 2017 negative payment adjustment while **"satisfactory participation"** refers to EPs participating in the "qualified clinical data registry (QCDR)" reporting mechanism.

What are quality measures?

Quality measures are indicators of the quality of care provided by physicians. They are tools that help us 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.

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Disclaimer: *If reporting for PQRS through another CMS program (such as the Medicare Shared Savings Program, Comprehensive Primary Care Initiative, Pioneer Accountable Care Organizations), 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 (VM), etc. requirements of each of these programs.*

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PQRS Measure Selection Considerations

The 2015 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 measures and must select which measures they would like to report.

How should I determine which measures to report?

Step 1: Review the Measures List	**Review the *2015 Physician Quality Reporting System (PQRS) Measures List***, available on the Measures Codes section of the CMS PQRS website, to determine which measures, associated domains, and reporting mechanism(s) may be of interest and applicable to the 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 2015. • Other quality reporting programs in use or being considered by the National Quality Strategy (see further explanation below).
Step 3: Review specifica-tions	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. • Group practices must report using an EHR or via registry in order to select their measures.

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The National Quality Strategy (NQS)

In 2015, 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 2017 negative payment adjustment.

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.

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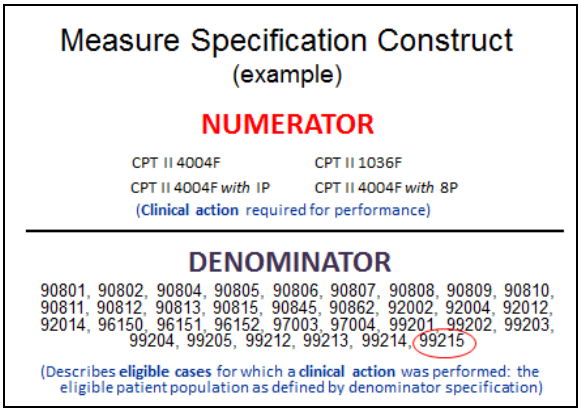
See below for an example of a measurement specification construct:



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-9-CM (future ICD-10-CM), CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc.), and place of service (if applicable). For registry 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 registry 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 or 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 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 2017 negative payment adjustment. Refer to **Appendix B: Decision Tree - Avoiding the 2017 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. Following are reporting mechanisms available to individual EPs and PQRS group practices.

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- Please note that PQRS defines a group practice as a single Tax Identification Number (TIN) with 2 or more individual EPs (as identified by Individual National Provider Identifier [NPI]) that have reassigned their billing rights to the TIN.

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	• GPRO Web Interface (25+ providers) • Qualified PQRS registry (2+ providers) • EHR direct product that is CEHRT (2+ providers) • EHR data submission vendor that is CEHRT (2+ providers) • CAHPS for PQRS using CMS-certified survey vendor (2+ providers) (CAHPS is supplemental to other reporting mechanisms) • *PQRS group practices must register for the GPRO and select their reporting mechanism by **June 30, 2015**. For more information about reporting PQRS measures as a group, visit the* Group Practice Reporting Option webpage.

Note: As outlined in the 2015 MPFS final rule, CMS will publicly report the individual EP and PQRS group practice quality measure data collected via all reporting mechanisms. This information is targeted for publication on Physician Compare in 2016, if technically feasible. For more information on public reporting, view the CMS Physician Compare Initiative website.

Analysis of PQRS Data: Reporting Frequency (previously known as Measure Tags) 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:

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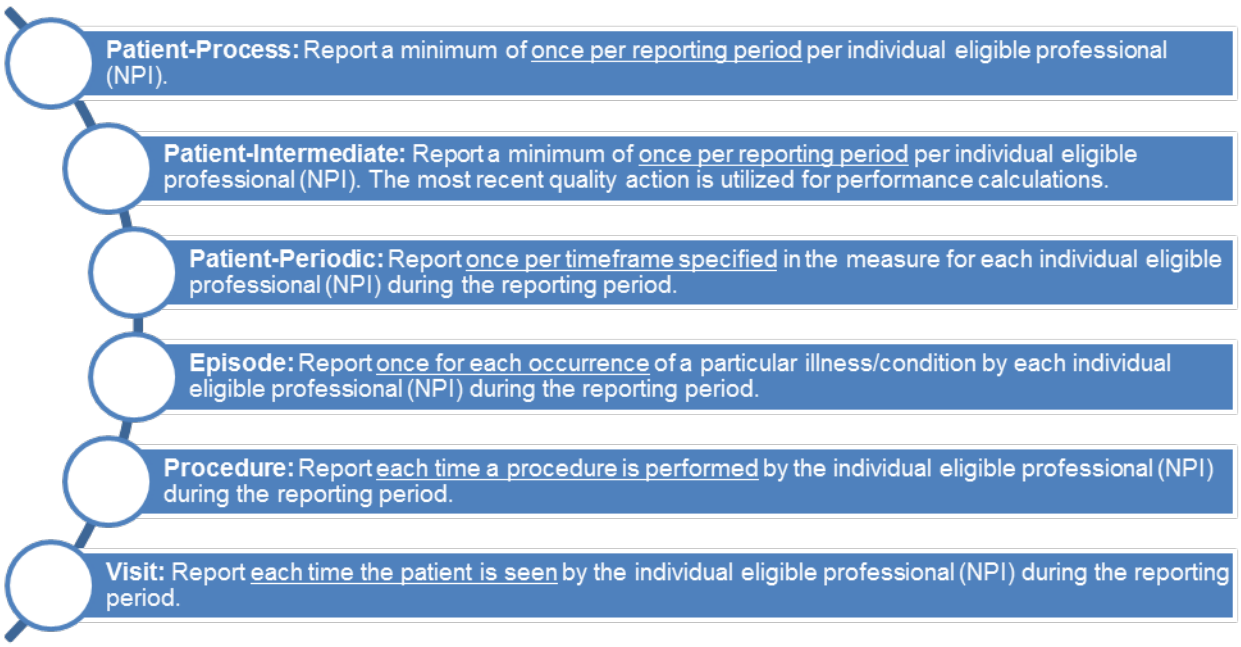

What is a performance timeframe?

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's Glossary of Terms**.

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Satisfactorily Report Measures

PQRS EPs and group practices can refer to the following educational resources:

- *2015 Physician Quality Reporting System (PQRS) Electronic Health Record (EHR) Reporting Made Simple*
- *2015 Physician Quality Reporting System (PQRS) Measures – Registry Reporting Made Simple*
- *2015 Physician Quality Reporting System (PQRS) Qualified Clinical Data Registry (QCDR) Participation Made Simple*
- *2015 Physician Quality Reporting System (PQRS) Measures – Claims Reporting Made Simple*
- *2015 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) Web Interface Reporting Made Simple*
- *2015 CAHPS for PQRS (Certified Survey Vendor) Made Simple*

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

"Satisfactory reporting" refers to participating in 2015 PQRS to avoid the 2017 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 Tree - Avoiding the 2017 PQRS Negative Payment Adjustment** for the *Decision Trees* designed to help participants select among the multiple reporting mechanisms available in PQRS

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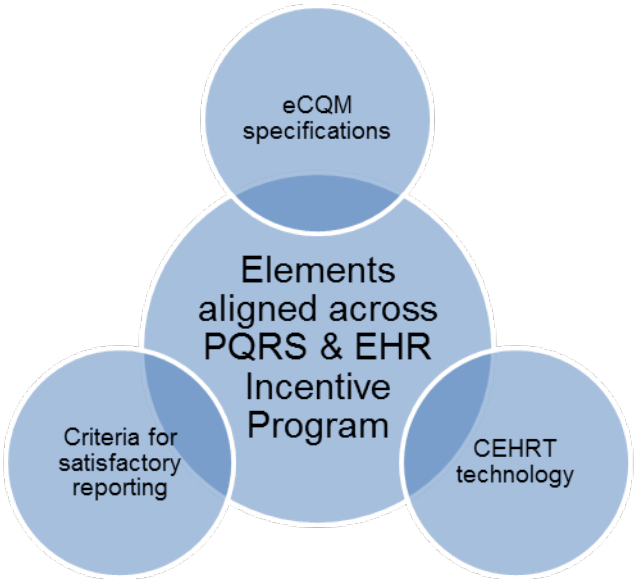
Reporting Electronically Using an EHR

EPs and PQRS group practices may report electronically using an Electronic Health Record (EHR) to satisfactorily report PQRS measures and avoid the 2017 PQRS negative payment adjustment.

Requirements for Reporting Electronically Using an EHR

To reduce the burden on providers participating in multiple quality reporting programs, CMS has aligned several reporting requirements for those reporting electronically using an EHR:



- eCQM specifications: The electronic clinical quality measures (eCQM) specifications are used for multiple programs, including the electronic reporting mechanism for PQRS as well as the Medicare EHR Incentive Program.

- **Criteria for satisfactory reporting:** The criteria for satisfactory reporting under PQRS using an EHR are aligned with the Medicare EHR Incentive Program. Satisfactory reporting of PQRS EHR quality measures will allow EPs and PQRS group practices to qualify for the clinical quality measures (CQM) component of Meaningful Use. Group practices electing to report electronically using an EHR can refer to the *Medicare EHR Incentive Programs Clinical Quality Measures for Eligible Professionals* document posted on the eCQM Library webpage for reporting guidance.

- **Using Certified EHR Technology:** The criteria for satisfactory electronic reporting using an EHR for PQRS are aligned with the clinical quality measure (CQM) component of the Medicare EHR Incentive Program, which requires EPs and group practices to submit CQMs using a direct EHR product that is Certified EHR Technology (CEHRT). The Office of the National Coordinator for Health Information Technology (ONC) certification process has established standards and other criteria for structured data that EHRs must use.

2015 eCQMs for EPs

The electronic clinical quality measures (eCQM) specifications are used for multiple programs, including the electronic reporting mechanism for PQRS as well as the Medicare EHR Incentive Program, to reduce the burden on providers participating in multiple quality programs. Please follow the link provided below to the Medicare EHR Incentive Program's eCQM Library webpage to obtain the *2014 eCQM Specifications for Eligible Professionals Table July 2014* and supporting documentation. **EPs and group practices electronically reporting PQRS using an EHR are required to use the July 2014 updated version of the 2014 eCQMs for the 2015 program year.**

By satisfactorily reporting eCQMs using direct EHR or EHR data submission vendor products, an EP or group practice will avoid the 2017 PQRS negative payment adjustment.

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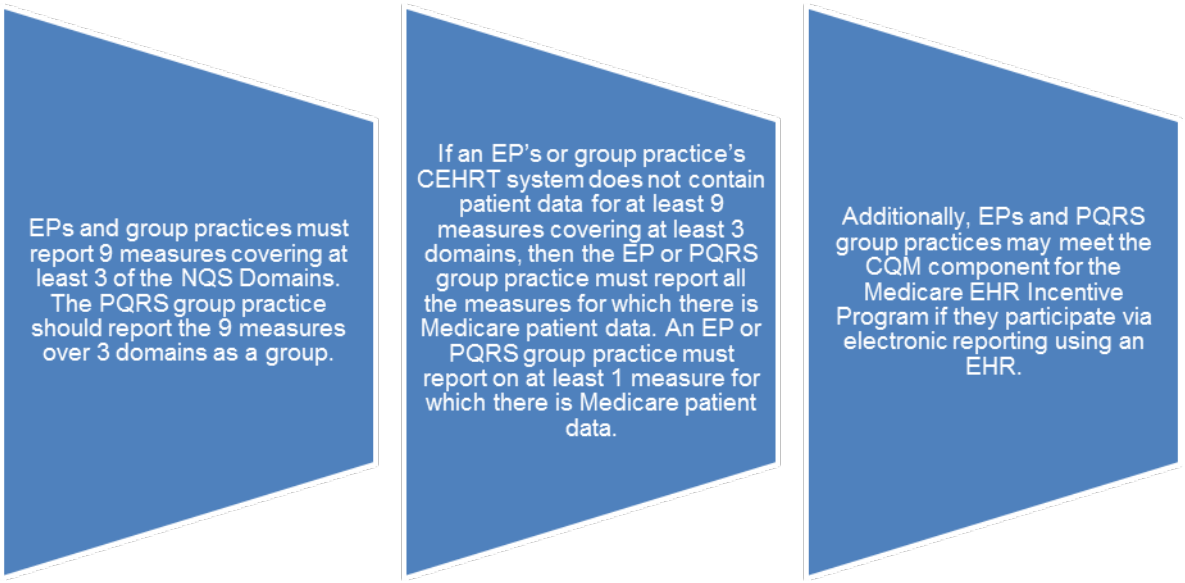
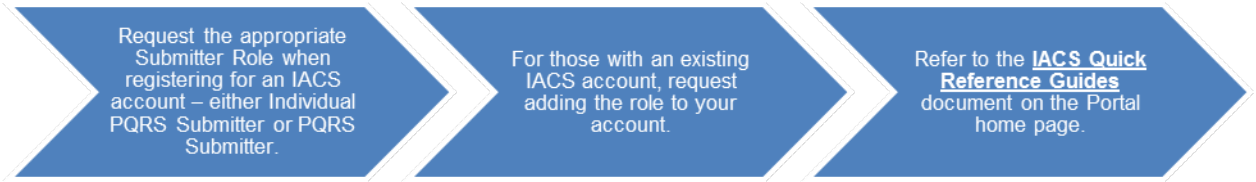


For 2014 and beyond, CMS discontinued the PQRS qualification requirement for data submission vendors and direct EHR vendors. The EHR products have to be certified (CEHRT) under the program established by ONC. Although CMS discontinued qualifying EHR products, vendors will be able to continue to submit test files. Allowing submission of test files is an important tool for providers and provides an opportunity to determine whether the vendor products are able to successfully submit data to CMS. Beginning in 2014, EPs and group practices must provide CMS their EHR Certification Number of the product being used by their direct EHR or EHR Data Submission Vendor (DSV).

Direct Submission from an EHR System

If EPs and group practices are submitting quality measure data directly from an EHR system, they must register for an Individuals Authorized Access to the CMS Computer Services (IACS) account. For more information about how EPs register for an IACS account, visit the Physician and Other Health Care Professionals Quality Reporting Portal (Portal).



Direct EHR Vendor

Direct EHR vendors are those vendors that are certifying an EHR product and version for EPs or group practices to use to directly submit their PQRS measures data to CMS in the CMS-specified format(s) on their own behalf.

Data format options for submitting data via Direct EHR vendor product that is CEHRT	
The Quality Data Model (QDM)-based Quality Reporting Documentation Architecture (QRDA) Category I format	The QDM-based QRDA Category III format

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Direct EHR vendor products must be able to transmit data using the QDM-based QRDA Category I and III formats. However, for reporting PQRS quality measures data to CMS, EPs and PQRS group practices need to submit data choosing one of these formats (either the QDM-based QRDA Category I or III).

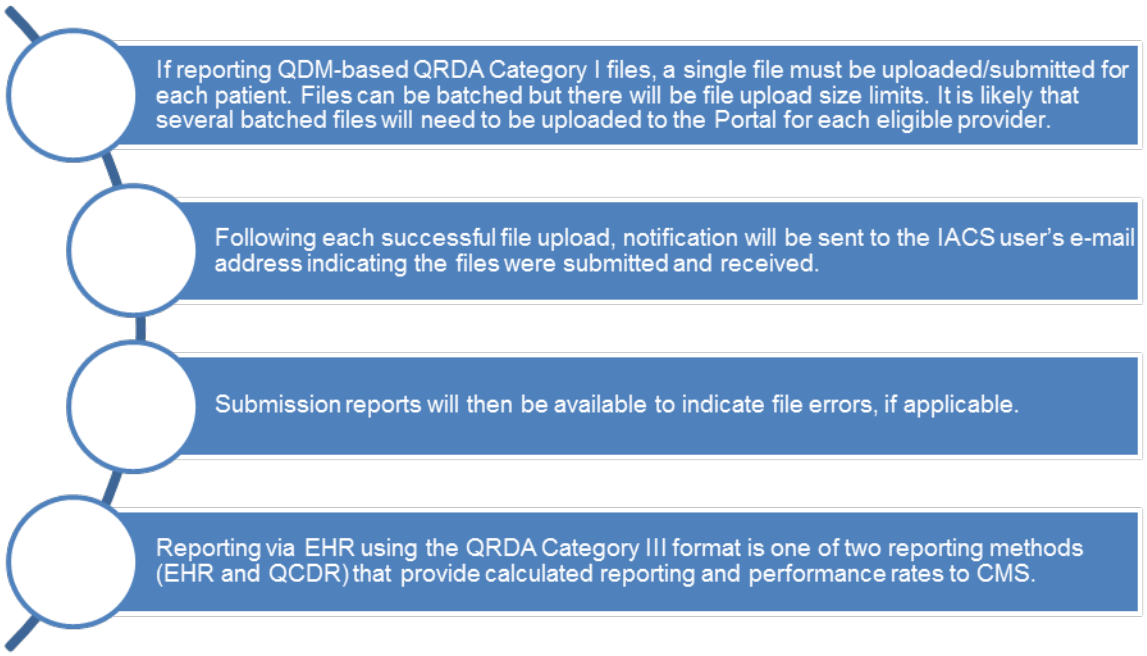
EHR Data Submission Vendor (DSV)

An EHR DSV is an entity that collects an EP's or PQRS group practice's clinical quality data directly from the EP's or PQRS group practice's EHR. DSVs will be responsible for submitting PQRS measures data from an EP's or group practice's CEHRT to CMS in a CMS-specified format(s) on behalf of the EP or the PQRS group practice for the program year.

Data submitted to CMS by an EHR DSV must be transmitted using the QDM-based QRDA Category I or III formats. Products must be able to transmit data using the QDM-based QRDA Category I and III formats. However, for purposes of reporting PQRS quality measures data to CMS, EPs and PQRS group practices need to submit data via their EHR choosing one of these formats (either QDM-based QRDA Category I or III).

Submission of Clinical Quality Measures (CQMs)

EPs and group practices must submit final electronic reporting files with quality measure data, or ensure that their EHR DSV submits files by the data submission deadline of **February 29, 2016**, to be analyzed and used for 2015 PQRS EHR measure calculations.



Resources

- *2015 Physician Quality Reporting System (PQRS) Electronic Health Record (EHR) Reporting Made Simple*

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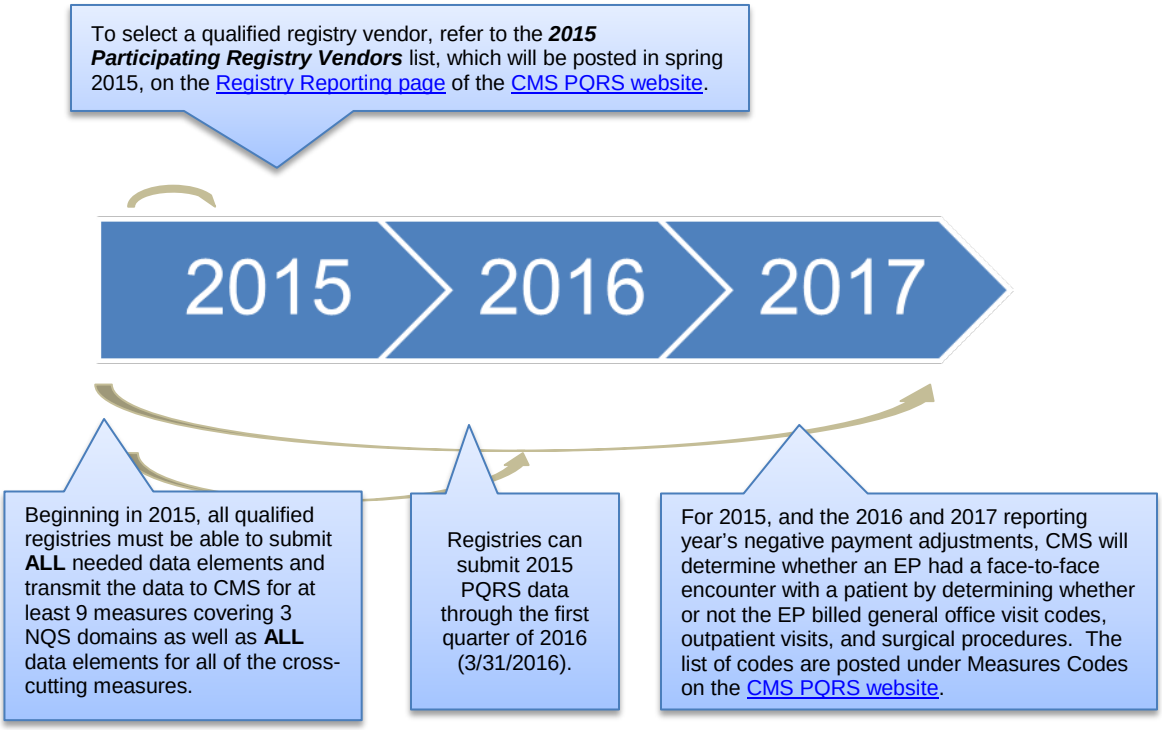
Reporting via Qualified Registry

EPs and PQRS group practices can avoid the 2017 PQRS negative payment adjustment by satisfactorily reporting quality measures data using a qualified registry. The qualified registry must submit this data to CMS via defined .xml specifications, which will be posted by fall 2015 on the Registry Reporting webpage of the CMS website.

Qualified Registry Vendors

A qualified registry is an entity that collects clinical data from an EP or PQRS group practice and submits it to CMS on behalf of the participants. EPs and PQRS group practices participating should work directly with their chosen registry in order to submit data satisfactorily on the selected measures or measures groups.



Reporting Criteria for Individual EPs

EPs wanting to satisfactorily report 2015 PQRS data to avoid the 2017 negative payment adjustment can do so by meeting one of the following criteria:

1. Report on at least 9 individual measures covering at least 3 NQS domains for at least *50% of the EP's* Medicare Part B FFS patients.	
	EPs who submit quality data for **less than 9** PQRS measures covering 3 NQS domains for at least 50% of the EP's Medicare Part B FFS patients **OR** who submit data for **9 or more** PQRS measures covering **less than 3 domains** for at least 50% of the EP's Medicare Part B FFS patients eligible for each measure **OR** who do not report on at least 1 cross-cutting measure if had a face-to-face encounter will be subject to Measure-Applicability Validation (MAV). (See http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html)

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Measures with a 0% performance rate will not be counted.
An EP who sees at least 1 Medicare patient (face-to-face encounter) must report on 1 cross-cutting measure.
For this reporting mechanism, EPs should use the ***2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures*** on the Measures Codes page of the CMS PQRS website at http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html to find applicable measures.

2. Report at least 1 measures group on a *20-patient sample*, a majority of which (at least 11 out of 20) must be Medicare Part B FFS patients.
For this reporting mechanism, EPs should use the ***2015 Physician Quality Reporting System (PQRS) Measures Groups Specifications Manual*** on the Measures Codes page of the CMS PQRS website at http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html to find applicable measures groups.
For more information, see ***2015 Physician Quality Reporting System (PQRS) Getting Started with Measures Groups***.
Beginning in 2015, the only reporting period available is 12 months.

Reporting Criteria for PQRS Group Practices

A group practice *must* have registered to report via qualified registry under the GPRO for 2015 PQRS. PQRS group practices can avoid the 2017 PQRS negative payment adjustment by meeting the following criteria for satisfactory reporting:

1. Report on at least 9 measures covering at least 3 NQS domains for at least 50% of the group's Medicare Part B FFS patients.
Group practices that submit quality data for less than 9 PQRS measures for at least 50% of their patients or encounters eligible for each measure, **OR** that submit data for **9 or more** PQRS measures covering **less than 3 domains** for at least 50% of their patients or encounters eligible for each measure **OR** who do not report on at least 1 cross-cutting measure if had a face-to-face encounter will be subject to MAV.
Measures with a 0% performance rate will not be counted.
An EP who sees at least 1 Medicare patient (face-to-face encounter) must report on 1 cross-cutting measure.
Those group practices electing to report via registry will use the ***2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures*** to find applicable measures. These specifications are located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

Resources

- *2015 Physician Quality Reporting System (PQRS) Measures – Registry Reporting Made Simple*

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Participation via Qualified Clinical Data Registry (QCDR)

A QCDR is a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. A QCDR will complete the collection and submission of PQRS quality measures data on behalf of EPs so that they may meet criteria for satisfactorily participating in 2015 PQRS. The data submitted to CMS via a QCDR covers quality measures across multiple payers and is not limited to Medicare. Reporting via QCDR is one of three reporting mechanisms (Qualified Registry, EHR, and QCDR) that provides calculated reporting and performance rates to CMS. See **Appendix H** for the QCDR process.

To select a QCDR, refer to the ***2015 Participating Qualified Clinical Data Registry*** list on the Qualified Clinical Data Registry Reporting page of the CMS PQRS website. This list will be posted spring 2015.

Note: The measures that may be submitted to a QCDR are not limited to the PQRS measure set, however, no more than 30 non-PQRS measures may be submitted.

Reporting Criteria for Individual EPs

EPs can avoid the 2017 PQRS negative payment adjustment by satisfactorily participating, according the following criteria:

1. **Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50% of the EP's applicable patients seen during the reporting period to which the measure applies.**

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

**EPs participating via QCDR should work with their selected QCDR to determine how to participate.*

Participants should also refer to the ***2015 Qualified Clinical Data Registry (QCDR) Participation Made Simple*** document***.*** This document serves as an educational resource to assist EPs and their staff with accurately reporting measures, and provides helpful information on how to get started with PQRS. It will be available as a downloadable document on the Qualified Clinical Data Registry Reporting webpage in December 2014.

Resources

- *2015 Physician Quality Reporting System (PQRS) Qualified Clinical Data Registry (QCDR) Participation Made Simple*

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Participation via the GPRO Web Interface

The GPRO Web Interface is a secure internet-based application (requires IACS login) available in the Portal to pre-registered users. Only PQRS group practices who register to participate through the GPRO Web Interface and ACOs will be allowed to report via GPRO Web Interface. The GPRO Web Interface provides a partially pre-filled beneficiary sample, which the group practice will be responsible for populating the remaining data fields and submitting. To avoid the negative PQRS payment adjustment in 2017, PQRS group practices must satisfactorily report quality data, or satisfactory complete the GPRO Web Interface during the 2015 reporting period.

Those group practices electing to report via the GPRO Web Interface should refer to the ***2015 GPRO Web Interface Narrative Measure Specifications*** and other supporting documentation, available on the GPRO Web Interface webpage, to ensure that the group practice will be able to report on the measures. Given the GPRO Web Interface assignment methodology, some group practices (such as groups consisting only of non-physician practitioners) might **not be able** to report PQRS quality measures using the GPRO Web Interface because no beneficiaries will be assigned to them. CMS advises those group practices to participate in the PQRS via another reporting mechanism.

Reporting Requirements for All PQRS Group Practices
A portion of the patients served by a group practice must be Medicare beneficiaries. The group practice must report on at least 1 measure for which there is Medicare patient data.
Report on all measures included in the GPRO Web Interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then report on 100% of assigned beneficiaries.
PQRS group practices of 100 or more EPs must report all CAHPS for PQRS summary survey modules via CMS-certified survey vendor (CMS **WILL NOT** bear the cost of administering this required survey) to supplement GPRO Web Interface reporting. CAHPS for PQRS is optional for groups of 2-99 EPs.

Individual EPs within a group practice that satisfactorily completes the GPRO Web Interface will also receive credit for the CQM component of the EHR Incentive Program. EHR Incentive Program EPs will still be required to report the other meaningful use objectives through the Medicare and Medicaid EHR Incentive Programs Registration and Attestation System.

Refer to **Appendix B: Decision Trees - 2015 PQRS Participation for Avoiding the 2017 Negative Payment Adjustment** for an illustration of the GPRO Web Interface reporting requirements. Also see **Appendix G** for the **GPRO Web Interface Process**.

Resources

- *2015 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) Web Interface Reporting Made Simple*
- *2015 PQRS GPRO Requirements*

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CAHPS for PQRS - CMS-Certified Survey Vendor

The CMS-certified survey vendor reporting mechanism is available to all PQRS and Medicare Shared Savings Program ACO group practices to supplement their PQRS reporting with the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS surveys. CAHPS for PQRS are patient experience surveys that measure experiences with, and ratings of, health care providers and plans. Complete information about the CAHPS for PQRS survey measures is available on the CAHPS webpage. The data collected on these surveys will be submitted on behalf of the group practice by the CMS-certified survey vendor.

Participation through the CMS-certified survey vendor may be optional or mandatory depending on the group practice's size, which is determined during the 2015 GPRO registration period, as follows:

- PQRS group practices of 2-24 EPs will have the ***option*** to participate via CMS-certified survey vendor in addition to reporting via EHR, qualified registry reporting mechanisms.
- PQRS group practices of 25-99 EPs have the ***option*** to participate via CMS-certified survey vendor in addition to reporting via EHR, qualified registry, or GPRO Web Interface reporting mechanisms.
- PQRS group practices of 100 or more EPs ***must*** participate via CMS-certified survey vendor in addition to another reporting mechanism elected during GPRO registration – EHR, qualified registry, or GPRO Web Interface.

  Note: *Shared Savings Program ACOs* ***must*** *participate via CMS-certified survey vendor in addition to reporting quality data through the GPRO Web Interface.*

The CAHPS for PQRS survey is equal to 3 individual measures and 1 NQS domain. Therefore, PQRS group practices who register to participate through the CMS-certified survey vendor will be allowed to report fewer individual PQRS measures via the addition reporting mechanism (applicable to qualified registry or EHR reporting only). However, group practices reporting via the GPRO Web Interface will not be allowed to report fewer measures – they must complete all available measures within the GPRO Web Interface.

Following are the reporting requirements for PQRS group practices who register for CAHPS for PQRS:

2-99 EPs	25-99 EPs	100 or more EPs
Group practices of 2-99 EPs that choose to register for CAHPS for PQRS will need to report on at least 6 additional measures covering at least 2 additional NQS domains via qualified registry, direct EHR product, or EHR data submission vendor.	Group practices of 25-99 EPs that choose to register for CAHPS for PQRS while reporting PQRS via GPRO Web Interface must report all required GPRO Web Interface measures.	Group practices of 100 or more EPs reporting CAHPS for PQRS survey is a requirement of satisfactory reporting for all available reporting mechanisms.

Please refer to the **Decision Tree** in **Appendix B: Decision Trees - 2015 PQRS Participation for Avoiding the 2017 Negative Payment Adjustment** for additional details on the reporting requirements of this mechanism.

Beginning in 2015, the CAHPS for PQRS survey will have 3 options for group practices to satisfactorily report:

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1: PQRS group practices of 2 or more EPs reporting via qualified registry with CAHPS for PQRS	2: PQRS group practices of 2 or more EPs reporting via EHR with CAHPs for PQRS	3: PQRS group practices of 25-99 EPs reporting via GPRO Web Interface

• Must participate via CMS-certified survey vendor to have 12 CAHPS for PQRS survey measures administered to eligible beneficiaries seen during the 12-month reporting period
• Must report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 NQS domains
  • If less than 6 measures apply, 5 measures must be reported
  • If an EP in the group sees at least 1 Medicare patient face-to-face, the group must report 1 cross-cutting measure
  • Groups reporting on less than 6 measures will be subject to MAV
	• Must participate via CMS-certified survey vendor to have 12 CAHPS for PQRS survey measures administered to eligible beneficiaries seen during the 12-month reporting period
	• Must report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 NQS domains
	  • At least 1 of these measures must contain Medicare patient data
		• Must participate via CMS-certified survey vendor to have 12 CAHPS for PQRS survey measures administered to eligible beneficiaries seen during the 12-month reporting period
		• Must report all 21 measures within the GPRO Web Interface and populate date fields for the first 248 consecutively ranked and assigned beneficiaries
		  • If less than 248 beneficiaries are available, groups must report on 100 percent of assigned beneficiaries
		  • At least 1 measure containing Medicare patient date must be reported

CMS will NOT bear the cost of administering CAHPS for PQRS for the 2015 program year. Please refer to the **Decision Trees** in **Appendix B** for additional details on the reporting requirements of this mechanism.

Note: *CAHPS for PQRS is required for group practices of 100 or more EPs participating in PQRS via GPRO, but is optional for group practices with 2-99 EPs participating in PQRS via GPRO. The group practice must contract with a CMS-certified survey vendor and cover the cost of administering the 2015 CAHPS for PQRS survey.*

Summary Survey Modules

The 12 CAHPS for PQRS summary survey modules will include the following:

Resources

- *2015 CAHPS for PQRS (Certified Survey Vendor) Made Simple*

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Reporting PQRS Data via Claims

The following is a list of sub-sections covered in the *"Reporting PQRS Data via Claims"* section:

1. Claims-based Reporting Overview

Claims-based reporting is readily accessible to EPs as it is a part of routine billing processes. However, it is not an option for PQRS group practices. There is no need to contact a registry or qualified EHR vendor to submit data, and it's simple to select measures and begin reporting (by adding the respective Quality-Data Code [QDC] to the claim). Medicare providers submit claims via the CMS-1500 form or CMS-1450 (or electronic equivalent) for reimbursement on billable services rendered to Part B FFS beneficiaries. EPs use their individual/rendering National Provider Identifier (NPI) to submit for services on Medicare Part B FFS beneficiaries.

Quality data reported to CMS through Part B MPFS claims (containing QDC line items for each EP's NPI) are processed to final action by the Medicare Administrative Contractor (MAC) and subsequently transferred to the National Claims History (NCH) where it is available for PQRS analysis. See **Appendix I** for a flow diagram of the PQRS claims-based process. Quality measures data reported on claims denied for payment are not included in PQRS analysis. QDC line items from claims are analyzed according to the measure specifications, including coding instructions, reporting frequency, and performance timeframes.

An example of a claim in CMS-1500 format that illustrates how to report several PQRS measures is provided. See **Appendix D** for the current CMS-1500 claim form (version 02/12).

For additional information on the measures, see the *2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures*.

2. Getting Started

	Ensure that the practice identifies and reports on all denominator eligible cases for the measures selected by the practice. Consider implementing an edit on the billing software that will flag each claim every time a combination of codes listed in a measure's denominator is billed so the entry QDCs is required prior to final claim submission. Additional PQRS educational resources are available as downloads on the CMS PQRS webpage.

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EPs may satisfactorily report in 2015 PQRS by meeting the following criteria:

- Report on at least 9 measures covering 3 NQS domains for at least 50% of the EP's Medicare Part B FFS patients. EPs that see 1 Medicare patient in a face-to-face encounter must also report on 1 cross-cutting measure.
- EPs that submit quality data for **less than 9** PQRS measures for at least 50% of their patients or encounters eligible for each measure, **OR** that submit data for **9 or more** PQRS measures covering **less than 3 domains** for at least 50% of their patients or encounters eligible for each measure will be subject to MAV.
- EPs that see 1 Medicare patient (face-to-face encounter), but do not report on 1 cross-cutting measure will be subject to MAV. (See the Analysis and Payment webpage)
- Measures with a 0% performance rate will not be counted.

3. Claims-based Reporting Coding

Claims follow a process so the information reaches the CMS National Claims History File (NCH). Current Procedure Terminology (CPT) codes are used to describe medical procedures and physicians' services, and are maintained and distributed by the American Medical Association. Use the CPT codes in the below tables when reporting data.

Use of Current Procedural Terminology (CPT) Category I Modifiers
• PQRS measure specifications include specific instructions on including the CPT Category I modifiers. Unless otherwise specified, CPT Category I codes may be reported with or without CPT modifiers. Refer to each individual measure specification for detailed instructions regarding CPT Category I modifiers that qualify or do not qualify a claim for denominator inclusion. • Note that surgical procedures billed by an assistant surgeon(s) will be excluded from the denominator population so his/her performance rates will not be negatively impacted for PQRS. Analysis will exclude otherwise PQRS-eligible CPT Category I codes, when submitted with assistant surgeon modifiers 80, 81, 82, or AS. The primary surgeon, not the assistant surgeon, is responsible for performing and reporting the quality action(s) in applicable PQRS measures. • Eligible CPT Category I procedure codes, billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population for applicable PQRS measure(s). Both surgeons taking part in PQRS will be fully accountable for the clinical action(s) described in the PQRS measure(s).

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CPT Category II Codes

- CPT Category II or CPT II codes, 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.

Quality-Data Codes

- 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. 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.

Use of CPT II Modifiers

- CPT II modifiers are unique to CPT II codes and may be used to report measures by appending the appropriate modifier to a CPT II code as specified for a given measure. The modifiers for a code cannot be combined and their use is guided by the measure's coding instructions, which are included in the numerator coding section of the measure specifications. Use of the modifiers is unique to CPT II codes and may not be used with other types of CPT codes. Only CPT II modifiers may be appended to CPT II codes. Descriptions of each modifier are provided below to help identify circumstances when the use of a modifier may be appropriate. Note that reporting an exclusion or reporting modifier will alter an EP's performance rate. Accurate reporting on all selected measures will count toward the reporting requirements, whether the clinical action is reported as complete or not complete (or performance met or not met).
- CPT II code modifiers fall into two categories; exclusion modifiers and the 8P reporting modifier.
- Exclusion modifiers may be appended to a CPT II code to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. These modifiers serve as denominator exclusions for the purpose of measuring performance. Not all exclusions will apply to every measure, and some measures do not allow any performance exclusions. Appending a performance measure exclusion modifier falls into one of three categories; see the graphic below for more detail.

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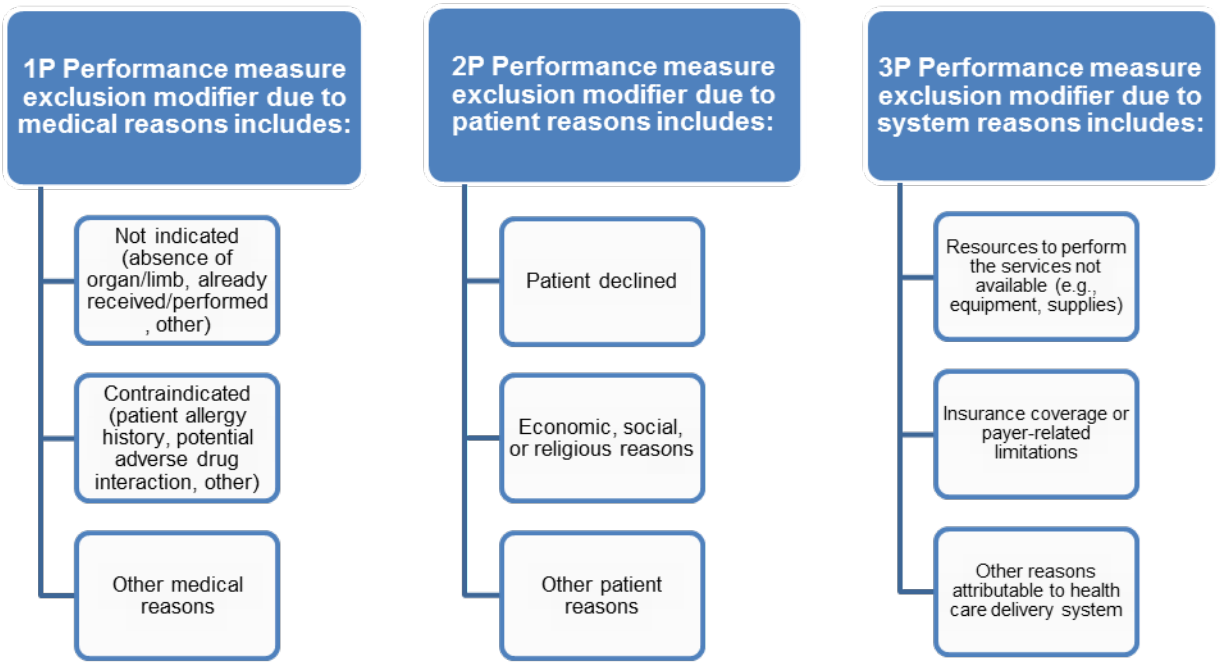
Performance measure exclusion modifier categories



- There may be instances in which a G-code is indicated to represent performance exclusion. The G-code may encompass the concepts of a medical, patient, and/or system exclusion.
- Generally, the 8P reporting modifier is available for use only with CPT II codes to facilitate reporting an eligible case when an action described in a measure is not performed and the reason is not specified. Instructions for appending this reporting modifier to CPT Category II codes are included in applicable measures. Use of the 8P reporting modifier indicates that the patient is eligible for the measure; however, there is no indication in the record that the action described in the measure was performed, nor was there any documented reason attributable to the exclusion modifiers. **8P Performance measure reporting modifier - action not performed, reason not otherwise specified.**
- The 8P reporting modifier facilitates reporting an eligible case on a given measure when the clinical action does not apply to a specific encounter. EPs can use the 8P modifier to receive credit for satisfactory reporting but will not receive credit for performance. EPs should use the 8P reporting modifier sensibly for applicable measures they have selected to report. The 8P modifier may not be used freely in an attempt to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

Note: *Measures with a 0% performance rate will not be counted. For example, an EP has selected and submitted QDCs during the reporting period for 2015 PQRS Measure #6, Coronary Artery Disease (CAD): Antiplatelet Therapy. The EP sees a patient for whom he does not choose to prescribe oral antiplatelet therapy and the reason is not specified. However, the claim(s) for services for that encounter contains International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), and CPT codes that will draw the patient into the measures' denominator during analysis. The 8P modifier serves to include the patient in the numerator when reporting rates are calculated for PQRS.*

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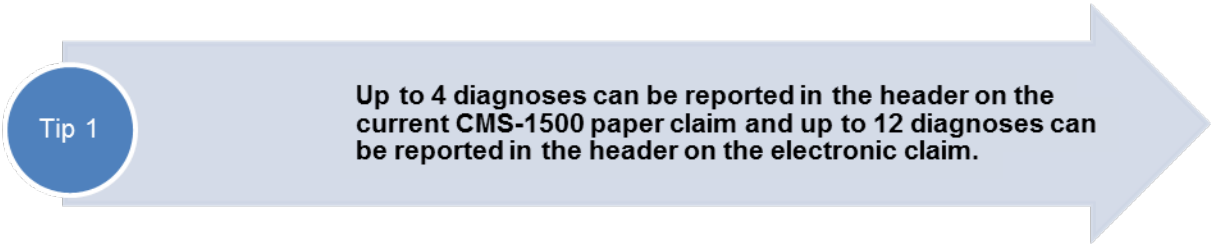
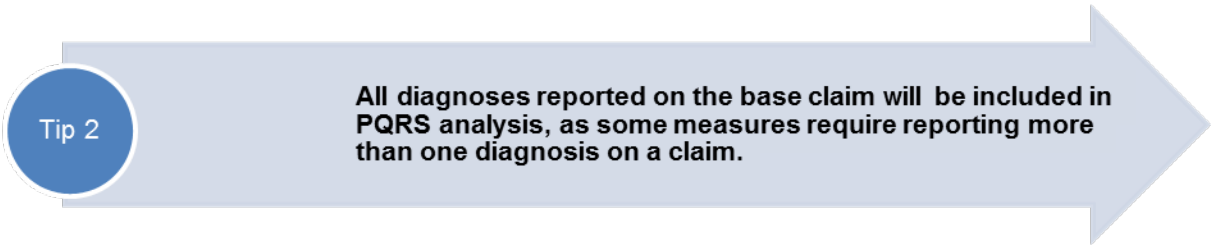
4. Claims-Based Reporting Principles

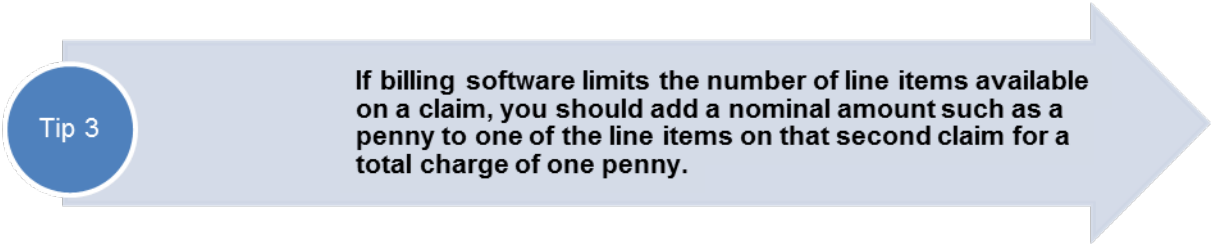
Below are some helpful tips when reporting via claims.



Only 1 diagnosis can be linked to each line item, although for PQRS all diagnosis codes will be taken into consideration for analysis.
PQRS analyzes claims data using ALL diagnoses from the base claim (Item 21 of the CMS-1500 or electronic equivalent) and service codes for each individual EP (identified by individual NPI).
EPs should review ALL diagnoses and encounter codes listed on the claim to make sure they are capturing ALL chosen measures applicable to that patient's care.



For line items containing a QDC, only 1 diagnosis from the base claim should be referenced in the diagnosis pointer field.
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, all diagnoses on the claim(s) are considered in PQRS analysis.



PQRS analysis will subsequently join claims based on the same beneficiary for the same date-of-service, for the same TIN/NPI and analyze as one claim.
Providers should work with their billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses, QDCs, or nominal charge amounts are not dropped.

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A sample CMS-1500 form can also be found in **Appendix D** of this document.

Principles for Reporting QDCs via Claims

The following principles apply for claims-based reporting of PQRS measures:

1. QDCs must be reported:
On the claim(s) with the denominator billing code(s) that represents the eligible Medicare Part B PFS encounter.
For the same beneficiary.
For the same date of service (DOS).
By the same EP (individual rendering NPI) that performed the covered service, applying the appropriate encounter codes (ICD-9-CM, ICD-10-CM, CPT Category I or HCPCS codes). These codes are used to identify the measure's denominator.

2. **QDCs must be submitted with a line-item charge of one penny ($0.01) at the time the associated covered service is performed.**
The submitted charge field cannot be blank.
The line item charge should be $0.01 – the beneficiary is not liable for this nominal amount.
Entire claims with a $0.01 charge will be rejected.
When the $0.01 nominal amount is submitted to the MAC, the PQRS code line will be denied but will be tracked in the National Claims History (NCH) for analysis.
Important: In an effort to streamline reporting of QDCs across multiple CMS quality reporting programs, **CMS strongly encourages all EPs and practices to bill 2015 QDCs with a $0.01 charge. EPs should pursue updating their billing software to accept the $0.01 charge prior to implementing 2015 PQRS.** EPs and practices will need to work with their billing software or EHR vendor to ensure this capability is activated. Entering the nominal charge of $0.01 on claims will help ensure the QDCs are processed into the CMS claims database.

3. When a group bills, the group NPI is submitted at the claim level; therefore, the individual rendering/performing physician's NPI must be placed on each line item, including all allowed charges and quality-data line items. **Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field (#33a on the CMS-1500 form or the electronic equivalent).**

Note: *Claims may **NOT** be resubmitted for the sole purpose of adding or correcting QDCs. If a denied claim is subsequently corrected through the appeals process to the MAC, with accurate codes that also*

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correspond to the measure's denominator, then QDCs that correspond to the numerator should also be included on the resubmitted claim as instructed in the measure specifications.

Remittance Advice (RA) / Explanation of Benefits (EOB)

The RA/EOB denial code **N620** is your indication that the PQRS codes are valid for the 2015 PQRS reporting year.

- The **N620** denial code is just an indicator that the QDC codes are valid for 2015 PQRS. It does not guarantee the QDC was correct or that reporting thresholds were met. However, when a QDC is reported satisfactorily (by the individual EP), the **N620** can indicate that the claim will be used in calculating incentive eligibility.

EPs who bill on a $0.00 QDC line item will receive the **N620** code. EPs who bill on a $0.01 QDC line item will receive the **CO 246 N620** code.
All submitted QDCs on fully processed claims are forwarded to the CMS warehouse for analysis by the CMS quality reporting program, so providers will first want to be sure they do see the QDC's line item on the RA/EOB, regardless of whether the RA **N620** code appears.

- Keep track of all cases reported so that you can verify QDCs reported against the remittance advice notice sent by the MAC. Each QDC line-item will be listed with the **N620** denial remark code.

Claim Adjustment Reason Code (CARC) for QDCs with $0.01

The **CARC 246** with Group Code CO or PR and with Remittance Advice Remark Code (RARC) **N620** indicates that this procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.

- In addition to **N620,** the remittance advice will show Claim Adjustment Reason Code (**CARC) CO or PR 246** (This non-payable code is for required reporting only).
- **CARC 246** reads: *This non-payable code is for required reporting only.*
- EPs who bill with a charge of $0.01 on a QDC item will receive **CO 246 N620** on the EOB.

Remittance Advice Remark Code (RARC) for QDCs with $0.00

The new RARC code **N620** is your indication that the PQRS codes were received into the CMS National Claims History (NCH) database.

- EPs who bill with $0.00 charge on a QDC line item will receive an **N620** code on the EOB.
- **N620** reads: *This procedure code is for quality reporting/informational purposes only.*

5. Submitting Claims

Submission through MACs

QDCs shall be submitted to MACs through one of the following options:

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Electronic-based Submission	Paper-based Submission
PQRS QDCs are submitted on the claim just like any other code; however, QDCs will have a nominal $0.01 (or $0.00) charge. Electronic submission, which is accomplished using the **ASC X 12N Health Care Claim Transaction (Version 5010)**, should follow the current HIPAA standard version of the ASC x12 technical report 3.	**Use the CMS-1500 or CMS-1450 claim form** as described in the sample claims provided in **Appendix D.** The CMS-1450 claim form may also be used as applicable.

Group NPI Submission

When a group bills, the group's NPI is submitted at the claim level, therefore, the individual rendering EP's NPI must be placed on each line item, including all allowed charges and quality-data line items.

Solo NPI Submission

The individual NPI of the solo practitioner must be included on the claim as is the normal billing process for submitting Medicare claims. For PQRS, the QDC must be included on the claim(s) representing the eligible encounter that is submitted for payment at the time the claim is initially submitted in order to be included in PQRS analysis.

Timeliness of Quality Data Submission

Claims processed by the MAC must reach the national Medicare claims system data warehouse (NCH file) by **February 26, 2016** to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

Resources

- *2015 Physician Quality Reporting System (PQRS) Measures – Claims Reporting Made Simple*

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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. New for the 2015 PQRS program year, EPs in Critical Access Hospital Method II (CAH II) may participate in the PQRS using all reporting mechanisms, including the claims-based reporting mechanism via the CMS-1450 form or electronic equivalent. 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.
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 group practices reporting via GPRO. 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	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.

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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-9-CM (01/01/2015-10/01/2015), ICD-10-CM (10/01/2015-12/31/2015), CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc.), and place of service (if applicable).** **UPDATE:** For more information on ICD-10 implementation, visit the CMS ICD-10 Website: http://www.cms.gov/Medicare/Coding/ICD10/index.html.
Denominator Exclusion	Patients with conditions who should be removed from the measure population and denominator before determining if numerator criteria are met.
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

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Eligible Professional (EP)	Refer to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS for a list of professionals eligible to report in 2015 PQRS. 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 qualify to earn a PQRS incentive. PQRS defines a group practice as a single Tax Identification Number (TIN) with 2 or more individual EPs (as identified by Individual National Provider Identifier [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: http://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.

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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 (also referred to as Measure Tag)	• **Patient-Process:** Report a minimum of once per reporting period per individual EP (NPI).
	  o If the measure is reported more than once during the reporting period, performance rates are calculated using the most advantageous QDC submitted.
	  o 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).
	  o If the measure is reported more than once during the reporting period, performance rates are calculated using the most recent QDC submitted.
	  o 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.
	  o 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.
	  o Usually reflects a clinical episode, difficult to determine from a single Part B claim.
	  o 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.

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Terms	Definitions
NPI	National Provider Identifier of the individual EP billing under the Tax ID ("NPI within the Tax ID").
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). PQRS measure numerators are CPT Category II codes and G-codes.
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 *2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry* contains all codes associated with each PQRS measure and instructions for data submission.
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]

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Terms	Definitions
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 *2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry* posted on the CMS Web site at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.
Reporting Options	2015 reporting mechanisms available for avoiding the payment adjustment: claims-based; registry-based; electronic health record (EHR); participation via qualified clinical data registry; CAHPS for PQRS, or group practice reporting option (GPRO). Refer to Appendix B: "Decision Tree – 2015 PQRS Reporting/Participation for Avoiding the 2017 Negative Payment Adjustment.
Reporting Period	The period during which PQRS measures are to be reported for covered professional services provided. 12-month (January 1, 2015 through December 31, 2015) time periods are available depending upon the 2015 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)

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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

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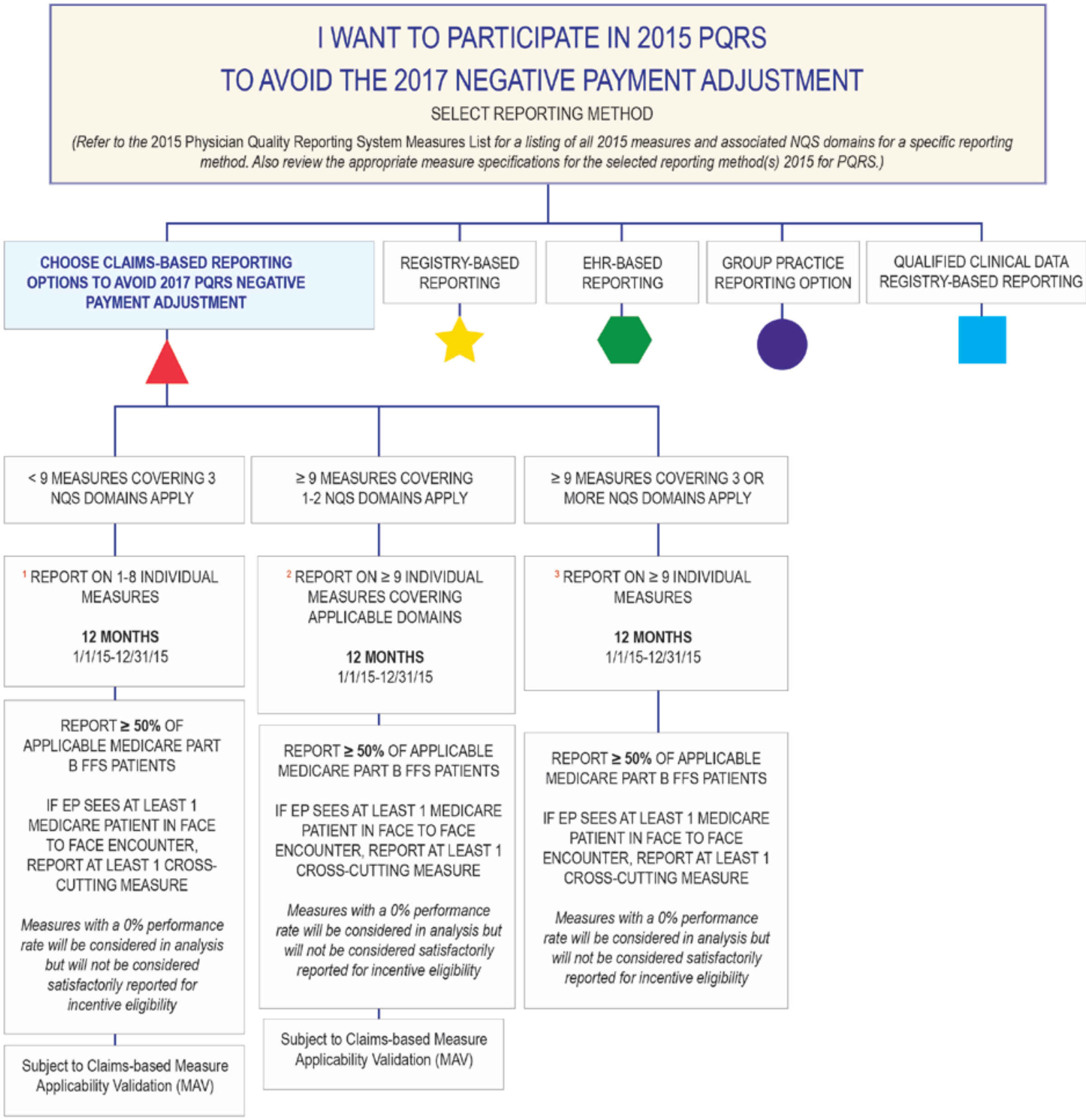
Appendix B: Decision Trees - 2015 PQRS Reporting/Participation for Avoiding the 2017 Negative Payment Adjustment



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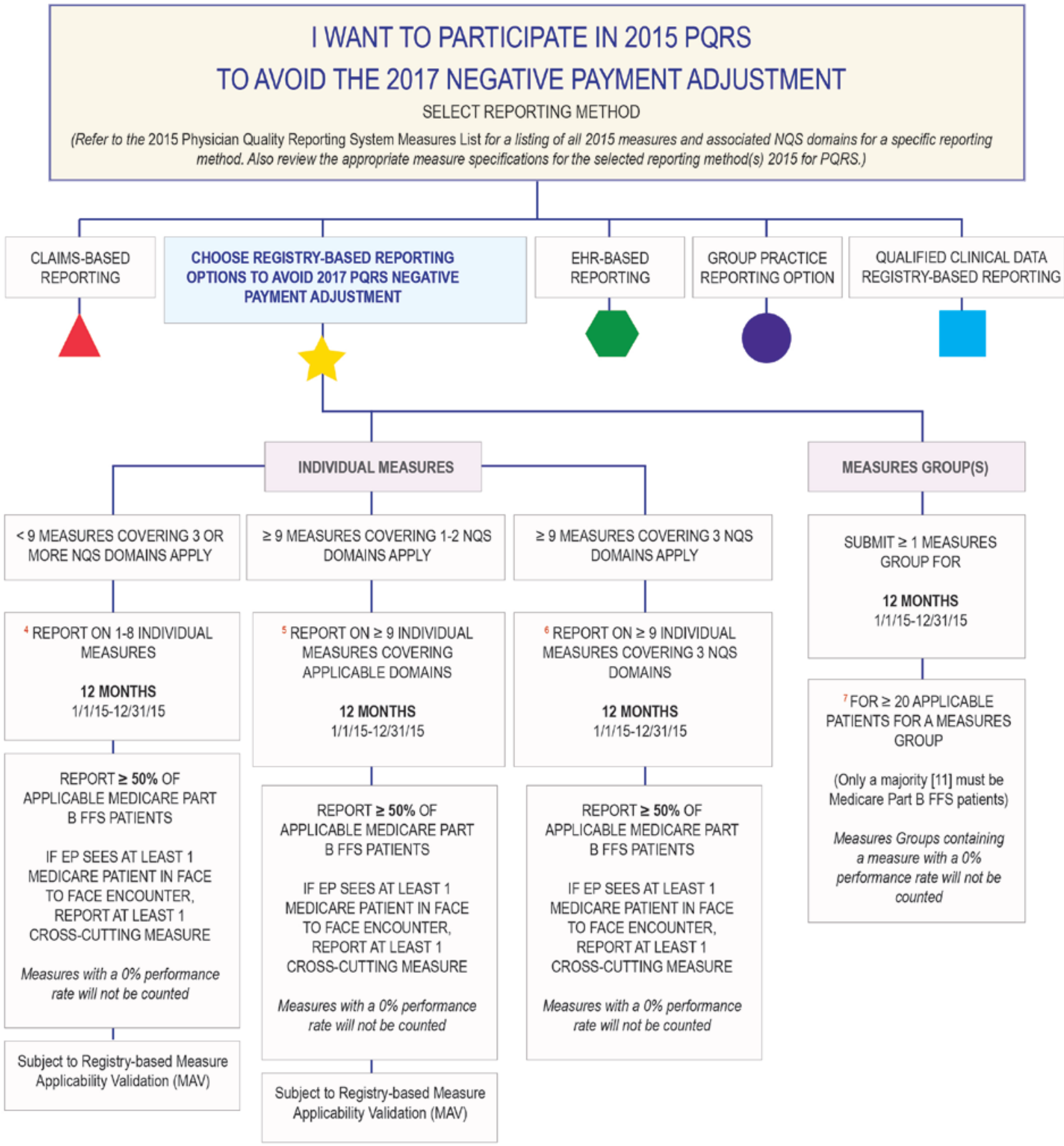

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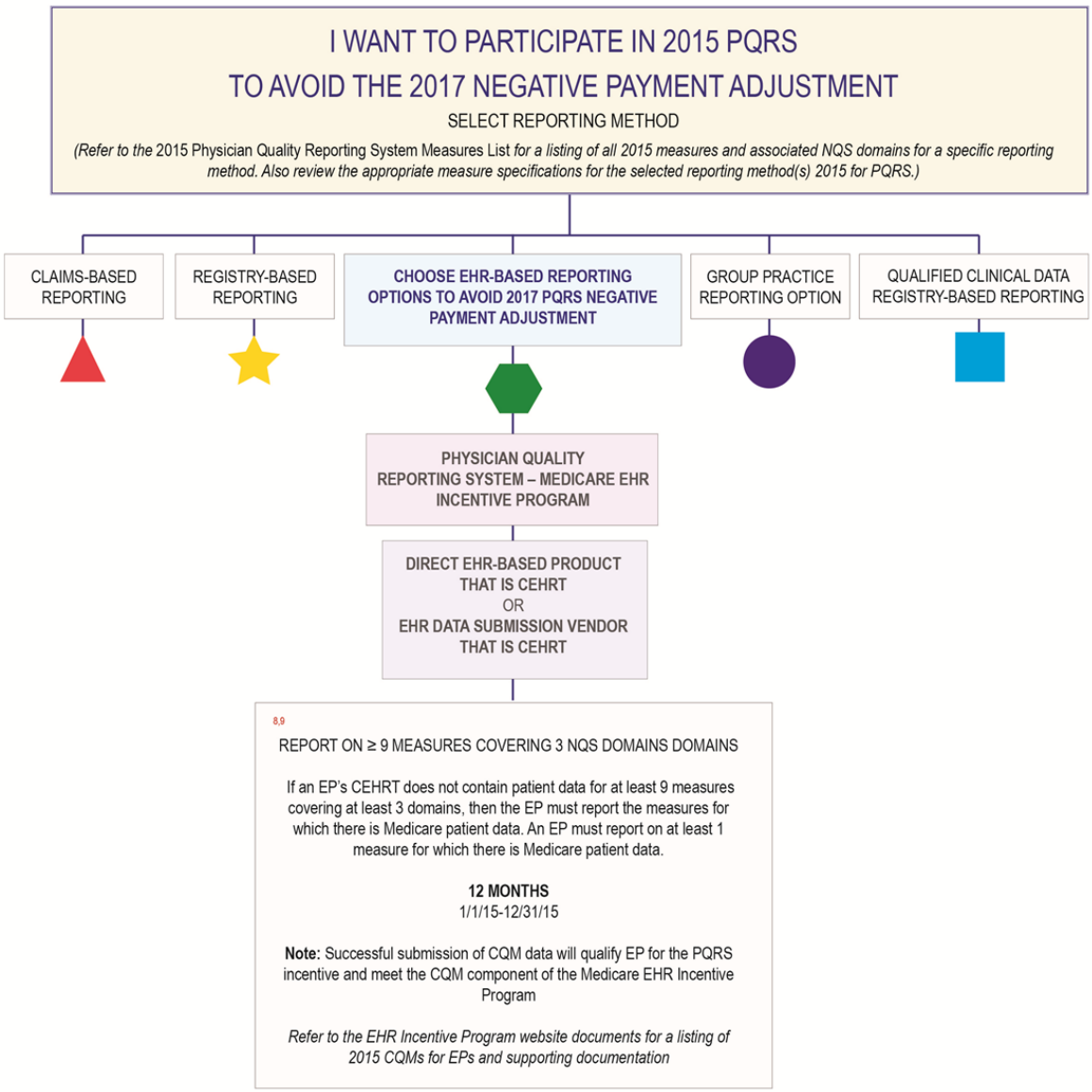

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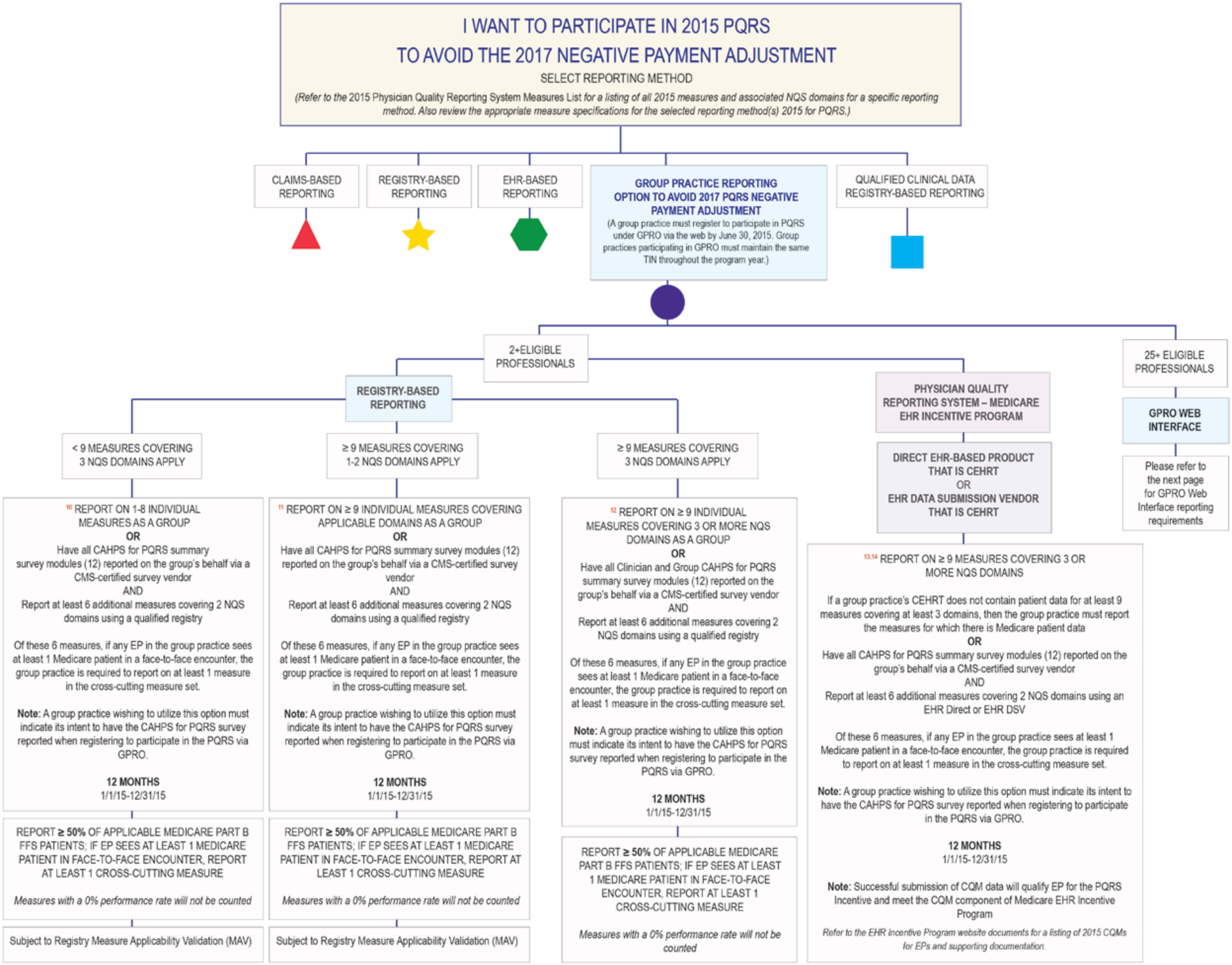

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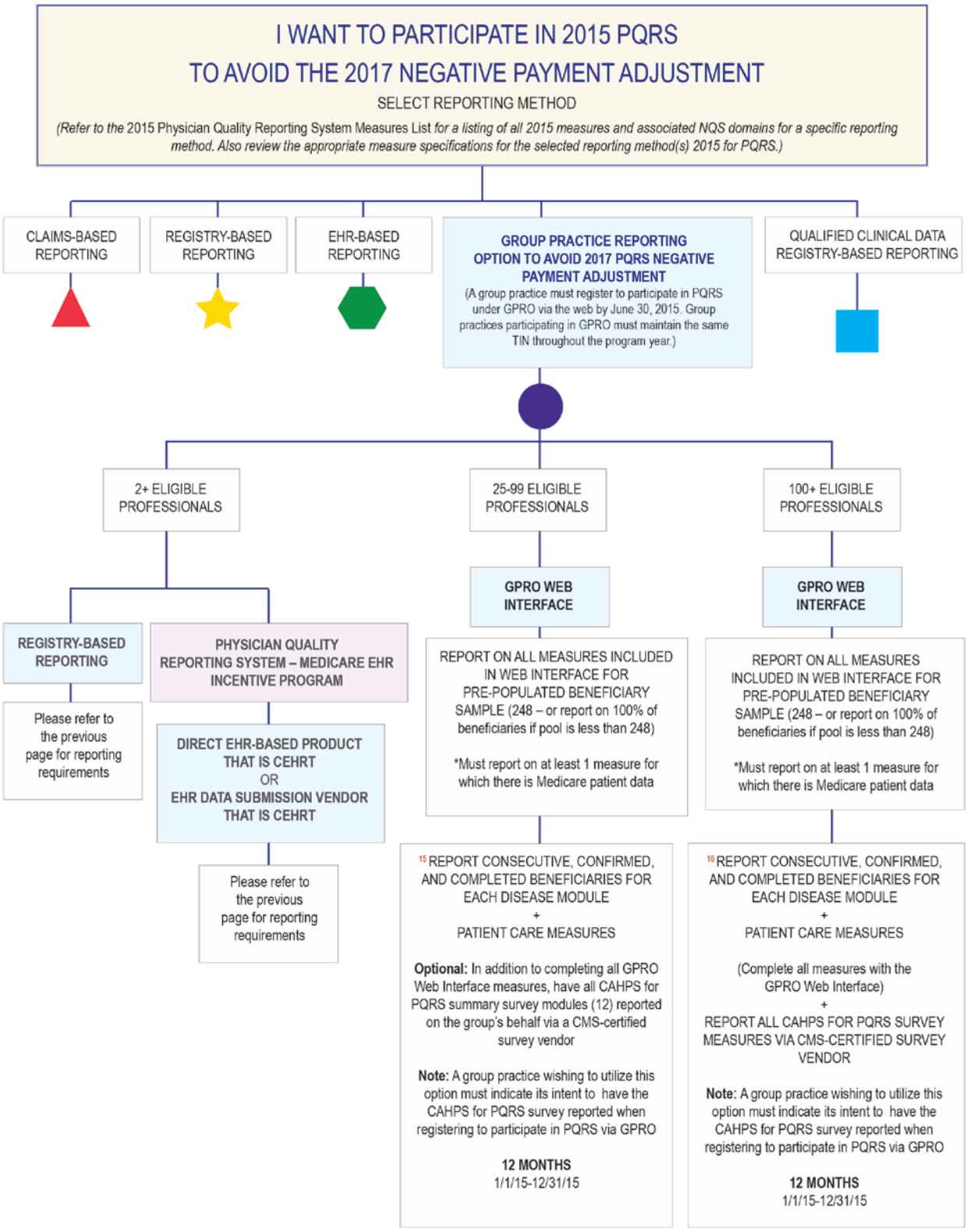

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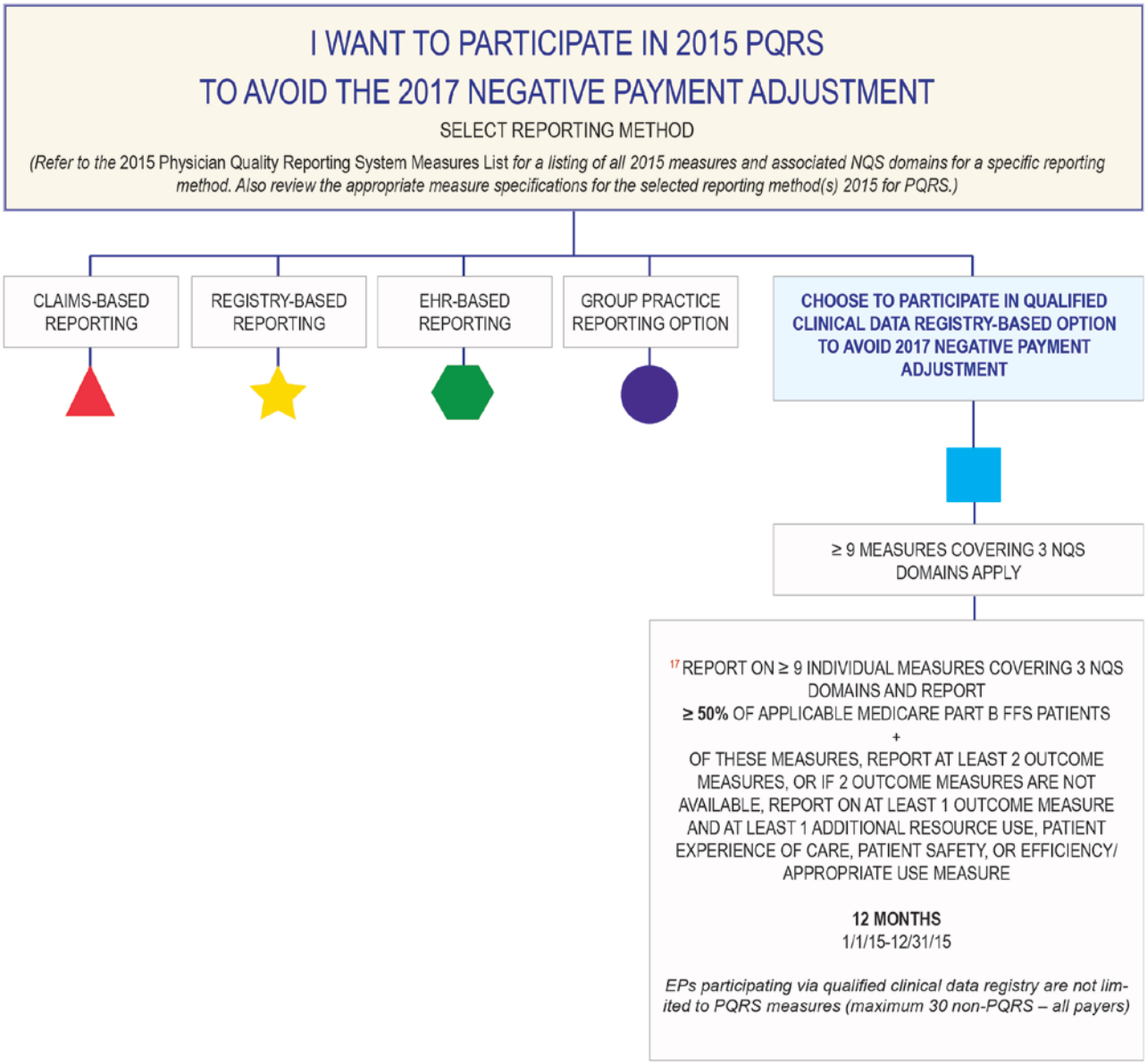

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2015 Program Reporting Options

Number assigned coordinates with appropriate box on the Appendix B: 2015 PQRS Participation for Avoiding the 2017 Negative Payment Adjustment Decision Tree.

1. Claims-based reporting of less than 9 individual measures covering 3 or more NQS domains for 50% or more of an EP's applicable Medicare Part B FFS patients and at least 1 cross-cutting measures if see at least 1 Medicare patient in a face-to-face encounter (12 months)

   Note: *This reporting mechanism is subject to Claims Measure-Applicability Validation (MAV)*

2. Claims-based reporting of at least 9 individual measures covering 1-2 NQS domains for 50% or more of an EP's applicable Medicare Part B FFS patients and at least 1 cross-cutting measures if see at least 1 Medicare patient in a face-to-face encounter (12 months)

   Note: *This reporting mechanism is subject to Claims Measure-Applicability Validation (MAV)*

3. Claims-based reporting of at least 9 individual measures covering at least 3 NQS domains for 50% or more of an EP's applicable Medicare Part B FFS patients (12 months)

4. Qualified registry-based reporting of less than 9 individual measures covering 3 or more NQS domains for 50% or more of an EP's/group's applicable Medicare Part B FFS patients and at least 1 cross-cutting measures if see at least 1 Medicare patient in a face-to-face encounter (12 months)

   Note: *This reporting mechanism is subject to Registry Measure-Applicability Validation (MAV)*

5. Qualified registry-based reporting of at least 9 individual measures covering at 1-2 NQS domains for 50% or more of an EP's/group's applicable Medicare Part B FFS patients and at least 1 cross-cutting measures if see at least 1 Medicare patient in a face-to-face encounter (12 months)

   Note: *This reporting mechanism is subject to Registry Measure-Applicability Validation (MAV)*

6. Qualified registry-based reporting of at least 9 individual measures covering at least 3 NQS domains for 50% or more of an EP's/group's applicable Medicare Part B FFS patients and of the measures report,at least 1 cross-cutting measure if see at least 1 Medicare patient in a face-to-face encounter (12 months)

7. Qualified registry-based reporting of at least one measures group for 20 or more patients, the majority (11) of which must be Medicare Part B FFS patients (12 months)

8. Direct CEHRT electronic reporting using an EHR of at least 9 individual measures covering at least 3 NQS domains (12 months)

9. CEHRT EHR Data Submission Vendor reporting of at least 9 individual measures covering at least 3 NQS domains (12 months)

10. GPRO-based reporting (2+ EPs) of 1-8 individual measures covering 3 NQS domains via registry for 50% or more of a group's applicable Medicare Part B FFS patients and at least 1 cross-cutting measures if see at least 1 Medicare patient in a face-to-face encounter OR Have all CAHPS for PQRS summary survey modules (12) reported on the group's behalf via a CMS-certified survey vendor *AND* Report at least 6 additional measures covering 2 NQS domains using a qualified registry; Of these 6 measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice is required to report on at least 1 measure in the cross-cutting measure set. (12 months)

    Note: *This reporting mechanism is subject to Registry Measure-Applicability Validation (MAV)*

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11. GPRO-based reporting (2+ EPs) of at least 9 individual measures covering 1-2 NQS domains via registry for 50% or more of the group's applicable Medicare Part B FFS patients and at least 1 cross-cutting measures if see at least 1 Medicare patient in a face-to-face encounter OR Have all CAHPS for PQRS summary survey modules (12) reported on the group's behalf via a CMS-certified survey vendor *AND* Report at least 6 additional measures covering 2 NQS domains using a qualified registry; Of these 6 measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice is required to report on at least 1 measure in the cross-cutting measure set. (12 months)

    Note: *This reporting mechanism is subject to Registry Measure-Applicability Validation (MAV)*

12. GPRO-based reporting (2+ EPs) of at least 9 individual measures covering at least 3 NQS domains via registry for 50% or more of the group's applicable Medicare Part B FFS patients and at least 1 cross-cutting measure if see at least 1 Medicare patient in a face-to-face encounter OR Have all CAHPS for PQRS summary survey modules (12) reported on the group's behalf via a CMS-certified survey vendor *AND* Report at least 6 additional measures covering 2 NQS domains using a qualified registry; Of these 6 measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice is required to report on at least 1 measure in the cross-cutting measure set. (12 months)

13. GPRO-based reporting (2+ EPs) of at least 9 individual measures covering at least 3 NQS domains via Direct EHR Product that is CEHRT OR Have all CAHPS for PQRS summary survey modules (12) reported on the group's behalf via a CMS-certified survey vendor *AND* Report at least 6 additional measures covering 2 NQS domains using a qualified registry; Of these 6 measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice is required to report on at least 1 measure in the cross-cutting measure set. (12 months)

14. GPRO-based reporting (2+ EPs) of at least 9 individual measures covering at least 3 NQS domains via EHR Data Submission Vendor that is CEHRT OR Have all CAHPS for PQRS summary survey modules (12) reported on the group's behalf via a CMS-certified survey vendor *AND* Report at least 6 additional measures covering 2 NQS domains using a qualified registry; Of these 6 measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice is required to report on at least 1 measure in the cross-cutting measure set. (12 months)

15. GPRO-based reporting (25-99 EPs) of all applicable measures included in the submission GPRO Web Interface provided by CMS for consecutive, confirmed, and completed patients for each disease module and preventive care measures; Report on at least 1 measure for which there is Medicare patient data. (12 months)

16. GPRO-based reporting (100+ EPs) of all applicable measures included in the submission GPRO Web Interface provided by CMS for consecutive, confirmed, and completed patients for each disease module and preventive care measures AND report all CAHPS for PQRS summary survey modules via CMS-certified survey vendor; Report on at least 1 measure for which there is Medicare patient data. (12 months)

17. Qualified clinical data registry-based reporting of at least 9 measures covering at least 3 NQS domains for 50% or more of the EP's applicable Medicare Part B FFS patients; of these measures report at least 2 outcome measures, OR if 2 outcome measures are not available, report on at least 1 outcome measure and at least one of the following types of measures - resource use, patient experience of care, efficient/appropriate use, or patient safety measure. (all payers) (12 months)

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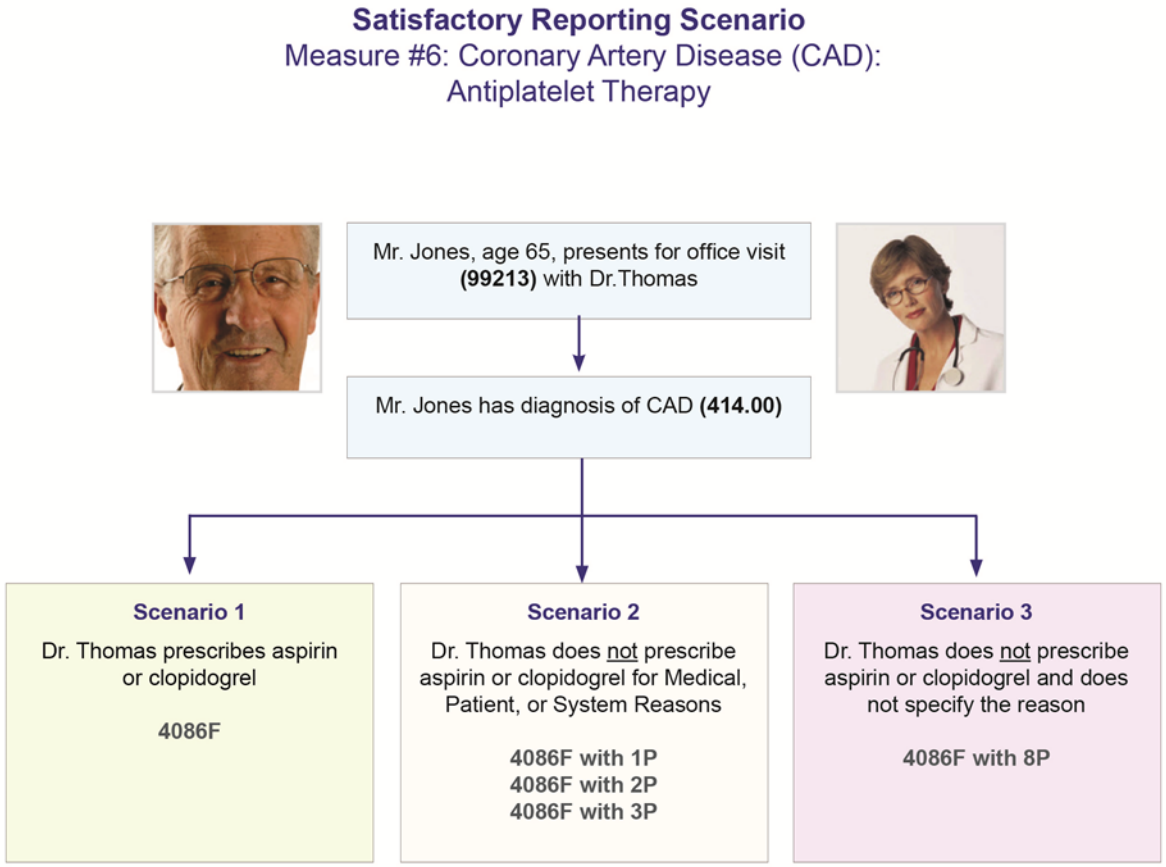
Appendix C: Satisfactory Reporting via Claims Scenario



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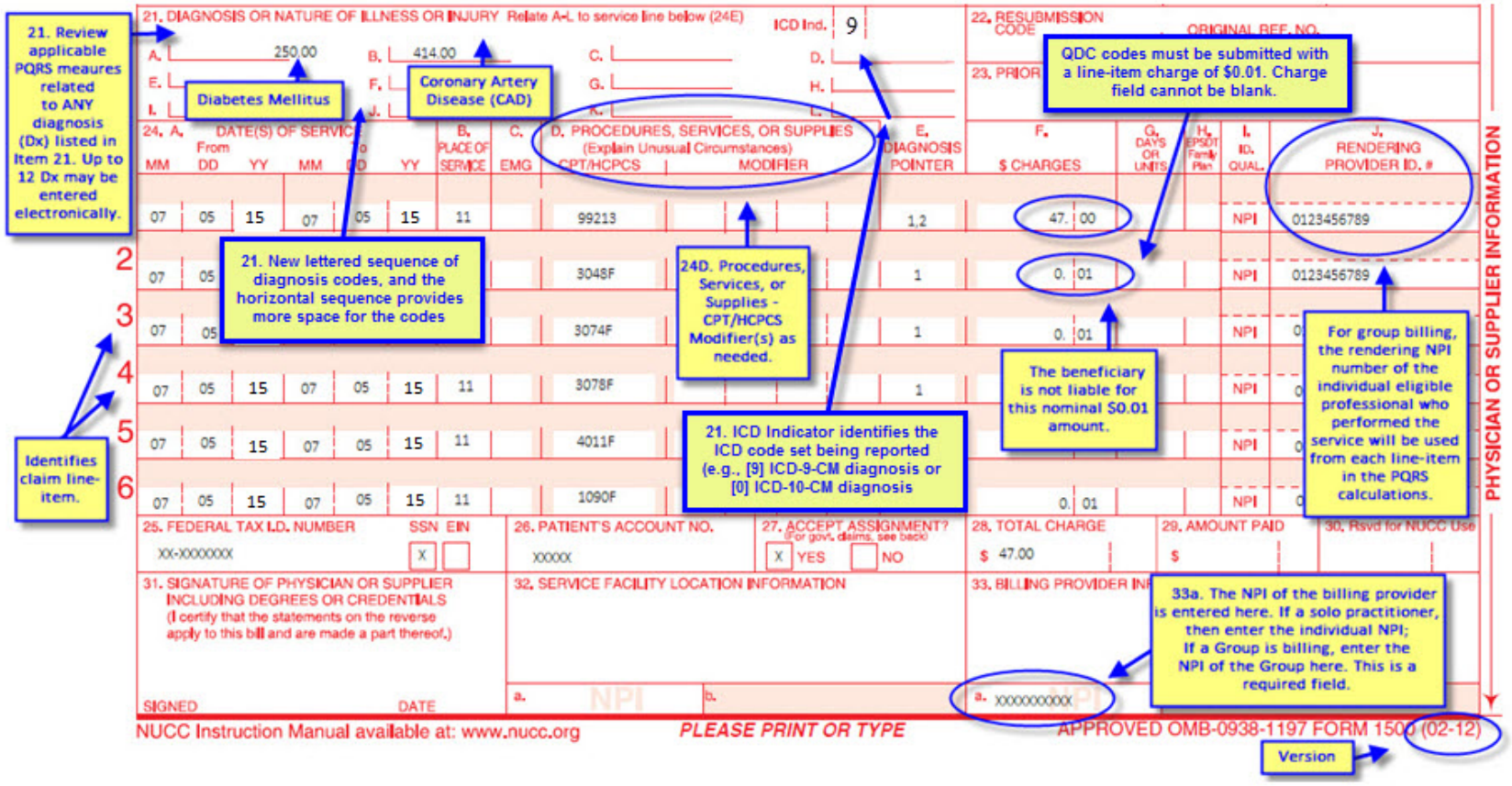
Appendix D: CMS-1500 Claim PQRS Example

Example of an individual NPI reporting on a single CMS-1500 claim.
See http://www.cms.gov/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 diabetes, coronary artery disease (CAD), and urinary incontinence:
- Measure #2 (LDL-C) with QDC 3048F + diabetes line-item diagnosis (24E points to DX 250.00 in Item 21);
- Measure #3 (BP in Diabetes) with QDCs 3074F + 3078F + diabetes line-item diagnosis (24E points to Dx 250.00 in Item 21);

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- Measure #6 (CAD) with QDC 4011F + CAD line-item diagnosis (24E points to Dx 414.00 in Item 21); and

- Measure #48 (Assessment - Urinary Incontinence) with QDC 1090F. For PQRS, there is no specific diagnosis associated with this measure. Point to the appropriate diagnosis for the encounter.

- 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.

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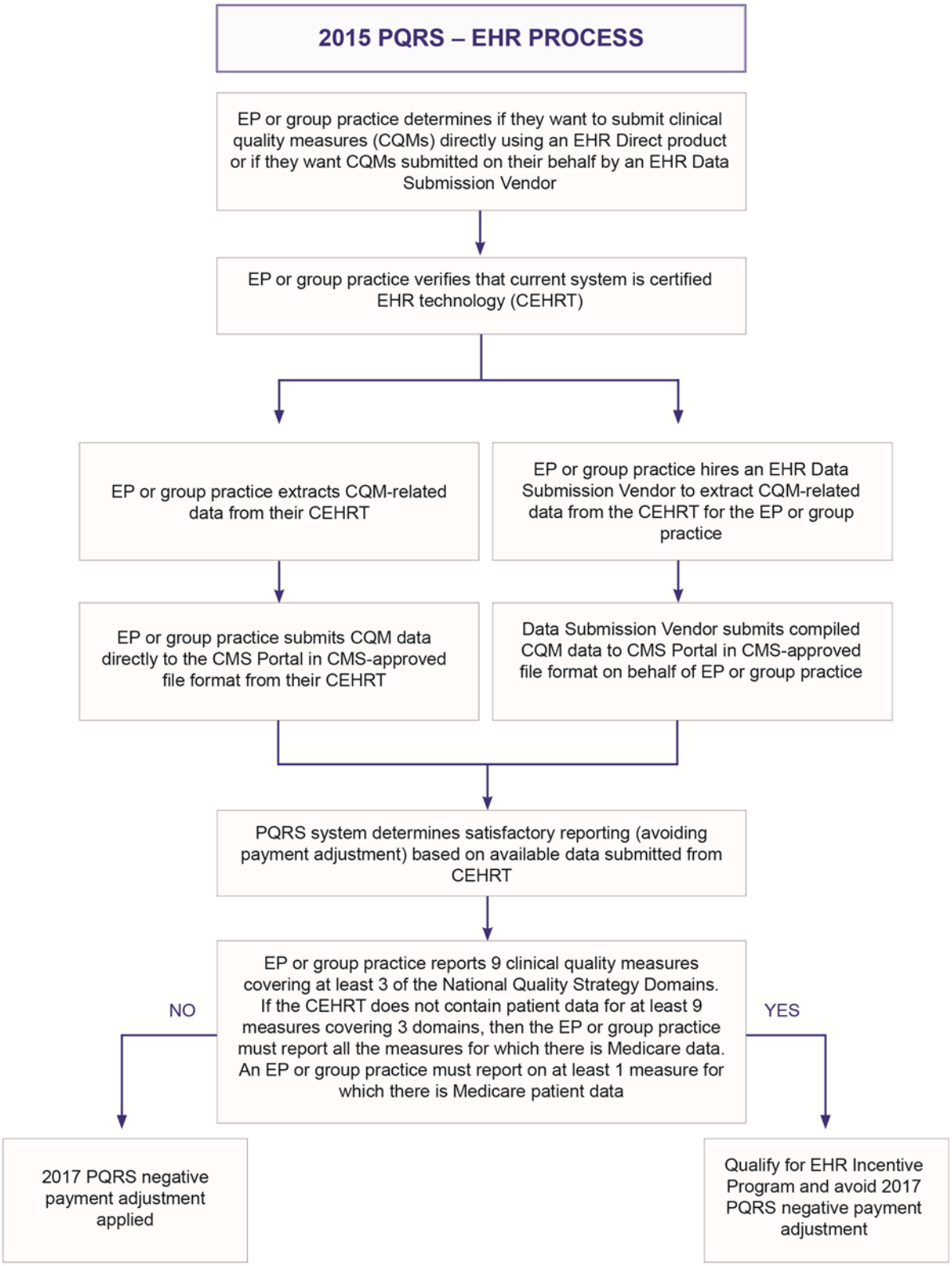
Appendix E: PQRS EHR Process



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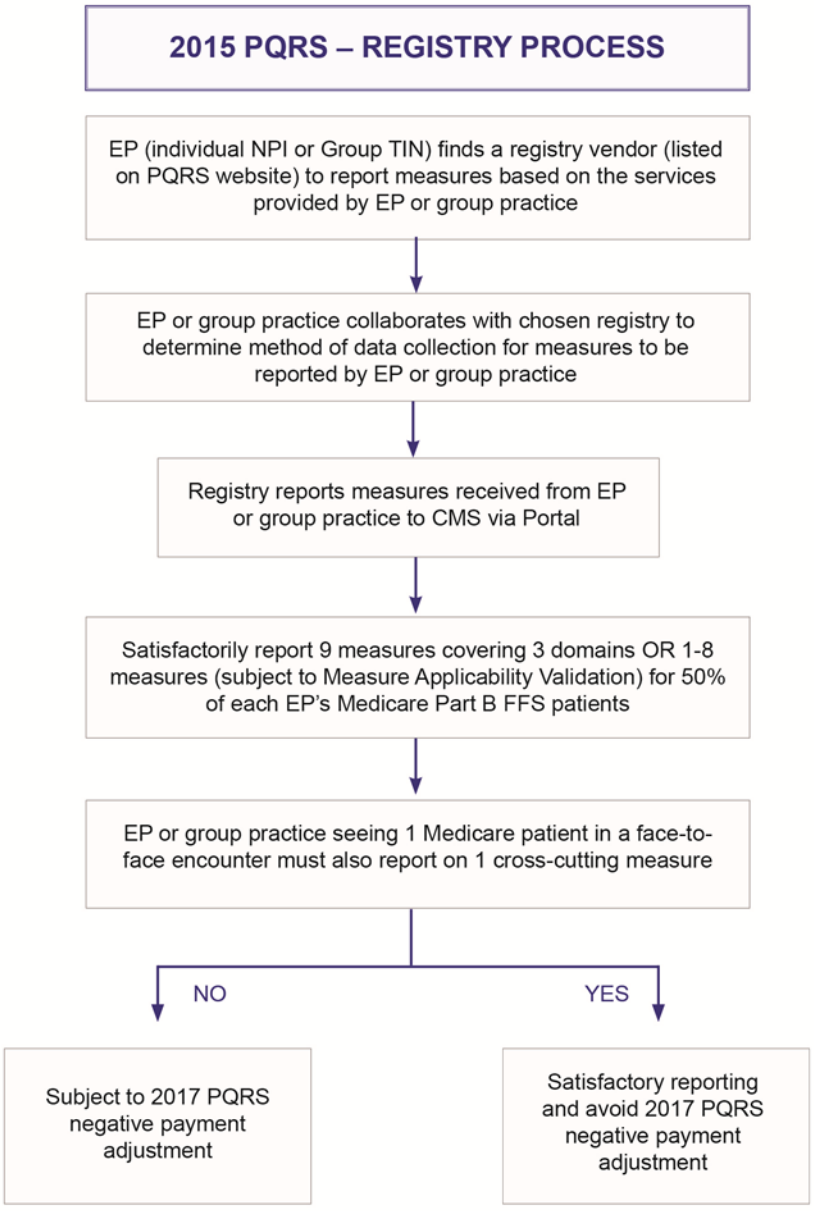
Appendix F: PQRS Registry Process



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.

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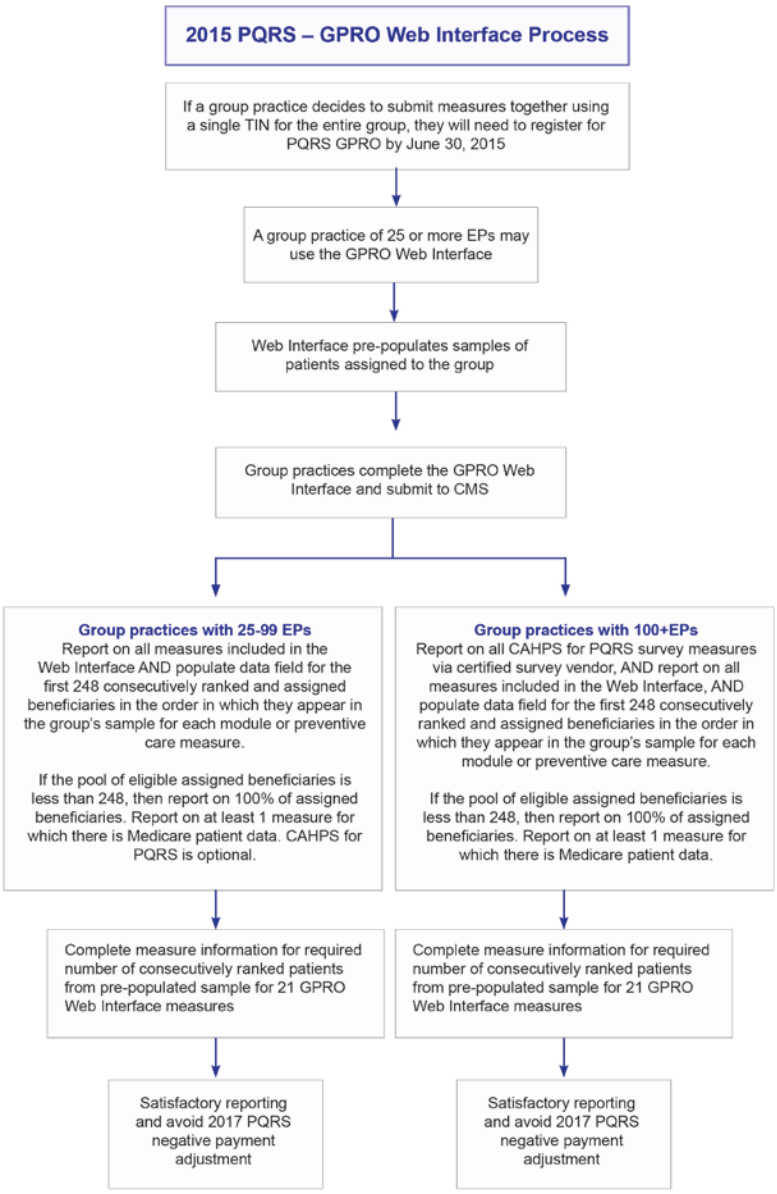
Appendix G: PQRS GPRO Web Interface Process



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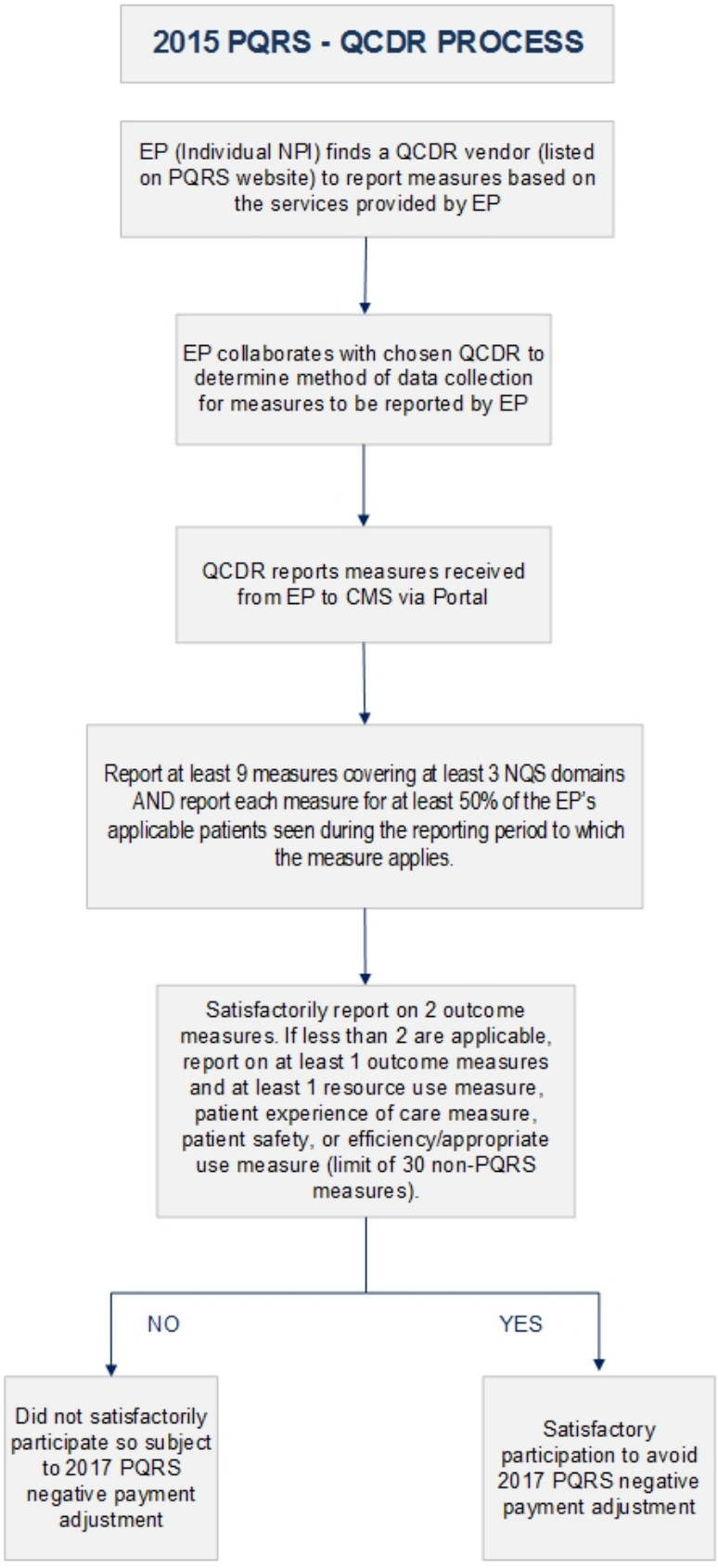
Appendix H: QCDR Process



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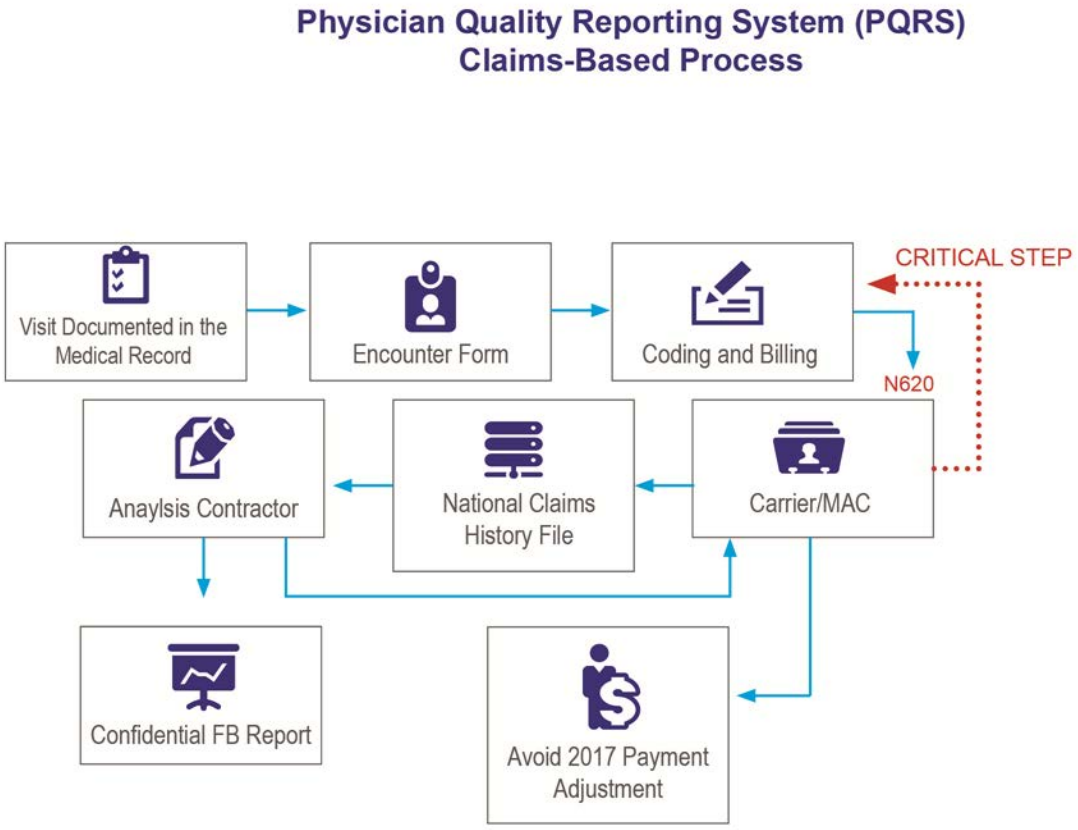
Appendix I: PQRS Claims-Based Process



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Appendix J: Revision Notes

2/4/2015

- p. 36 Claims-based reporting flow – changed references to “2 cross-cutting measures” to “1 cross-cutting measure”
- p. 37 Registry flow – changed references to “2 cross-cutting measures” to “1 cross-cutting measure”
- p. 43 bullet 12 – changed reference to “2 cross-cutting measures” to “1 cross-cutting measure”

2/25/2015

- p. 8 revised first paragraph as cross-cutting measures are not in addition to but are part of the 9 measures over 3 domains
- p. 31 updated EP definition so in sync with posted *List of 2015 PQRS EPs*
- p. 40 GPRO Web Interface decision tree – updated boxes 15-16 to include “*Must report on at least 1 measure for which there is Medicare patient data”
- p. 41 QCDR decision tree – updated box 17 to “Of these measures, report at least 2 outcome measures, or if 2 outcome measures not available, report on at least 1 outcome measure and at least 1 additional resource use, patient experience of care, patient safety, or efficiency/appropriate use measure”
- p. 42 bullet 7 – removed cross-cutting statement from measures group reference to now read “Qualified registry-based reporting of at least one measures group for 20 or more patients, the majority (11) of which must be Medicare Part B FFS patients (12 months)”
- p. 43 updated bullets 15-17 text description to match updated decision trees
- p. 50 QCDR process flow – updated box 6 to “Of these measures, report at least 2 outcome measures, or if 2 outcome measures not available, report on at least 1 outcome measure and at least 1 additional resource use, patient experience of care, patient safety, or efficiency/appropriate use measure”

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