

Volume

1

2013 PHYSICIAN QUALITY REPORTING SYSTEM

A Guide to Getting Started Reporting & Improving



**Quality Improvement
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Getting Started with 2013 PQRS Reporting

The Physician Quality Reporting System (PQRS) is a voluntary reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). EPs report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer.)

PQRS was introduced by CMS in 2006. Each year the rules, measures, incentives, and payment adjustment change.

The incentives for PQRS reporting are:

- 2013: +0.5%
- 2014: +0.5%

No PQRS incentives are scheduled past 2014.

The payment adjustments for non-reporting are:

- 2015: -1.5% based on 2013 reporting
- 2016: -2.0% based on 2014 reporting
- 2017 and thereafter: -2.0% based on a 2-year look-back period

Getting Started

Step 1: Are you eligible for the PQRS Incentive Program?

Eligible Providers include most physicians, podiatrists, optometrists, dentists and chiropractors, as well as practitioners and therapists. A complete listing of eligibility requirements can be found [here](#).

Step 2: Determine which PQRS reporting method best fits your practice.

CMS has published a visual [Decision Tree](#) to help you. There are four methods of reporting to earn an incentive in 2013. These methods are: Claims, Qualified Registry, Qualified EHR (Direct and Data Submission Vendor), and the Group Practice Reporting Option (GPRO). In addition for 2013 only, you may avoid a 2015 payment adjustment—but not earn an incentive—by reporting PQRS using Administrative Claims.

If you are a provider that is participating in the EHR Incentive Program (i.e., Meaningful Use), you may find it valuable to submit PQRS using your EHR (either Direct or a Data Submission Vendor) if it is qualified. Doing so will help you develop skills that will be required to submit Clinical Quality Measures for 2014 Meaningful Use and PQRS.

Step 3: Decide if you will report individually or as a group.

Groups are defined as two or more EPs operating under the same Tax Identification Number (TIN). Groups of 100+ EPs must report PQRS as a Group in 2013 to avoid Value-Based Modifier payment adjustments in 2015. Groups with 2-99 EPs may elect to report PQRS as a Group or as Individuals.

Group reporters must establish an [Individualized Authorized Access to CMS Computer Services \(IACS\)](#) account and self-nominate between July 15 and October 15 via the [CMS PV-PQRS Registration System](#). Individual reporters do not have to self-nominate nor register *unless they elect to report PQRS using Administrative Claims*.

For more information on the PV-PQRS Registration System and IACS accounts, please view this [webinar](#). Providers may contact the Quality Net Help Desk for assistance: 866-288-8912 TTY/TDD at 877-715-6222 (Monday – Friday 7:00 a.m.-7:00 p.m. CST) email at qnetsupport@sdps.org.

Step 4: Understand the specific requirements to earn an incentive for the method of reporting you've selected.

To earn a PQRS incentive in 2013, you must achieve one of the following:

- Individual EPs:
 - Claims:
 - Report at least 3 measures for 50% of eligible Medicare Part B FFS patients, OR
 - Report 1 Measures Group for at least 20 Medicare Part B FFS patients
 - Qualified Registry:
 - Report at least 3 measures for 80% of eligible Medicare Part B FFS, OR
 - Report 1 Measures Group for at least 20 patients, the majority of which must be Medicare Part B FFS patients
 - Qualified EHR Direct or Data Submission Vendor:
 - Option 1: Report at least 3 measures for 80% of eligible Medicare part B FFS patients, OR

- Option 2: Participate in the PQRS-EHR Incentive pilot (3 core plus 3 menu measures that are also measures in the EHR Incentive Program)
- Groups (GPRO)
 - Registry, Groups 2+ EPs: Report at least 3 measures for 80% of eligible Medicare Part B FFS patients, OR
 - GPRO Web Interface:
 - Groups 25-99 EPs: Report all measures for the first 218 consecutively assigned beneficiaries, OR
 - Groups 100+ EPs: Report all measures for the first 411 consecutively assigned beneficiaries

Step 5: Understand how you can avoid a payment adjustment in 2015 (based on 2013 reporting.)

Requirements to avoid a payment adjustment are less stringent than to earn an incentive.

To Avoid a Payment Adjustment:

- Option 1: Meet the requirements for satisfactorily reporting for the 2013 PQRS incentive payment (Individuals or GPRO, as discussed in Step 4), OR
- Option 2: Report one valid measure:
 - Individuals: Report at least one valid measure or measures group via claims, qualified registry, or qualified EHR
 - GPRO: Report at least one valid measure via qualified registry or Web-Interface, OR
- Option 3: Elect to participate in CMS-calculated Administrative Claims (Individuals or GPRO). Individuals and Groups electing Administrative Claims must Register in the [CMS Portal](#) prior to October 15, 2013 (see Step 3 above).

For detailed requirements, instructions and measure specifications, please refer to the following sections:

- Claims-Based reporting
- Registry-based Reporting
- EHR-Based Reporting (Direct and Data Submission Vendor)
- Group Practice Reporting Option (GPRO)

For additional assistance

Primaris is providing assistance to Missouri providers with reporting PQRS measures in 2013. Missouri providers may contact Sandy Pogones at Primaris by email at spogones@primaris.org or phone at (573) 673-4531.

Providers may also contact the Quality Net Help Desk for assistance: 866-288-8912 TTY/IDD at 877-715-6222 (Monday – Friday 7:00 a.m.- 7:00 p.m. CST) or email at qnetsupport@sdps.org.

2013 Claims-Based Reporting

Note: If you have not yet read “Getting Started,” please refer to Steps 1-5.

Step 6: Decide which reporting option you will use.

Individual providers may report either of the following via Claims (Note: Groups cannot report via Claims):

- Three individual measures for 50% of eligible Medicare Part B FFS patients seen in 2013, OR
- One Measures Group for at least 20 eligible Medicare Part B FFS patients seen in 2013.

Measures or Measures Groups containing a measure with a zero percent performance rate will not be counted.

Step 7: Read the CMS PQRS Implementation Guide.

- For Individual PQRS measures: [2013 Claims Reporting Made Simple](#) and [2013 PQRS Implementation Guide](#)
- For Measures Groups: [2013 Getting Started with Measures Groups](#)

Step 8: Select your measures and download the specifications.

- Individual Measures Specifications: [2013 Measure Specification for Claims and Registry Reporting](#)
- Measures Groups Specifications: [2013 Specifications for Measures Groups](#)

Step 9: Flag eligible cases.

If your practice management software has the capability, turn-on alerts/flags to help identify eligible PQRS patients as they are seen. Many vendors have pre-defined alerts that align with PQRS measures. Be certain you distinguish between alerts for individual measures versus measures groups. If flags can't be set electronically, determine a manual method to identify eligible patients.

Step 10: Enter the correct PQRS codes on the claim.

Record the correct diagnosis, CPT and Quality Data Codes (QDC) for each measures on the claim and submit the claim as usual.

QDCs should be submitted on the line item as a zero charge, or with a nominal amount if billing software doesn't permit a zero charge line item. The charge field cannot be left blank. QDCs will be denied and then passed on for PQRS analysis and payment. You will see a denial code “N365” on the Remittance Advice. This code does not mean the data was submitted correctly; it only means the codes were passed on for PQRS analysis (and not stripped from the claim by the clearinghouse). You cannot submit/resubmit a claim for the sole purpose of PQRS reporting or to correct a PQRS code.

Step 11: Track your progress.

Access your feedback reports for [individuals](#) or [organizations](#) information on PQRS submissions. Mid-year and end-of-year reports are distributed. Your practice management software may also have the ability to generate PQRS reports to monitor your reporting

rate. Finalize all claims submissions by February 28, 2014 for consideration in 2013 PQRS reporting.

Step 12: Receive your incentive payment.

Incentive payments are made in the fall of 2014 as a single consolidated payment. Look for payment code “LE” to indicate an incentive payment, along with “PQ13” to identify the payment as the 2013 PQRS incentive payment. Paper remittance advice will read, “This is a PQRS incentive payment.”

EHR-Based PQRS Reporting

Note: If you have not yet read “Getting Started,” please refer to Steps 1-5.

Eligible professionals using a Qualified EHR to report PQRS will find this method makes good use of EHR capabilities, fits well into the daily workflow, and will prepare the practice for electronic reporting of Clinical Quality Measures for the EHR Incentive Program (e.g., Meaningful Use) in 2014. The entire care team can assist with proper documentation at the point-of-care. Documentation for PQRS purposes is consistent with documentation for Meaningful Use, Patient-Centered Medical Homes, Accountable Care Organizations, HEDIS, and other quality initiatives. You may be able to report the same or similar measures for all programs.

Step 6: Determine if you are eligible to report via an EHR method in 2013.

You must meet the following requirements to report PQRS using the EHR method:

- You must be using a 2013 [Qualified EHR-Direct Vendor](#) or must be working with a [Qualified EHR Data Submission Vendor](#). Refer to the links for vendor names, version numbers, measures supported and contact information.
- The EHR must have been in use for the entire reporting period (January 1 – December 31, 2013). You may be able to upgrade to a newer qualified version during the reporting period. Contact your vendor to determine when the upgrade must occur.
- All eligible encounters for the year must be documented in the EHR, along with all diagnoses, services and procedure codes. Some measures include SNF, hospital, or other types of visits.
- Data elements must be recorded as structured data in the manner specified by your vendor.

Read and understand [PQRS 2013 EHR Reporting Made Simple](#).

Step 7: Select your measures.

There are 51 individual measures which may be reported using a qualified EHR in 2013, including the Clinical Quality Measures (CQMs) that are part of Meaningful Use. You must report a minimum of three individual measures, but you may report as many measures as you like to improve your chances of success. Many measures share the same patient population and/or the same data elements. Select measures that contain data elements you consistently capture (such as vitals or labs.)

Step 8: Review the Measure Specifications.

[EHR Measure Specifications](#) identify the data elements, encounter, diagnosis, procedure and other codes that must be captured and properly mapped/linked in your EHR. Contact your vendor for documentation guidance for your specific EHR.

Step 9: Determine a workflow that assigns each staff and provider specific responsibilities for performing and documenting services.

Most of the documentation and much of the care itself can be done by members of the care team other than the physician, especially for preventive and chronic care

measures. Standing orders and protocols will improve efficiency and quality of care delivered.

Step 10: Use clinical decision support to identify eligible patients in need of service or improper documentation of services provided.

Use the clinical decision support functions of your EHR to set reminders for clinical quality measures that apply to population groups. Run lists of patients who do not meet evidence-based criteria. Use built-in PQRS reports and Dashboards to monitor your performance throughout the year.

Identify patients who have not met the measure(s) and discuss results among staff and physicians at monthly meetings. Determine why patients did not meet the measure and establish a plan for improvement.

Don't wait until the end of the year to discover documentation or service issues.

Step 10: If you are using an EHR-Direct Vendor, establish an IACS account for EHR submissions.

If you are using an EHR-Direct Vendor, you must establish an IACS account in order to submit PQRS EHR data. Complete this process in the fall of 2013. At minimum, the following roles must be established:

- Security Official (2-Factor): This role is not the same as the PV-PQRS Security Officer. The Security Official must create the organization/individual IACS account, submit IRS documentation, and approve other roles. This role must be established first.
- EHR Submitter: This role will upload the data to the CMS Portal.
- End-User: This role will be able to access feedback reports.

Quick Reference Guides can be found [here](#) (see the Quick Reference Guide link under the sign-in button). Create your IACS account using the [CMS Portal](#). Select "Account Management," then "New User Registration," then "Physician Quality Reporting System/eRX." Follow the instructions in the guides for creating various roles.

Contact the QualityNet Help Desk at 866-288-8912 or qnet support@sdps.org for assistance with IACS accounts.

Data Submission Vendors will establish the required IACS accounts—there is no need for the EP to do so.

Step 11: Create the PQRS QRDA Files and Upload to the CMS Portal

Make certain all TINs and NPIs are current and accurately recorded within your EHR/with your Data Submission Vendor, as incentives are determined based on the TIN/NPI combination.

If you are using an EHR-Direct Vendor you will need to create standard files in QRDA (Quality Reporting Document Architecture) format. Qualified EHR vendors have this

capability built-in. Follow instructions provided by your vendor for creating the files. Files must be created and uploaded to the [CMS Portal](#) between January 1 and February 28, 2014. Begin this process as early as possible, as errors and delays are likely.

Data Submission Vendors will create and submit the QRDA files on your behalf.

Registry-Based PQRS Reporting

Note: If you have not yet read “Getting Started,” please refer to Steps 1-5.

Step 6: Identify a Qualified Registry.

CMS has published a listing of [Qualified Registries](#) for 2013 PQRS reporting. The listing identifies the vendors, measures and/or measures groups they support, costs and contact information. Contact the registry for specific information regarding requirements, deadlines, and procedures for participation.

Step 7: Decide which reporting option you will use.

Individual providers may report either of the following via registry:

- Three individual measures for 80% of eligible Medicare Part B FFS patients seen in 2013, OR
- One Measures Group for at least 20 patients, a majority (11 patients) of which must be Medicare Part B FFS patients seen in 2013.

Groups (two or more eligible providers) may report the following via registry:

- Three individual measures for 80% of eligible Medicare Part B FFS patients seen in 2013.

Measures or Measures Groups containing a measure with a zero percent performance rate will not be counted.

Step 8: Read the CMS PQRS Implementation Guide.

- [2013 PQRS Registry Reporting Made Simple](#), AND
- [2013 Getting Started with Measures Groups](#) if you plan to report a Measures Group

Step 9: Select your Measures and Download the Specifications

Verify that the registry you selected supports the measures/measures group you wish to report.

- Individual Measures Specifications: [2013 Measure Specification for Claims and Registry Reporting](#)
- Measures Groups Specifications: [2013 Specifications for Measures Groups](#)

Step 10: Work directly with your registry.

Enter into a Business Agreement with your registry. The registry will provide you with specific instructions on how to submit data for the selected measures or measures group. The registry will in turn, submit PQRS data to CMS on your behalf during the first quarter of 2014. You will work directly with your registry to ensure data is submitted appropriately for incentive purposes.

Step 11: Track your progress.

Registries are required to provide at least 2 feedback reports to participants. Use the feedback reports to monitor and improve your performance.

Step 12: Receive your incentive payment.

Incentive payments will be made in the fall of 2014 as a single consolidated payment. Look for payment code “LE” to indicate an incentive payment, along with “PQ13” to identify the payment as the 2013 PQRS incentive payment. Paper remittance advice will read, “This is a PQRS incentive payment.”

Group Practice Reporting Option

Note: If you have not yet read “Getting Started” please refer to Steps 1-5.

A “group practice” under 2013 consists of a single Tax Identification Number (TIN) with 2 or more EPs who have reassigned their Medicare billing rights to the TIN.

Benefits are that one set of quality measures data is reported on behalf of all EPs within the group, which reduces the need to keep track of each EP’s reporting efforts separately. Incentive payments are based on all Medicare Part B FFS claims submitted under the TIN, so payments may be larger.

Potential drawbacks are that members of an approved group may not earn a PQRS incentive as an individual, and if the group is unsuccessful, all EPs will miss the incentive/incur the payment adjustment.

Step 6: Download GPRO Implementation Guides.

Download and understand [GPRO Requirements for 2013 PQRS Reporting](#) and [2013 GPRO Made Simple](#).

Step 7: Determine the method of group reporting and download measure specifications.

Qualified Registry: All groups may report using a [Qualified Registry](#). Column 8 in the listing of Qualified Registries indicates if the GPRO option is available. The listing also provides measures supported, price and contact information. Groups must report at least 3 individual measures for 80% of their eligible Medicare Part B FFS patients seen during the reporting period. If reporting using a Registry, follow Steps 6-12 for “2013 Registry Reporting.” Groups are not allowed to report a Measures Group.

GPRO Web-Interface: Groups of 25 or more EPs may report using the Web-Based Interface. CMS will provide a listing of assigned beneficiaries to the practice which is partially completed, and the practice must populate the remaining data fields. The web interface contains 18 measures, two of which are composite measures, for a total of 22 individual measures. Groups with 25-99 EPs must report all measures for 218 assigned beneficiaries, and groups of 100+ EPs must report all measures for 411 assigned beneficiaries. Download the [2013 Measures List and Specifications](#) for the web interface.

Step 8: Create an IACS account and register in the PV-PQRS Registration System.

See instruction in Step 3 for creating an IACS account and registering in the PV-PQRS Registration System. Providers should create the IACS Approver Role of “PV-PQRS Group Security Official.” Following creation of the account, groups must self-nominate and select their method of PQRS reporting in the PV-PQRS Registration System. (Groups of 100+ EPs should also indicate if they intend to elect “Quality Tiering” for the 2013 Value-Based Modifier at the same time.) The deadline date for self-nomination and election is October 15, 2013.

Contact the QualityNet Help Desk at 866-288-8912 or qnet-support@sdps.org for assistance with IACS accounts and the PV-PQRS Registration System.

Step 9: Determine a workflow that assigns each staff and provider specific responsibilities for performing services and capturing data for each of the measures.

Most of the documentation and much of the care itself can be done by members of the care team other than the physician, especially for preventive and chronic care measures. Standing orders and protocols will improve efficiency and quality of care delivered.

Step 10: If using an EHR, use clinical decision support to identify eligible patients in need of service or improper documentation of services provided.

Use the clinical decision support functions of your EHR to set reminders for clinical quality measures that apply to population groups. Run lists of patients who do not meet evidence-based criteria. Use built-in reports to monitor your performance throughout the year.

Identify patients who have not met the measure(s) and discuss results among staff and physicians at monthly meetings. Determine why patients did not meet the measure and establish a plan for improvement.

Don't wait until the end of the year to discover documentation or service issues.

Monitor performance throughout the year and take steps to improve.

Step 11: If reporting via the web-based interface, complete all data fields upon receipt of the assigned beneficiary files from CMS and submit to CMS.

Files will be sent during the first quarter of 2014. Follow instructions for completion and upload.

Contact the QualityNet Help Desk at 866-288-8912 or qnetssupport@sdps.org for assistance with GPRO reporting.

Primaris provides abstraction services for completion of the Web-based interface. Contact Cora Butler cbutler@primaris.org for additional information.



Improve Your Numbers

Primaris assists providers in Missouri through initiatives to enhance patient care by improving the processes by which care is delivered to patients and beneficiaries. By empowering providers and organizations with resources and education, Primaris hopes to sustain long term improvements. The following sections are intended to support patient care initiatives.

PQRS Resources

- [2013 PQRS Requirements and Updates](#) – Important information about changes and requirements for PQRS reporting in 2013
- [CMS Sponsored Calls](#) – National provider calls (scheduled and recorded) that offer training on PQRS, EHR Incentive Program (Meaningful Use), Value-based Modifier and other topics
- [CMS PQRS Decision Tree](#) – A visual description of the methods available for 2013 PQRS reporting and the options and requirements for each
- [PQRS Payment Adjustment Tip Sheet](#) – How to avoid 2015 PQRS payment adjustments (based on 2013 PQRS reporting)
- [CMS PQRS Frequently Asked Questions](#)

Claims Reporting for PQRS

- [2013 Claims Reporting Made Simple](#) – Quick reference guide to reporting PQRS using claims
- [2013 PQRS Implementation Guide for Claims-Based Reporting](#)– Detailed guide that explains claims-based PQRS reporting
- [2013 Measure Specification for Claims and Registry Reporting](#)–Detailed instructions and codes for reporting individual measures
- [2013 Getting Started with Measures Groups](#) – Guide that explains reporting using a measures group
- [2013 Specifications for Measures Groups Reporting Using Claims and Registry](#)– Detailed instructions and codes for measures groups

Registry Reporting for PQRS

- [2013 PQRS Registry Reporting Made Simple](#) – Step-by-step instructions for reporting PQRS using a qualified registry

- [2013 Qualified Registry Vendors Listing](#) – Detailed listing showing vendors that offer a qualified registry for reporting 2013 PQRS, the measures they support, costs, and contact information.
- [2013 Measure Specifications for Claims and Registry Reporting](#) – Detailed instructions and codes for reporting individual measures
- [2013 Getting Started with Measures Groups](#) – Guide that explains reporting using a measures group
- [2013 Specifications for Measures Groups Reporting Using Claims and Registry](#) – Detailed instructions and codes for measures groups

EHR Reporting (Direct and Data Submission Vendor) for PQRS

- [PQRS 2013 EHR Reporting Made Simple](#) – Overview of requirements for EHR-based reporting
- [2013 Qualified EHR-Direct Vendor Listing](#) – Detailed listing showing vendors that are qualified to report PQRS directly from their EHR, contact information and qualified version numbers
- [2013 Qualified EHR Data Submission Vendors Listing](#) – Detailed listing showing vendors that are qualified to report PQRS on behalf of participants by accessing data directly from the participant’s EHR
- [2013 PQRS Medicare EHR Incentive Pilot Participation Guide](#) – Overview of requirements to participate in the pilot programs that will satisfy both EHR Incentive Program Clinical Quality Measures reporting and PQRS reporting for 2013
- [2013 EHR PQRS Documents for Eligible Professionals: Measure Specifications](#) – Detailed instructions and approved codes for reporting individual measures using EHR or EHR Data Submission Vendor methods.

Group Reporting (GPRO) for PQRS

- [GPRO Requirements for 2013 PQRS Reporting](#) – Guide to the options and requirements for reporting PQRS as a group in 2013
- [2013 GPRO Made Simple](#) – A quick reference guide to 2013 GPRO reporting
- [2013 Measures List and Specifications](#) – Detailed instructions and codes for reporting the GPRO web interface measures

Self-Nomination and Election Requirements for Groups and Individuals

- [Self-Nomination and Election Requirements](#) – Explanation of how to establish an IACS account and register in the PV-PQRS Registration System for Group Self-Nomination, Election of Method of Group Reporting, Election of Quality Tiering for Groups, and Election of the Administrative Claims option for Individuals and Groups.

Physician Resources

Better quality healthcare is the goal of our program. By providing quality improvement projects that address effectiveness, efficiency and economy, we hope to enhance the experiences of Medicare beneficiaries. This section of our website serves as an area for you, the provider, to get tips and guidelines for improving the numbers you report, thereby improving the quality of care you provide. By better managing patients in prevention and cardiac care areas, you will improve patient satisfaction.

Patient compliance and education materials

COLORECTAL
CANCER
SCREENING

Colorectal cancer (CRC) screening is sometimes avoided because of fear of pain, embarrassment, lack of awareness of the importance of screening, misperceptions about screening effectiveness, or lack of resources. The way you approach patients about the importance of screening can make a difference in how they react. Research suggests that the manner in which a physician starts the conversation about CRC can mean the difference between getting screened or not. In addition to the conversation you have with your patients about CRC, you can enhance the importance of the subject through displays of printed materials or videos.

Materials

Follow the links below to find posters, fliers and fact sheets on colorectal cancer screening and prevention materials.

- [Patient Compliance How To](#)
- [CRC Clinician's Guide: Screening Action Plan](#)
- [Print Materials/Posters/Fact Sheets from the CDC](#)
- [Posters and Brochures from the University of South Carolina Center for Colon Cancer Research "What's Up Your Butt" Campaign](#)

Resources on Guidelines for Screening and Prevention

Statistics from the Kaiser Family Foundation suggest 65.2% of Missouri adults aged 50 and over have never received a flexible colonoscopy or sigmoidoscopy.

- [Mayo Clinic](#) – provides an overview
- [CDC](#) – describes ways to assess and reduce risks
- [American Cancer Society](#) – addresses Medicare coverage for cancer prevention and early detection
- [National Cancer Institute](#) – provides a risk calculator tool that can estimate the risk of colorectal cancer for men and women who are between the ages of 50 and 85
- [American Society of Colon & Rectal Surgeons](#) – addresses how genetics can play a role in colorectal cancer

BREAST
CANCER
SCREENING

Stories of false positives, anxiety and unnecessary biopsies are frustrating for patients. They're reasons why some patients may avoid having mammograms, even though the risk factors are there. That's why they need your guidance in helping them understand those risk factors and why mammograms help save lives. The following lists provide resources you may find useful in educating your patients.

Materials

Follow the links below to find posters, fliers and fact sheets on breast cancer and mammogram screening.

- [Just Ask Mammography Poster](#)
- [Educational Materials Catalog from Susan G. Komen for the Cure](#) (multiple languages)
- [CDC Podcast](#)
- [Posters and Spanish materials from the CDC](#)

Resources on Guidelines for Screening and Prevention

According to the National Breast Cancer Foundation each year it is estimated that nearly 200,000 women and 1,700 men will be diagnosed with breast cancer and more than 40,000 will die.

- [National Breast Cancer Foundation](#) – General information
- [Susan G. Komen for the Cure](#) – Advocacy and events
- [American Cancer Society](#) - Treatment of breast cancer
- [Centers for Disease Control and Prevention](#) – Statistics and screening

Quitting tobacco can be a stressful challenge. Research shows that stress itself is a key barrier for individuals who are trying to kick the tobacco habit. Add to that the withdrawal symptoms a person gets from being addicted to nicotine and it is obvious how difficult quitting can be. As a health care professional you have the ability to decrease some of that stress by educating patients about the resources available to help them quit.

Materials

Follow the links below to find posters, fliers and fact sheets designed for tobacco cessation programs.

- [Look What Happens When You Quit Flier](#)
- [Stop Sign poster](#)
- [Smoking Cessation Resources handout](#)
- [American Cancer Society Free Brochures](#)
- [Quitting Smoking Brochures from the American Heart Association](#)
- [Fact Sheets from the National Cancer Institute](#)
- [Smokeless Tobacco poster from the National Institutes of Health](#)

Resources for Education and Tobacco Cessation

According to the American Lung Association every year in the U.S. over 392,000 people die from tobacco-caused disease, making it the leading cause of preventable death. The following resources can provide strategies to motivate tobacco users who are ready to quit.

- [American Cancer Society](#) – Help for cravings and other tough situations
- [American Lung Association](#)
- [American Heart Association](#)– Quitters win
- [National Cancer Institute](#) – Free Help to Quit Smoking
- [American Legacy Foundation](#)
- [CDC: Office on Smoking/Health](#)
- [Clean Air KC](#)

C A R D I A C
C A R E

- [Missouri Partnership on Smoking and Health](#)
- [Tobacco Prevention Center – St. Louis University](#)
- [Secondhand Smoke](#)
- [Highlight Missouri – Smoking and Tobacco Use](#)

Heart disease is the leading cause of death for both men and women in the United States. Despite this fact, many individuals don't take the necessary steps to prevent it from happening to them. Being committed to providing comprehensive, quality cardiovascular care can make a big difference in your patients' overall health. The following resources may help you.

Materials

Follow the links below to find posters, fliers and fact sheets designed for cardiac care programs.

- [Know and Follow Your Signals poster](#)
- [AHA Educational Brochures](#)
- [AHA Health Fair Kits](#)
- [National Heart Lung and Blood Institute campaign materials](#)

Resources for Cardiac Care Education

According to the American Heart Association, diseases of the heart are the No. 1 killer in America. The following links provide resources for the latest research and information about heart attack and stroke prevention.

- [The American Heart Association](#)
- [Mayo Clinic](#) – articles on current trends in cardiovascular medicine
- [Million Hearts Campaign](#)
- [Centers for Disease Control and Prevention \(CDC\)](#)
- [Johns Hopkins](#) – heart attack prevention white papers
- [Johns Hopkins](#) – hypertension and stroke white papers
- [Cardio Smart](#) – from the American College of Cardiology

F L U
I M M U N I Z A T I O N S

There are a lot of rumors about flu vaccination. It's your responsibility to provide patients with the information they need to make an informed decision based on current facts. The following links provide resources for printable display items and education.

Materials

The following resources provide fact sheets, brochures and other printable materials that may be useful in educating patients.

- [CDC Information Statements and Recommendations](#)
- [CDC Brochures, Fact Sheets, Posters](#)
- [Tools and Materials from U.S. Dept of Veterans Affairs](#)
- [Flu level tracker by zip code](#)
- [National Foundation for Infections Disease: Ten Reasons to be Vaccinated](#)

Resources for Flu Immunization Education

The CDC Advisory Committee on Immunization Practices (ACIP) recommends that most individuals 6 months of age and older get the influenza vaccine every year.

- [CDC Flu Activity and Surveillance](#)
- [Flu Facts from the National Foundation for Infectious Diseases](#)
- [Childhood Influenza Immunization Coalition](#)
- [Real Stories, Real people](#)
- [Food and Drug Administration Safety and Availability](#)
- [Flu.gov](#)

Pneumonia is the leading cause of vaccine-preventable death in the United States. Developing an action plan and workflow process that supports pneumococcal vaccination will help prevent disease and hospitalization of your elderly patients.

Materials

- [Fact Sheets from the Missouri Department of Health and Senior Services](#)

Resources for Pneumonia Immunization Education

Pneumococcal infections can be hard to treat because of drug resistance, making prevention through vaccination the best option for many patients. Vaccines protect not only those who get immunized, but also the people around them. The following are links to resources for pneumonia education for patients and providers.

- [CDC Pneumonia Stats](#)
- [American Family Physician](#)
- [World Health Organization, Pneumococcus Resources](#)
- [Immunization Action Coalition](#)

Tips for Consistent Follow-through

Create a standing order for vaccinations as a way to ensure all eligible patients are properly vaccinated. As staff perform and document vitals and the patient history, a standing order would allow administration of needed vaccines. Staff should be comfortable discussing the provider's position on vaccines. For example, "All Dr X's patients are vaccinated unless there is a specific medical reason to not vaccinate. The vaccines can save your life—and if you're around children, they may prevent you from spreading disease to them. The pneumococcal vaccine protects against the bacterium that causes middle ear infection, sinus infections, pneumonia, blood stream infections and meningitis. These diseases occur year-round unlike influenza. Vaccines or medical exclusions are documented. Assign staff to ask if patient has questions after reading brochures or other educational materials.



Frequently Asked Questions

Why should I participate in PQRS?

Providers have the opportunity to use PQRS to measure and improve the care of the patients they serve. It is well-known that the first step toward improvement of any process or outcome is measurement. PQRS measures are evidence-based, developed by medical professionals. Participation is one way to prepare for pay-for-performance programs, such as Patient-Centered Medical Homes, Accountable Care Organizations and Value-Based Purchasing. A financial incentive is available for successful participation through 2014. Beginning in 2015 (based on 2013 reporting) professionals that do not participate will receive a payment adjustment. Performance on PQRS will be used to determine the Quality component of the Value-Based Modifier.

PQRS using the EHR option helps the practice learn to use their EHR for quality measurement, patient safety, improving patient care, and achieving practice goals. EPs learn the essentials of documenting certain parts of the visit in structured format and in specified fields, as required by their particular vendor, to allow accurate reporting of data. This harnesses the power of an EHR—clinical data is needed to improve outcomes and to determine the effectiveness of various treatments. Accurate data capture will empower physicians with information about their practice that was not previously available. Structured documentation also allows providers to exchange information with other providers to improve care transitions and care coordination.

I am planning to submit PQRS. What are my options?

CMS published a great visual description of the PQRS program that details each method for reporting and the options and requirements for each.

I am planning to submit using Claims or a Registry. What are my options?

When submitting via claims, you may submit three individual measures for 50% of your Medicare Part B PFS patients to which the measures apply. In 2013 you may also submit one Measures Group for 20 Medicare Part B PFS patients. These same options are available for submission through a Qualified Registry, except the reporting threshold for individual measures is 80% of eligible Medicare Part B Patients.

I would like to submit using the EHR option. How do I know if my EHR is qualified?

There are two options for reporting using an EHR: Qualified EHR-Direct and EHR-Data Submission Vendor (DSV). EHR-Direct means the EHR is capable of creating a standard “QRDA” file (e.g., Quality Reporting Document Architecture) that the EP then uploads to the CMS portal following the close of the calendar year. With the EHR-DSV method, a vendor obtains data directly from the provider’s EHR, then creates and uploads the QRDA files on behalf of the provider. A [list of qualified EHR-Direct vendors](#) can be found on the CMS Web site, under “Electronic Health Record Reporting. The site also contains a [list of qualified EHR-DSVs](#).

How can providers avoid the 2015 penalty?

There are three options available to avoid the 2015 payment adjustment:

- Option 1: Meet the requirements for satisfactorily reporting to earn a 2013 incentive either individually or as a group, OR
- Option 2: Report at least one valid measure (or measures group) via claims, participating registry, or participating/qualified EHR for individuals, or via GPRO web-interface or registry for groups, OR
- Option 3: Elect to participate in the CMS-calculated administrative claims-based reporting mechanism. To participate using Administrative Claims, between July 15, 2013 and October 15, 2013:
 - Step 1: [Create a CMS IACS account](#) if you don’t already have one, or add the PV-PQRS Security Official role if you have an existing account.
 - Step 2: [Go to the CMS Portal](#) and select the PV PQRS option, near the bottom of the page, register and elect Administrative Claims.

Groups that are part of an ACO/Medicare Shared Savings Program will meet PQRS reporting requirements through their ACOs.

I am a physician working at a rural health clinic. Am I eligible for the PQRS program?

Maybe. The Rural Health Clinic itself is not eligible for PQRS, but the individual providers working in the clinic may be eligible if they also bill for Medicare Part B PFS outside the all-inclusive RHC rate. Only those allowable charges billed under Medicare Part B PFS will be considered when calculating the incentive payment.

In general, services payable under fee schedules or methodologies other than the Medicare PFS are not included in PQRS (for example, services provided in federally qualified health centers, portable x-ray suppliers, independent laboratories, independent diagnostic testing facilities, hospitals (including critical access), rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for Physician Quality Reporting since DME is not paid under the PFS. Those charges filed under Part A will not be considered.

What patients should be included in PQRS?

Only Medicare Part B PFS beneficiaries should be reported for PQRS. This includes Medicare (primary or secondary) and Railroad Retirement. PQRS does not include Medicare Part A or Medicare Advantage.

Do practices need to have an EHR in order to participate in PQRS?

No. Practices do not need an EHR to participate in PQRS. It is possible to participate with a paper system through the Claims or Registry options.

May I submit PQRS using more than one method?

Yes. CMS will review data submitted via all methods/options to determine satisfactory reporting. However, each reporting option is considered separately and the EP must successfully report within each option. EPs cannot combine reporting options to reach the 3 measure requirement, the reporting rate requirement, or the Measures Group requirement. In the event an EP satisfies the reporting criteria for multiple methods, (s)he will earn only one incentive payment for the most advantageous reporting method for which the EP qualifies. There is no penalty if multiple options are attempted.

For example, an EP could submit 3 individual measures for at least 50% of their patients via claims. Then, after the close of the year, the EP could also submit 3 measures directly to CMS using a qualified EHR. If claims submission failed to meet the 50% reporting requirement, but EHR submission satisfactorily met the 80% reporting requirement, the EP would receive an incentive covering the full year. If both methods satisfactorily met the reporting requirements, the EP would receive one incentive based on the full year of reporting. This may be a good strategy to help the practice familiarize itself with direct reporting to CMS via the EHR, as this is where future reporting is headed. The EP could NOT submit one measure via claims and two measures via the EHR in order to meet the 3 measure reporting requirement.

Can EPs participate in all three Incentive Programs—i.e., PQRS, e-Prescribe, and the EHR (Meaningful Use) programs—and receive incentives for each?

The three programs are distinctly separate programs. PQRS incentives and EHR (Meaningful Use) incentives are available regardless of participation in other programs. EPs that participate in the Medicare or Medicare Advantage options for the EHR Incentive Program (Meaningful Use) will not receive an incentive for participation in the e-Prescribe Incentive program.

How will I know if I correctly submitted PQRS? Will I receive feedback?

In 2013 CMS is providing one [intermittent feedback report](#) for EPs that submit via claims to help them identify potential reporting errors. The EP should also keep the

remittance notices (RA) for PQRS cases submitted. A Remark Code (N365) and a message which reads, “This procedure code is not payable. It is for reporting/information purposed only” will appear on the RA to indicate the claim was passed on for PQRS consideration. This will show that the PQRS codes were not stripped from the claim and were submitted for consideration under PQRS. However, this code does NOT indicate whether or not the PQRS codes were accurate or complete. A provider will not know if (s)he was successful until the final feedback reports are available, usually in summer of the following year.

Registries are required to provide at least two feedback reports to participants. EPs reporting through an EHR should use the report features within their systems to monitor performance throughout the year.

If the provider successfully reports PQRS, CMS will send the incentive payments via the same route that all other payments to the EP are made. The remittance notice will show a code “LE”.

How can I improve our performance rate for PQRS measures?

The following suggestions may help improve performance rates:

- Have a plan ready at the start of the reporting period to achieve highest performance rates.
- Assign specific responsibilities for each requirement of the measure to an identified staff person.
- A strong statement from the physician to their patients recommending preventive services has been consistently shown to be the most effective means of improving compliance. Plan your statement, rehearse, and communicate with conviction to your patients. Make certain your staff’s message is consistent with your own.
- Make every encounter an opportunity to promote prevention services and meet evidence-based criteria.
- If a patient refuses services, ask probing questions to discover the reason and develop a solution together with the patient.
- Make sure educational documents are available to your patients.
- Determine an efficient workflow for referring and scheduling with specialists.
- For electronic systems:
 - Document all data elements used in each measure in designated structured fields. Your vendor should be able to tell you how to properly document to allow accurate reporting.
 - Activate alerts to identify patients who meet the denominator criteria for measures you select.
 - Ask that all orders be entered electronically using CPOE and link all results to the order so they can be tracked. Send reminders to patients with open orders.
 - Run comparative monthly reports by provider showing how each is performing on the measures and post in the break room. Discuss and implement plans for improvement at staff meetings using rapid-cycle techniques.

- For paper-based systems:
 - Use the [worksheets provided by the AMA](#) or other professional organizations to help collect the information for eligible patients. Have the front desk place a worksheet on the medical chart when eligible patients check-in. The clinical team should review appointment schedules to ensure all eligible patients are identified.
 - Ask clinical staff to document information in a consistent manner and place within the chart. This will make it easier to locate the required information and make certain it is coded for PQRS. Example: document all orders for preventive care on an order sheet and all results on a health maintenance record.
 - Keep copies of the N365 notices so you have a record of patients submitted.

I've heard about many providers who have submitted PQRS and never received payment. How can I improve my chances of success?

Providers are encouraged to use electronic capability for PQRS reporting in order to improve chances of success. Providers who report using a qualified EHR or registry enjoy greater than 90 percent success rates.

If I have questions about PQRS, whom should I contact?

The [CMS PQRS website](#) has a large quantity of information available, so check there first.

You may also contact the QualityNet Helpdesk:

- QualityNet Help Desk (7:00 a.m. to 7:00 p.m. CST)
 - Phone: 1-866-288-8912
 - TTY: 1-877-715-6222
- Email: Qnetsupport@sdps.org

Quality Improvement Organizations have been contracted by the Centers for Medicare & Medicaid Services (CMS) to provide local assistance to providers in their respective states. Primaris is the QIO for Missouri. You may contact Sandy Pogones at Primaris by phone at 1-800-735-6776, or e-mail at spogones@primaris.org.

For additional educational resources, [please refer to the CMS Website](#).