2014 PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

A Guide to Getting Started, Reporting and Improving

Quality Improvement Organizations
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PRIMARIS

2014 PQRS Guide

MO-14-06-PREV March 2014 This material was prepared by Primaris, the Medicare Quality Improvement Organization for Missouri, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

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Getting Started with 2014 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.

2014 is the last year providers can earn an incentive under the PQRS program. The incentive for successful reporting is +0.5% of Medicare Part B allowable charges.

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

In addition, providers in groups of 10+ EPs that do not report PQRS in 2014 will incur an automatic -2.0% adjustment in 2016 for non-participation in the Value-Based Modifier program.

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.

If you are participating in another CMS program, such as the Medicare Shared Savings Program, Comprehensive Primary Care Initiative or Pioneer Accountable Care Organizations, please check the program's requirements for information on how to report quality data to earn a PQRS incentive and/or avoid the PQRS payment adjustment.

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

There are five methods by which individual EPs may report in 2014: Medicare Part B Claims, Qualified Registry, Certified EHR-Direct, Certified EHR Data Submission Vendor and Qualified Clinical Data Registry. Groups of 2+EPs may report using three methods: Qualified Registry, Certified EHR-Direct and Certified EHR Data Submission Vendor. Groups of 25+ may report using five different methods: Qualified Registry, Certified EHR-Direct, Certified EHR Data Submission Vendor, GPRO Web Interface or CG-CAHPS CMS Certified Survey Vendor.

If you are an individual provider that is also participating in the EHR Incentive Program (i.e., Meaningful Use), you may find it valuable to submit PQRS using certified EHR technology (CEHRT). Doing so may allow you to satisfy PQRS requirements, the Clinical Quality Measures portion of Meaningful Use and Value-Based Modifier requirements with one submission. Groups may satisfy these requirements using CEHRT, the GPRO Web Interface or a Certified Survey Vendor.

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

EPs may report either individually or as a group for PQRS in 2014. EPs that report as individuals do not need to register. Group practices wanting to report measures under the Group Practice Reporting Option (GPRO) in the 2014 PQRS program year need to register.

Groups are defined as two or more EPs operating under the same Tax Identification Number (TIN). To elect group reporting, a representative of the group must self-nominate the group and elect their reporting method by September 30, 2014 through the CMS PV-PQRS Registration System. If group reporting is elected, providers within that TIN may NOT report individually and must report using the method chosen by the group.

A potential benefit of group reporting is 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. Also, incentive payments are based on all Medicare Part B FFS claims submitted under the TIN, so payments may be larger. Finally, poor performance by one member of the group may be offset by high performance by other

members. Group reporting is more reflective of "team-based" care than individual reporting.

Potential drawbacks are that if the group is unsuccessful in PQRS reporting, all EPs will miss the incentive/incur the payment adjustment. In addition, all members of the group must report the same measures, a requirement some multi-specialty groups may find undesirable.

Please see CMS PQRS Group Practice Reporting Options 2014 requirements for more details.

Important Note regarding the Value-Based Modifier (VBM) Program: Groups should consider the impact of their PQRS decision on the VBM program. The VBM program uses measures reported through PQRS as one determinant of the Quality Score. The VBM is calculated on a Group level. Groups of fewer than 10 EPs are not yet included in the VBM in 2014, so may report either individually or as a group with no impact on the VBM. However, groups of 10+ EPs are included in the VBM in 2014, and must satisfy requirements for PQRS group reporting to avoid an automatic downward VBM payment adjustment in 2016. Groups may satisfy this requirement in one of two ways:

1. Self-nominate as a Group through the CMS PV-PQRS Registration System, as described above, and meet the requirements to avoid a payment adjustment, OR
2. For groups that do not self-nominate, at least 50% of the EPs in the group must participate in PQRS as individuals and meet the requirements to avoid a payment adjustment. Individuals may report using any method and may report any measures (e.g., members of the group do not have to report the same measures, nor do they need to participate using the same method.) Group performance will be determined by calculating a weighted average of all measures reported by individual EPs within their TIN.

Providers may contact the Quality Net Help Desk for assistance in registering for Group Reporting: 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.

Beginning in 2014, individual PQRS measures have been categorized to one of six National Quality Strategy (NQS) domains of care. Providers should plan to report measures from at least three different domains. The domains are:

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

To earn an incentive in 2014, **Individual EP**s must achieve one of the following:

Table 1

2014 PQRS REPORTING REQUIREMENTS FOR INDIVIDUALS			
Reporting Period	**Measure Type**	**Reporting Mechanism**	**Satisfactory Reporting Criteria for Earning an Incentive Payment in 2014**
12-month (Jan. 1 – Dec. 31, 2014)	Individual Measures	Claims*	Report at least 9 measures covering at least 3 NQS domains for at least 50% of Medicare Part B FFS patients seen during the reporting period. The MAV process will apply if fewer than 9 measures are reported.*
12-month (Jan. 1 – Dec. 31, 2014)	Individual Measures	Qualified Registry*	Report at least 9 measures covering at least 3 of the NQS domains for 50% of eligible Medicare Part B FFS patients seen during the reporting period. The MAV process will apply if fewer than 9 measures are reported.*
12-month (Jan. 1 – Dec. 31, 2014)	Individual Measures	Direct EHR product that is CEHRT and EHR Data Submission Vendor that is CEHRT	Report at least 9 measures covering at least 3 of the NQS domains. If the CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report the measures for which there is Medicare patient data. An EP must report on at least 1 measure for which there is Medicare patient data.
6 or 12-month (Jan. 1 – Dec. 31, 2014)	Measures Group	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
12-month (Jan. 1 – Dec. 31, 2014)	Individual Measures selected by the Registry	Qualified Clinical Data Registry*	Report at least 9 measures covering at least 3 NQS domains for at least 50% of applicable patients seen during the reporting period, including at least one outcome measure.*
Measures with 0% performance rate do not count. ***To avoid the payment adjustment, at least 3 measures must be satisfactorily reported.**			

To earn an incentive in 2014, **Groups** must achieve one of the following:

Table 2

2014 PQRS REPORTING REQUIREMENTS FOR GROUPS			
Reporting Period	**Reporting Mechanism**	**Group Practice Size**	**Satisfactory Reporting Criteria for Earning an Incentive Payment in 2014**
12-month (Jan. 1 – Dec. 31, 2014)	GPRO Web Interface	25-99 EPs	Report on all measures included in the web interface for the first 218 assigned beneficairies.
12-month (Jan. 1 – Dec. 31, 2014)	GPRO Web Interface	100+ EPs	Report on all measures included in the web interface for the first 411 assigned beneficairies. In addition report all CG-CAHPS survey measures using a CMS certified survey vendor (CMS conducts the survey)
12-month (Jan. 1 – Dec. 31, 2014)	Qualified Registry*	2+ EPs	Report at least 9 measures covering at least 3 of the NQS domains for 50% of eligible Medicare Part B FFS patients seen during the reporting period. The MAV process will apply if fewer than 9 measures are reported.*
12-month (Jan. 1 – Dec. 31, 2014)	Direct EHR product that is CEHRT and EHR Data Submission Vendor (DSV) that is CEHRT	2+ EPs	Report at least 9 measures covering at least 3 of the NQS domains. If the CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report the measures for which there is Medicare patient data. An EP must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan. 1 – Dec. 31, 2014)	CMS Certified CG-CAHPS Survey Vendor + Qualified Registry, EHR-Direct, EHR DSV or GPRO Web Interface	25+ EPs	Report all CG-CAHPS survey measures via a CMS-certified survey vendor, AND report at least 6 measures covering at least 2 NQS domains using a qualified registry, certified EHR-Direct or EHR DSV, or all Web Interface measures.
Measures with 0% performance rate do not count. ***To avoid the payment adjustment, at least 3 measures must be satisfactorily reported.**			

Step 5: Understand how you can avoid a payment adjustment in 2016 (based on 2014 reporting.)

If reporting via Claims, a Qualified Registry, or a Qualified Clinical Data Registry, the requirements to avoid a payment adjustment are less stringent than to earn an incentive. Specifically, providers must successfully report only three measures (rather than nine measures covering three domains) to avoid a payment adjustment. Please refer to the tables in Step 4, and note those items marked with an "*". The criteria to avoid a payment adjustment when reporting using EHR-Direct, EHR Data Submission Vendor, GPRO Web interface or Certified Survey Vendor are the same as to earn an incentive.

Once you have completed Steps 1-5, please refer to appropriate section in the following pages (depending on the method you select) for further requirements, instructions, and measure specifications.

- Claims Reporting
- Qualified Registry Reporting
- Certified EHR Reporting (Direct and Data Submission Vendor)
- Qualified Clinical Data Registry Reporting
- Group Practice Reporting Option (GPRO) Web Interface
- CMS Certified CG-CAHPS Survey Vendor

For additional assistance

Primaris is providing assistance to Missouri providers with reporting PQRS measures in 2014. 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/TDD at 877-715-6222 (Monday – Friday 7:00 a.m.-7:00 p.m. CST) or email at qnetsupport@sdps.org.

Claims-Based Reporting

Claims-based reporting is done by including Quality Data Codes (QDC) on eligible Medicare Part B claims at the time the claim is filed. There are 110 different PQRS claims-based measures in 2014. CMS has decreased the number of measures and options for reporting through claims, in anticipation of eventually eliminating this option in favor of registries and electronic reporting. There is no longer an option for reporting a measures group via Claims (measures groups are only available through Registry reporting beginning in 2014). Claims-based reporting is not available to groups.

Read Steps 1-5 under "Getting Started".

Then download "**2014 PQRS Claims-based Reporting Made Simple**" and the **2014 PQRS Implementation Guide** and read the instructions for reporting using Claims.

Step 6: Select your measures and download the specifications.

Review the **2014 Individual Claims and Registry Measure Specifications** to determine which measures may apply to your practice. Some measures in this document are only available for registry reporting, so make certain you select those for claims-based reporting. It is important to use the current year specifications because changes may have been made from prior years. Select at least nine measures covering three domains to report.

If you satisfactorily submit data for fewer than nine measures or fewer than three NQS domains, CMS will follow a Measures Applicability Validation process to determine if more measures could have been submitted.

Measures with a zero percent performance rate will not be counted.

Step 7: 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. If flags can't be set electronically, determine a manual method to identify eligible patients. You must report on at least 50% of all Medicare Part B patients that you saw during the reporting period and who were eligible for the individual measures, as defined by the denominator criteria. Keep in mind that even if you didn't perform the quality action for a particular measure, you must still report the measure for eligible patients in order to achieve a 50% *reporting* rate. Measure specifications will provide instructions on how to report that a quality action was NOT taken for an eligible patient (e.g., in such a case, the *performance rate*—not the *reporting rate*--for the measure will be adversely affected).

Step 8: Enter the correct PQRS code(s) on the claim.

Record the correct diagnosis, CPT and Quality Data Codes (QDC) for each measure on the claim and submit the claim as usual. Some measures require that you report only once during the reporting period; others may require reporting on every eligible visit or more

than once. Follow instructions in the PQRS Implementation Guide for the measures you select.

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.

QDCs should be submitted on the line item as a zero charge, or with a nominal amount (such as $0.01) if billing software doesn't permit a zero charge line item (e.g., 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 9: Track your progress.

Access your Interim Feedback Report. An interim feedback report will be available late summer 2014 for PQRS codes submitted during the first three months of the year, to help you monitor your submissions. (CMS will post instructions to access the report under "Educational Resources" on the CMS Website.) 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, 2015 for consideration in 2014 PQRS reporting.

Step 10: Receive your incentive payment.

Incentive payments are made in late summer 2015 as a single consolidated payment with a notation on the remittance advice.

Step 11: Access your Final Feedback Report.

A final feedback report covering all submissions for the year will be available in late summer 2015. Download this report to determine reporting rates, performance rates, eligibility status, and incentive payments. There are two ways to access your final Feedback reports:

1. Organization Reports (include all providers under the TIN that submitted PQRS). Each Organization must have established an IACS account and an End User role to access feedback reports. The End User must log into the CMS Portal to access the reports.
2. Individual providers can retrieve their NPI level report without having an IACS account. Go to the CMS Portal, select "Communications Support Page" from the left-hand menu. Select "Create NPI Level Report Request", complete the information and submit.

Qualified Registry-Based PQRS Reporting

Qualified registries report PQRS on behalf of participating professionals. EPs reporting through a qualified registry are allowed to report either nine individual measures across three domains or one measures group. Both individuals and groups may report using a qualified registry. Registry reporting does not require the EP to have an EHR.

Read Steps 1-5 under "Getting Started".

Download "2014 PQRS Registry Reporting Made Simple" and the 2014 PQRS Implementation Guide and read the instructions for reporting using a qualified registry.

Step 6: Identify a Qualified Registry.

CMS has published and will periodically update the listing of Qualified Registries. The listing identifies the vendors, measures and/or measures groups they support, capability to report for individuals and/or groups, 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:

- Nine individual measures covering at least three domains for 50% of eligible Medicare Part B FFS patients seen in 2014, OR
- One Measures Group for at least 20 patients, a majority (11 patients) of which must be Medicare Part B FFS patients seen in 2014. (There is a 6-month option for reporting a measure group that is identical to the 12-month option.)

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

- Nine individual measures for 50% of eligible Medicare Part B FFS patients seen in 2014. (Note: The Measures Group option is NOT available for group reporting.)

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

Step 8: Select your Measures and Download the Specifications

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

Individual Measures Specifications: Review the 2014 Individual Claims and Registry Measure Specifications document to determine which measures may apply. It is important to use the current year specifications because changes may have been made from prior years. Select at least nine measures across three domains to report.

If you satisfactorily submit data for fewer than nine measures or fewer than three NQS domains, CMS will follow a **Measures Applicability Validation** process to determine if more measures could have been submitted.

Measures Groups Specifications: Review the **2014 PQRS Measures Group Specifications** document to determine which measures groups may apply to your practice. Do not use specifications for individual measures, as these may differ from specifications for the measures group.

Step 9: Work directly with your registry.

Enter into a Business Agreement with your registry. The registry will provide you with specific instructions on how to collect 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 2015. You will work directly with your registry to ensure data is submitted appropriately and on time.

Step 10: 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 are made in late summer 2015 as a single consolidated payment with a notation on the remittance advice.

Step 13: Access your Final Feedback Report.

A final feedback report covering your PQRS 2014 submission will be available in late summer 2015. Download this report to determine reporting rates, performance rates, eligibility status, and incentive payments. There are two ways to access your final Feedback reports:

1) Organization Reports (include all providers under the TIN that submitted PQRS). Each Organization must have established an IACS account and an End User role to access feedback reports. The End User must log into the **CMS Portal** to access the reports.
2) Individual providers can retrieve their NPI level report without having an IACS account. Go to the **CMS Portal**, select "Communications Support Page" from the left-hand menu. select "Create NPI Level Report Request," complete the information and submit.

Certified EHR-Based PQRS Reporting (Direct and Data Submission Vendor)

Eligible professionals may report electronically engineered quality measures, called "eCQMs,"using certified EHR technology (e.g., "CEHRT")—either Direct or through a Data Submission Vendor-- to meet 2014 PQRS requirements. This method makes good use of EHR capabilities and fits well into daily workflow of practices that have implemented EHRs. The entire care team can assist with capturing data at the point-of-care, making it possible to use rules, reminders, tracking tools and reports to electronically manage patient populations. Data submission to CMS is done only once a year in January-February 2015, giving the provider the entire year to make improvements. Both individuals and groups may report PQRS through EHR-based methods.

All EHRs certified to 2014 standards have the capability to generate standard "Quality Reporting Documentation Architecture", or "QRDA" files," which can be uploaded to CMS to satisfy PQRS requirements. Beginning in 2014 eCQMs will be used for multiple programs, including PQRS, Meaningful Use and the Value-Based Modifier program, so providers may be able to report measures once to meet clinical quality measure reporting requirements for all programs (See "**How to Report Once for Medicare Quality Reporting Programs**.") CMS is engineering an increasing number of eCQMs and there are 64 individual measures available for 2014.

Both EHR-Direct and EHR Data Submission Vendor methods use the same processes and eCQMs for PQRS reporting. The only difference between the two methods is in who generates the PQRS files and submits them to CMS. With EHR-Direct, the provider builds and submits the files; when using a Data Submission Vendor, the vendor builds and submits the files on behalf of the provider. All data for both methods must originate in the EHR.

Read Steps 1-5 under "Getting Started".

Download "**2014 PQRS EHR-based Reporting Made Simple**" and the **2014 PQRS Implementation Guide** and read the instructions for reporting using the EHR

Step 6: Determine if you are eligible to report via an EHR method in 2014.

EPs using the EHR-based PQRS reporting are required to use an EHR product or EHR Data Submission Vendor certified to the June 2013 version of the eCQMs with the exception of CMS140, which is to be reported using the December 2012 version (CMS140v1). For more information on determining if your product is CEHRT, please visit the **EHR Incentive Program Certified EHR Technology website**. (CMS is no longer "qualifying" EHRs for PQRS—qualification has been replaced by ONC certification.) In addition:

- All patient visits during the reporting period must be contained in the EHR, since PQRS reporting covers the entire year (January 1 – December 31, 2014.) However, you should be able to upgrade to a newer qualified version during the reporting period.

- 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, so read specifications carefully for the measures you select.
- Data elements must be documented in the manner specified by your vendor in order to be captured by built-in PQRS report generation software.
- Verify which of the 64 measures your EHR is capable of reporting—the vendor is only required to offer a minimum of nine measures covering three domains for certification. If your EHR contains fewer than nine measures for which you have Medicare patient data, then you must report the measures for which there is Medicare data. At least one measure must contain Medicare patients, or a different method of reporting must be used.
- Although both individuals and groups may report using CEHRT, if you elect to report as a group, you must verify that your EHR has the capability to do so.

Step 7: Select your measures.

There are 64 individual measures which may be reported using CEHRT in 2014. You must report a minimum of nine individual measures covering at least three domains, but you may report as many measures as you like. Many measures share the same patient population (for example, diabetes measures) and/or the same data elements. Select measures that contain data elements you consistently capture (such as vitals or labs) or intend to capture.

Measures with a zero percent performance rate will not be counted.

Step 8: Review the Measure Specifications.

Download the **2014 CQM Measure Specifications for Eligible Professionals** for the measures you select. These 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 accomplished by non-physician members of the care team, especially for preventive and chronic care measures. Determine what work must be done by physicians and what can be done by other staff. Standing orders and protocols will improve efficiency and quality of care delivered. Establish expectations and develop processes for capturing data for your selected measures and train all staff and physicians prior to the start of or early in 2014.

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 patient 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 change and improvement.

Don't wait until the end of the year to discover documentation or service issues—that will be too late to make improvements.

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

If you are using the EHR-Direct method, you must establish an IACS account in order to submit PQRS EHR data. Complete this process in the fall of 2014. 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 Security Official role must be established first.
- PQRS (EHR) Submitter: This role will upload the data to the CMS Portal.
- End-User: This role will be able to access feedback reports.

Create your IACS accounts following instructions in the Quick Reference Guides found on the **CMS Portal**.

Contact the QualityNet Help Desk at 866-288-8912 or **qnetsupport@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 or with your Data Submission Vendor, as incentives and penalties 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 using built-in software from your vendor. 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, 2015. 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. Follow instructions provided by your DSV.

Step 12: Receive your incentive payment

Incentive payments will be made in late summer 2015 as a single consolidated payment with a notation on the remittance advice.

Step 13: Access your Final Feedback Report.

A final feedback report covering your PQRS 2014 submission will be available in late summer 2015. Download this report to determine reporting rates, performance rates, eligibility status, and incentive payments. There are two ways to access your final Feedback reports:

1. Organization Reports (include all providers under the TIN that submitted PQRS). Each Organization must have established an IACS account and an End User role to access feedback reports. The End User must log into the CMS Portal to access the reports.
2. Individual providers can retrieve their NPI level report without having an IACS account. Go to the CMS Portal, select "Communications Support Page" from the left-hand menu. Select "Create NPI Level Report Request", complete the information and submit.

Qualified Clinical Data Registry

The Qualified Clinical Data Registry (QCDR) is a new PQRS option in 2014, available for individual EP reporting. The QCDR collects clinical data for the purpose of tracking and improving performance for an identified patient population. Many specialty societies and other entities offer participation in clinical registries, and they may seek qualification from CMS to submit PQRS on behalf of their participants. The difference between a QCDR and a qualified registry is that QCDRs are not limited to measures within PQRS. Also, QCDRs collect data on multiple payers and possess benchmarking capacity. QCDRs must define their measures for CMS and must report at least one outcome measure. QCDRs may report e-measures that are available under EHR-based PQRS/EHR Incentive program, if desired.

Read Steps 1-5 under "Getting Started".

Download "**2014 PQRS Qualified Clinical Data Registry Participation Made Simple**" and the **2014 PQRS Implementation Guide** and read the instructions for reporting using a qualified QCDR.

Step 6: Identify a Qualified Clinical Data Registry.

CMS will publish a listing of **Qualified Clinical Data Registries** in summer of 2014. The list will include the name of the QCDR, contact information, cost information and measures available for reporting.

Step 7: Select your Measures and Obtain the Specifications

Providers must report a minimum of nine measures covering three domains for at least 50% of the EP's eligible patients seen during the 2014 reporting period. At least one of the nine measures must be an outcome measure.

Step 8: Work directly with your registry.

Enter into a Business Agreement with your QCDR. The QCDR will provide specific instructions on how to collect data for the selected measures. The QCDR will in turn, submit PQRS data to CMS on your behalf during the first quarter of 2015.

Step 10: Track your progress.

QCDRs are required to provide at least four feedback reports during the year to participants. Use the feedback reports to monitor and improve your performance.

Step 11: Receive your incentive payment.

Incentive payments are made in the fall of 2015 as a single consolidated payment with a notation on the remittance advice.

Step 12: Access your Final Feedback Report.

A final feedback report covering your PQRS 2014 submission will be available in late summer 2015. Download this report to determine reporting rates, performance rates, eligibility status, and incentive payments. There are two ways to access your final Feedback reports:

1) Organization Reports (include all providers under the TIN that submitted PQRS). Each Organization must have established an IACS account and an End User role to access feedback reports. The End User must log into the CMS Portal to access the reports.
2) Individual providers can retrieve their NPI level report without having an IACS account. Go to the CMS Portal, select "Communications Support Page" from the left-hand menu. Select "Create NPI Level Report Request", complete the information and submit.

Group Practice Reporting Option-Web Interface

The Web-Interface reporting option is available only to groups of 25 or more eligible professionals. 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.

Providers that are participating in the Medicare Shared Savings Program as an ACO must follow instructions provided by their ACO for group reporting.

Read Steps 1-5 under "Getting Started".

Download **2014 Web Interface Reporting Made Simple** and the **2014 PQRS Implementation Guide** and read the instructions for reporting using the GPRO Web Interface.

Step 6: Create an IACS account and register in the PV-PRQS Registration System.

One authorized representative of a group practice must **establish or modify an existing IACS account**, selecting the Approver Role of "PV-PQRS Group Security Official" and creating an organization. An additional role of "PV-PQRS Group Representative" can be requested after the group practice has an approved primary Group Security Official in IACS. Following creation of the account, groups must self-nominate and select their method of PQRS reporting in the **PV-PQRS Registration System**. After logging in, the user will select the Registration hyperlink from the PV-PQRS dropdown. The portal opened April 1, 2014 and the deadline date for self-nomination and election is September 30, 2014.

Note: If your group practice is participating in an ACO, you do not have to register your group in the PV-PQRS system.

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

Step 7: Download Measure Specifications.

Download the **2014 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes** file. Read and understand each measure.

Step 8: Determine a workflow that assigns each staff and/or provider specific responsibilities for performing services and capturing data for each of the measures.

If planned correctly, data required for the Web Interface measures can be captured in your EHR. Identify all data elements needed for the 22 measures and determine a process for documentation. Most of the documentation and much of the care itself can likely be done by members of the care team other than the physician.

Group practices that successfully complete the PQRS GPRO Web Interface will also satisfy the CQM component of the Medicare EHR Incentive Program as long as the EHR product is CEHRT. Manual data entry is allowed for completion of the Web interface. EPs will still be required to report the other meaningful use operational objectives through the Medicare EHR Incentive Programs Registration and Attestation System.

Step 9: 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. Run lists of patients who are eligible but do not meet measure criteria. Use built-in reports to monitor your performance throughout the year. Don't wait until the end of the year to discover documentation errors or service issues.

Step 10: Attend CMS Training Calls for GPRO Web Interface Users.

CMS holds training calls to address questions and issues with GPRO web interface submission. Refer to the **CMS Website**, selecting the GPRO Web Interface option from the left side of the screen for more information. Calls will be held late 2014 and early 2015.

Step 11: Receive Assigned Beneficiary files from CMS and complete all data fields.

Files will be sent during the first quarter of 2014. Follow instructions for completion. Data may be updated on the data entry tabs or by uploading an XML file. Submit the files to CMS as instructed.

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

Primaris can assist practices with mining their data for completion of the Web-based interface. Contact Cora Butler **cbutler@primaris.org** for additional information.

Step 12: Receive your incentive payment.

Incentive payments are made in late summer 2015 as a single consolidated payment with a notation on the remittance advice.

CMS Certified Survey Vendor

A CMS-certified survey vendor is a new reporting mechanism, beginning in 2014, available to group practices of 25+ EPs that participate in PQRS as a Group (GPRO). The group contracts with a CMS-certified vendor, who then administers a 12-module "Clinician & Group Consumer Assessment of Healthcare Providers and Systems" (CG CAHPS) survey to the group's patients. The results of the survey will subsequently be posted on the CMS Physician Compare website.

There is a cost associated with administering the CG-CAHPS which the practice must bear. The only exception is for groups of 100 or more EPs that report via the GPRO Web Interface—CMS will administer and bear the cost for these groups because the CG-CAHPS is required (while it is optional for other groups.)

The CG-CAHPS survey will be considered the equivalent of 3 individual measures and 1 NQS domain. Therefore, group practices that register for this method of reporting 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, or report all measures in the GPRO Web Interface.

Download the 2014 CMS-certified Survey Vendor Made Simple document and the **2014 PQRS Implementation Guide** and read the instructions for reporting using the CMS Certified Survey Vendor.

Step 6: Create an IACS account and Register in the PV-PRQS Registration System.

One authorized representative of a group practice must **establish or modify an existing IACS account**, selecting the Approver Role of "PV-PQRS Group Security Official" and creating an organization. An additional role of "PV-PQRS Group Representative" can be requested after the group practice has an approved security official in IACS. Following creation of the account, groups must self-nominate and select the Certified Survey Vendor method as well as an additional method of PQRS reporting for the group in the **PV-PQRS Registration System**. After logging in, the user will select the Registration hyperlink from the PV-PQRS dropdown. The portal opens April 2, 2014 and the deadline date for self-nomination and election is September 30, 2014.

Note: If your group practice is participating in an ACO, you do not have to register your group in the PV-PQRS system.

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

Step 7: Understand the Survey Questions.

The CMS-certified survey vendor will administer and collect all 12 summary survey modules and submit the results to CMS on behalf of the group practices' patients. The results will subsequently be posted on the CMS Physician Compare website.

The 12 summary survey modules for use with the PQRS program include the following:

1. Getting Timely Care, Appointments, and Information
2. How Well Providers Communicate
3. Patient's Rating of Provider
4. Access to Specialists
5. Health Promotion & Education
6. Shared Decision Making
7. Health Status/Functional Status
8. Courteous and Helpful Office Staff
9. Care Coordination
10. Between Visit Communication
11. Helping You to Take Medication as Directed
12. Stewardship of Patient Resources

The complete version of the CG-CAHPS can be found here.

Step 7: Identify and contact a CMS-certified Vendor.

A list of CMS-certified survey vendors and contact information will be available soon on the **CMS PQRS website** certified vendor link. Group practices will need to contact a CMS-certified survey vendor from the approved list. Check the CMS website frequently for further updates and information on deadlines.

Step 8: Complete the requirements of PQRS reporting using an additional method of reporting.

In addition to the CG-CAHPS survey, groups must also report additional measures to meet the requirements for 2014 PQRS reporting. Follow the instructions for group reporting using one additional method as appear elsewhere in this document. All members of the group must report the same measures and must use the same method.

Step 9: Receive your incentive payment.

Incentive payments are made in late summer 2015 as a single consolidated payment with a notation on the remittance advice.

Improve Your Numbers–Resources

Better quality healthcare is the goal of Primaris projects. Through collaboration with providers and stakeholders in quality improvement projects, Primaris improves effectiveness, efficiency and economy of healthcare services and enhances the experiences of Medicare beneficiaries. This section provides tips, guidelines, resources, and patient engagement tools to help improve your processes and sustain these improvements over time.

Physician Practice and Patient Engagement Resources

GENERAL PREVENTION SCREENING

Good health comes not just from receiving quality medical care but from stopping disease before it starts. Monitor your patient population and give prevention high priority in your practice.

Materials

- **Medicare Learning Network** – Website for educational publications for providers
- **Medicare Guide to Fee-For-Service Prevention Services** – Comprehensive Coding and Billing Guide to Medicare Prevention Services (October 2013 Revision)
- **The ABCs of Providing the Initial Preventive Physical Exam** – Quick Reference Guide
- **The ABCs of Providing the Annual Wellness Visit** – Quick Reference Guide

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. 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.

- FluFit: American Cancer Society evidence-based campaign to improve colorectal cancer screening rates
- CRC Clinician's Guide: Screening Action Plan
- Print Materials/Posters/Fact Sheets from the CDC

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.

- 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.

- Translated Komen Educational Materials in 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.

- Susan G Komen Events - Advocacy and events
- Resources from Susan G. Komen for physicians
- American Cancer Society - Treatment of breast cancer
- Centers for Disease Control and Prevention – Statistics and screening

TOBACCO CESSATION

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.

- Medicare Guide to Tobacco Cessation Counseling Services
- Look What Happens When You Quit poster from CDC
- American Cancer Society Free Brochures
- Quitting Smoking Brochures (and other topics) from the American Heart Association
- Fact Sheets from the National Cancer Institute
- Smokeless Tobacco poster from the National Institutes of Health
- CDC Videos on Smoking Cessation
- Second-hand Smoke – Effects on Children and Adults

Resources for Education and Tobacco Cessation

According to the American Lung Association every year in the U.S. over 392,000 people 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 Heart Association– Quitters win, Dealing with Urges and other resources
- National Cancer Institute – Free Help to Quit Smoking
- CDC: Office on Smoking/Health – Patient stories
- Missouri Highlights on Smoking and Tobacco Use – CDC statistics
- Missouri Partnership on Smoking and Health
- Clean Air KC
- Tobacco Prevention Center – St Louis University
- Tobacco Treatment Specialist Certification Program – Mayo Clinic

CARDIAC CARE

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.

- Medicarehttps://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Cardiovascular-Disease-Services-Booklet-ICN907784.pdf Coverage for Cardiovascular Disease Services
- Know and Follow Your Signals poster
- AHA Educational Brochures
- AHA Health Fair Kits

- National Heart Lung and Blood Institute campaign materials – Latinas, African-American, women, cookbooks, other 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
- Million Hearts Campaign – Pledge your support for this nationwide initiative
- Centers for Disease Control and Prevention (CDC)
- Cardio Smart – from the American College of Cardiology
- Understanding New Heart Attack and Stroke Prevention Guidelines – ACC and AHA new guidelines released November 2013

FLU IMMUNIZATIONS

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 – flu facts and resources especially for children
- Real Stories, Real people
- Food and Drug Administration Safety and Availability
- Flu.gov

PNEUMONIA IMMUNIZATIONS

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 Pneumococcal Disease
- Immunization Action Coalition

CMS PQRS Resources

- 2014 PQRS Overview Fact Sheet – General information about requirements for PQRS reporting in 2014
- PQRS Timeline 2014 – 2016
- What's New for 2014 – Changes to PQRS effective in 2014
- 2014 Physician Quality Reporting System Implementation Guide. - Detailed guide covering all methods of reporting 2014 PQRS
- 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
- How to Report Once for Medicare Quality Reporting Programs – Guide to reporting once to satisfy quality reporting requirements for PQRS, Meaningful Use, Value-Based Modifier and other CMS programs
- 2014 PQRS: Maintenance of Certification (MOC) Program Incentive Made Simple – Board-certified physicians may earn an extra 0.5% incentive by meeting MOC requirements established by participating specialty boards.
- CMS PQRS Frequently Asked Questions

Claims Reporting for PQRS

- 2014 PQRS Claims-based Reporting Made Simple - Quick reference guide to reporting PQRS using claims
- 2014 Individual Claims and Registry Measure Specifications - Detailed instructions and codes for reporting individual measures

Qualified Registry Reporting for PQRS

- 2014 PQRS Registry Reporting Made Simple--Step-by-step instructions for reporting PQRS using a qualified registry
- 2014 Qualified Registry Vendors Listing –Listing of qualified registry vendors in including measures they support, costs, and contact information.
- 2014 Individual Claims and Registry Measure Specifications - Detailed instructions and codes for reporting individual measures
- 2014 Getting Started with Measures Groups and PQRS Measures Group Specifications – Detailed instructions and codes for reporting PQRS using a Measures Group.

EHR Reporting (Direct and Data Submission Vendor) for PQRS

- 2014 PQRS EHR-based Reporting Made Simple - Overview of requirements for EHR-based reporting
- EHR Incentive Program Certified EHR Technology website – To report using an EHR or EHR Data Submission Vendor, systems must be certified by the Office of the National Coordinator for Health Information Technology.
- 2014 CQM Measure Specifications for Eligible Professionals - Detailed instructions and approved codes for reporting individual measures using EHR Direct or EHR Data Submission Vendor.

Qualified Clinical Data Registry Reporting for PQRS

- 2014 PQRS Qualified Clinical Data Registry Participation Made Simple - Requirements for participation in a Qualified Clinical Data Registry to report PQRS.
- Qualified Clinical Data Registries – Look for a published listing of qualified clinical data registries in the summer of 2014.

Group Reporting (GPRO) for PQRS

- Group Practice Reporting Options - Guide to the options and requirements for reporting PQRS as a group in 2014
- CMS PV-PQRS Registration System – Site to register the group for 2014 group practice reporting option (GPRO)
- GPRO Guide for Vendors (Direct and Data Submission Vendors) – Certified Vendors should refer to this guide for instructions on GPRO reporting.
- 2014 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes – Detailed instructions and codes for reporting the GPRO web interface measures

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 (0.5%) is available for successful participation through 2014. Professionals that do not participate in PQRS in 2014 will receive a -2.0% payment adjustment in 2016. PQRS reporting is a required component of the Value-Based Modifier and performance rates will impact your quality score. Providers in groups with 10+ EPs in 2014 must report PQRS or face an automatic -2.0% VBM payment adjustment in 2016. This is in addition to the PQRS payment adjustment.

Reporting PQRS using data generated from your EHR 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've heard I can report once to meet the requirements for PQRS and the EHR Incentive Program. How do I do this?

Under certain conditions, the "Report Once" option allows individual EPs or Groups to:

- Satisfy PQRS Incentive Requirements for 2014
- Avoid the 2016 PQRS Payment Adjustment
- Satisfy the CQM component of the Medicare EHR Incentive Program
- Satisfy the VBM reporting requirement:
    - If at least 50% of the individual EPs under a TIN successfully avoid the 2016 PQRS Payment Adjustment, OR
    - If the Group successfully avoids the 2016 PQRS Payment Adjustment

The "Report Once" option is only available to EPs who are beyond their first year of Meaningful Use. EPs in their first year of Meaningful Use in 2014 must attest to their CQMs by October 1, 2014 to avoid a Meaningful use payment penalty in **2015**.

EPs will **still be required to report the Meaningful use "operational objectives**" through the Medicare Incentive Program and Attestation System. EPs reporting through Medicaid cannot use the Report Once option.

The Report Once option **requires a full year of clinical quality data** to be submitted (even though the EHR Incentive Program requires only 90 days in 2014). Providers that use the report once option will have their EHR incentive payment delayed until after the first quarter of 2015.

Individuals: Individuals may report 9 measures covering 3 domains using a Direct EHR product that is certified EHR Technology (CEHRT) or a Data Submission Vendor that is CEHRT. The eCQMs must be certified to the June 2013 version (except for CMS140v1: Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer where the EHR needs to be certified to the Dec 2012 version). EPs using EHRs that are not certified to the June 2013 version of eCQMs cannot use the "report once" option. Instead, they must attest to their CQMs for MU and select a different reporting method for PQRS reporting.

Individuals may also report once using a Qualified Clinical Data Registry if the QCDR is CEHRT.

Groups: Groups that self-nominate may report once by reporting 9 measures covering 3 domains using a Direct EHR product that is CEHRT or a Data Submission Vendor that is CEHRT (to the eCQM June 2013 version as discussed above). Groups of 25+ may also report once using the GPRO Web Interface or the Certified Survey Vendor Option (e.g., CG-CAHPS measures plus 6 EHR-based measures or all GPRO Web Interface measures).

Please see the CMS Guide "How to Report Once for Medicare Quality Reporting Programs" for more information.

Where can I find a list of PQRS measures?

Refer to the earlier sections in this document, which provide a direct link to all PQRS measures for each method of reporting. All PQRS measures and their available reporting methods can also be found in the 2014 Physician Quality Reporting System (PQRS) Measures List, available in the **2014 PQRS Measure List Implementation Guide** zip file.

There are 284 measures available for reporting in 2014. In keeping with CMS move toward electronic reporting, the number of measures available through Claims has declined. See the table below for the numbers of measures available by method:

Reporting Option	Total 2014 Count
Claims Measures	110
Registry Measures	201
EHR Measures	64
GPRO Web Interface Measures	22
Certified Survey Vendor	CG-CAHPS (12 Summary Survey Modules)
Measure Groups	25

How can providers avoid the 2016 PQRS penalty?

To avoid a -2.0% PQRS payment adjustment in 2016, an EP must:

- Meet the requirements for satisfactorily reporting to earn a 2014 incentive either individually or as a group, using any available methods of reporting (See Tables 1 and 2, Step 4 of this manual), OR.
- If reporting via Claims or Registry, report at least three valid individual measures.

In 2013 we elected an "Administrative Claims" option that allowed us to not report anything and still avoid a payment adjustment in 2015. Can we do that again in 2014 to avoid a 2016 payment adjustment?

No, Administrative Claims was a one-time option available only in 2013. Providers must report PQRS for calendar year 2014 using one of the methods in Step 4, Tables 1 or 2, to avoid 2016 payment adjustments.

Who is eligible to report PQRS?

Refer to the list of eligible professionals. In general, any physician, practitioner or therapist that bills Medicare Part B is eligible to participate. Members of an ACO should contact their ACO for specific instructions.

Beginning in 2014, professionals who reassign benefits to a Critical Access Hospital (CAH) that bills professional services at a facility level, such as CAH Method II billing, can now participate (in all reporting methods *except* for claims-based). To do so, the CAH **must** include the individual provider NPI on their Institutional (FI) claims.

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?

In general only services provided to Medicare Part B PFS beneficiaries are reported for PQRS. This includes Medicare (primary or secondary) and Railroad Retirement. PQRS does not include Medicare Part A or Medicare Advantage. However, when reporting aggregate data (QRDA III) using certified EHR/EHR Data Submission Vendor, or Qualified Clinical Data Registry, data from all payers is included. If reporting a Measures Group, the majority of the patients (e.g., at least 11) must be Medicare.

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, Qualified Registry, or through a Qualified Clinical Data Registry (depending on the requirements of the various registries). GPROs may participate through the Web Interface, Qualified Survey Vendor or a Qualified Registry without the use of an EHR.

How do I know if my EHR is capable of reporting PQRS?

Beginning in 2014 all EHRs certified to the 2014 standards by an ONC authorized testing and certifying body must have the capability to report at least 9 measures covering three domains of care for PQRS CMS will no longer be *qualifying* EHRs or EHR Data Submission Vendors (DSV). Check the Certified Health IT Product List (CHPL) to see if your EHR/EHR DSV version is certified to 2014 standards.

May I submit PQRS using more than one method?

Yes. CMS will review data submitted via all methods to determine satisfactory reporting. However, each reporting method is considered separately, and EPs cannot combine reporting methods to reach the 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 methods are attempted.

It should be noted, however, that if group reporting is elected, providers within that TIN may NOT report individually and must report using the method chosen by the group. The EP may NOT report as an individual.

For example, an EP could submit 9 individual measures covering at least 3 domains for at least 50% of their patients via claims. Then, after the close of the year, the EP could also submit 9 measures directly to CMS using a certified EHR. If claims submission failed to meet the 50% reporting requirement, but EHR submission satisfactorily met the 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 providers familiarize themselves with direct reporting via the EHR, as this is where future reporting is headed. The EP could NOT submit two measures via claims and seven measures via the EHR in order to meet the nine 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 e-Prescribe Incentive program has terminated. PQRS and the EHR Incentive Program (Meaningful Use) are distinctly separate programs and providers may earn incentives under both.

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

If reporting via Claims: CMS will provide one intermittent feedback covering the first quarter of Claims submissions to help providers identify potential reporting errors. Check the CMS website "Spotlight" section for information. The reports will be available in late summer of 2014. 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 late summer of the following year (2015).

Qualified Registries are required to provide at least two feedback reports to participants.

Qualified Clinical Data Registries are required to provide at least four feedback reports to participants.

EHR-based Reporting: EPs reporting through an EHR should use the report features within their systems to monitor performance throughout the year.

CMS will provide final feedback reports in the late summer/early fall 2015 to all providers and/or groups that reported at least one valid PQRS measure during 2014.

If the provider successfully reports PQRS, CMS will send the incentive payments via the same route that all other Medicare payments to the EP are made.

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 and for receiving results and entering them into the EHR.
- 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 share with providers. Or, ideally, empower providers to run their own reports, if desired, so they can use electronic capabilities to "drill down" into the measures to see which patients did not meet the measures in real time. 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. 2014 is the last year providers can earn a PQRS incentive.

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. If you are a Missouri provider, 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.