2014 Physician Quality Reporting System (PQRS): Implementation Guide

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Introduction

The 2014 Implementation Guide is provided to promote understanding about how to apply 2014 Physician Quality Reporting System (PQRS) measures in clinical practice and to facilitate satisfactory reporting of quality data by eligible professionals (EPs) or group practices that wish to report in PQRS. PQRS is a reporting program that provides an incentive payment to identified EPs or group practices participating in the Group Practice Reporting Option (GPRO) that satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board, Medicare Secondary Payer, and Critical Access Hospitals (CAH) method II). Medicare Part C–Medicare Advantage beneficiaries are not included.

This guide provides information for becoming 2014 incentive eligible as well as avoiding the 2016 payment adjustment. Those that report satisfactorily for the 2014 program year and receive an incentive will also avoid the 2016 PQRS payment adjustment. Additional information on how to avoid future PQRS payment adjustments can be found in supporting documentation on the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Note: "Satisfactory reporting" refers to participating in PQRS to earn the incentive payment (and avoid the 2016 payment adjustment) while "satisfactory participation" refers to EPs participating in the new "qualified clinical data registry" reporting option for 2014.

Eligible professionals or group practices participating in GPRO, using their individual rendering National Provider Identifier (NPI) or Tax Identification Number (TIN), may report the quality action for measure(s) contained within PQRS. Providers not defined as EPs in the Tax Relief and Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to report measures for PQRS. Most services payable under fee schedules or methodologies other than the PFS are not included in 2014 PQRS (for example, services provided in federally qualified health centers, portable x-ray suppliers, independent laboratories including place-of-service code "81", independent diagnostic testing facilities, hospitals, rural health clinics, ambulance providers, and ambulatory surgery center facilities). Suppliers of durable medical equipment (DME) are not eligible to report measures via PQRS since DME is not paid under the PFS. A list of EPs can be found on the PQRS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

In general, quality measures consist of a unique denominator (eligible patient population) and numerator (clinical action) that permit calculating the percentage of the measure specific eligible patient population receiving a particular process of care or achieving a particular clinical outcome/result. It is important to review and understand each measure specification especially as it pertains to a specific reporting option. The measure specification specific to the reporting option will provide definitions and specific instructions for satisfactorily reporting the measure. This guide provides a web address under each reporting option for easy location of the measures specifications. Also refer to Appendix A, "Glossary of Terms," which further defines the terms denominator and numerator as well as other terms commonly used in PQRS.

Note: If participating in PQRS through another CMS program, please check the program's requirements for information on how to simultaneously report under PQRS and the respective program.

PQRS Measure Selection Considerations

The measures in 2014 PQRS address various aspects of care, such as prevention, chronic- and acute-care management, procedure-related care, resource utilization, and care coordination. Measure selection should begin with a review of the *2014 Physician Quality Reporting System (PQRS) Measures List* to determine which measures, associated domains, and reporting option(s) may be of interest to the practice and applicable to the EP or group practice. Please note, not all measures are available under all of the PQRS reporting options. EPs or group practices should avoid individual measures that do not or may infrequently apply to the services they provide to Medicare patients. The measures list is available as a downloadable document from the Measures Codes section of the CMS PQRS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.

The following factors should be considered when selecting measures for reporting:

- Clinical conditions usually treated
- Types of care typically provided – e.g., preventive, chronic, acute
- Settings where care is usually delivered – e.g., office, emergency department (ED), surgical suite
- Quality improvement goals for 2014
- Other quality reporting programs in use or being considered

Beginning in 2014, *most* PQRS reporting options require an EP or group practice to report 9 or more measures covering at least 3 National Quality Strategy (NQS) domains for incentive purposes. The domains associated with the measures are as follows:

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

After making a selection of potential measures, review the specifications for the selected reporting option for each measure under consideration and select those measures that apply to services most frequently provided to Medicare patients by the EP or group practice. Individual EPs or group practices participating in GPRO should review each measure's denominator coding to determine which patients may be eligible for the selected PQRS measure(s). These eligible patients (or denominator) would be appropriate to report the selected measure(s) clinical action or numerator.

PQRS Denominators and Numerators

Measures consist of two major components:

1) A denominator that describes the eligible cases for a measure (the eligible patient population associated with a measure's numerator)
2) A numerator that describes the clinical action required by the measure for reporting and performance

Each component is defined by specific clinical codes described in each measure specification along with reporting instructions.

Reporting Methods

PQRS offers several reporting methods for measures. There may be different options available within the specific reporting method to satisfactorily report to be eligible for the 2014 incentive or to avoid a 2016 payment adjustment. This guide offers tools, *Decision Trees*, that assist with providing illustrated instruction of a specific reporting method and provides the options available for earning incentive or avoidance of the payment adjustment. Refer to Appendix B: Reporting for 2014 PQRS Incentive Payment AND Appendix C: Avoiding the 2016 PQRS Payment Adjustment, for the *Decision Trees* designed to help participants select among the multiple reporting methods available in PQRS. EPs should consider which reporting method best fits their practice and should choose measures within the same option of reporting. Following are reporting methods available to individual EPs and group practices taking part in GPRO.

Individual EPs

To satisfactorily report or to satisfactorily participate in the 2014 PQRS program, individual EPs may choose to report quality data via:

1. EHR Direct Product that is Certified Electronic Health Record Technology (CEHRT)
2. EHR data submission vendor that is CEHRT
3. A qualified PQRS registry
4. Participation through a Qualified Clinical Data Registry (QCDR)
5. Medicare Part B claims submitted to CMS

GPRO

GPRO was introduced in 2010 as a reporting method for group practices to qualify to earn a PQRS incentive. PQRS defines a group practice as a single Tax Identification Number (TIN) with 2 or more individual EPs (as identified by Individual National Provider Identifier [NPI]) that have reassigned their billing rights to the TIN.

Group practices may choose to report PQRS quality data via:

1. GPRO Web Interface
2. Qualified PQRS Registry
3. EHR Direct Product that is CEHRT
4. EHR data submission vendor that is CERT
5. CMS-certified survey vendor

Group practices reporting via GPRO must register for their selected reporting method by September 30, 2014. For more information about reporting PQRS measures as a group, visit the Group Practice Reporting Option webpage at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/PQRS/Group_Practice_Reporting_Option.html.

Analysis of PQRS Data: Reporting Frequency (also referred to as Measure Tags) and Performance Timeframes

Reporting frequency and performance timeframes are considerations for satisfactorily reporting through claims, qualified registry, electronic health record (EHR) direct product, EHR data submission vendor, the GPRO Web Interface, CMS-certified survey vendor, or participating via a qualified clinical data registry.

Each measure specification includes a reporting frequency (also referred to as a measure tag) for each denominator-eligible patient seen during the reporting period. The reporting frequency described in the instructions applies to each individual EP and group practice submitting individual PQRS measures. PQRS uses the reporting frequency to analyze each measure for determination of satisfactory reporting, according to the reporting frequency in the "Instructions" section of the measure:

- Patient-Process: Report a minimum of once per reporting period per individual eligible professional (NPI).
- Patient-Intermediate: Report a minimum of once per reporting period per individual eligible professional (NPI).
- Patient-Periodic: Report once per timeframe specified in the measure for each individual eligible professional (NPI) during the reporting period.
- Episode: Report once for each occurrence of a particular illness/condition by each individual eligible professional (NPI) during the reporting period.
- Procedure: Report each time a procedure is performed by the individual eligible professional (NPI) during the reporting period.
- Visit: Report each time the patient is seen by the individual eligible professional (NPI) during the reporting period.

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

Educational support PQRS eligible professionals should also refer to:

- *2014 PQRS EHR Reporting Made Simple*
- *Satisfactorily Reporting 2014 Physician Quality Reporting System (PQRS) Measures – Registry Reporting Made Simple*
- *2014 PQRS Qualified Clinical Data Registry (QCDR) Participation Made Simple*
- *Satisfactorily Reporting 2014 Physician Quality Reporting System (PQRS) Measures – Claims Reporting Made Simple*
- *2014 PQRS Group Practice Reporting Option (GPRO) Web Interface Reporting Made Simple*
- *2014 PQRS CMS-Certified Survey Vendor Reporting Made Simple*

The criteria for satisfactory reporting as well as the Clinical Quality Measures (CQMs) available for reporting under the PQRS EHR-based reporting mechanism are aligned with the Medicare EHR Incentive Program. The Medicare EHR Incentive Program requires that an EP or group practices participating under the Group Practice Reporting Option (GPRO) submit clinical quality measures using Certified EHR Technology (CEHRT). EHR products will have to be certified under the program established by the Office of the National Coordinator for Health Information Technology (ONC). The ONC certification process tests the submission of data on eCQMs available for reporting under the EHR Incentive Program. For purposes of PQRS, the EP's or group practices direct EHR product or EHR Data Submission Vendor must be certified to the specified versions. Satisfactory reporting of PQRS EHR quality measures will allow EPs and group practices participating under the GPRO to qualify for the CQM component of Meaningful Use.

Those group practices electing to report via EHR will use the *Medicare EHR Incentive Programs Clinical Quality Measures (eCQM) for Eligible Professionals* posted on the eCQM Library webpage http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html. The EHR system utilized by group practices must be CEHRT under ONC. For further information about the EHR reporting method, review the Reporting via EHR section of this guide.

2014 Clinical Quality Measures (CQMs) for Eligible Professionals

Beginning in 2014, the CQM specifications will be used for multiple programs, including the EHR-based reporting option for the PQRS as well as the Medicare EHR Incentive Program to reduce the burden on providers reporting quality measures. Please follow the link provided below to the Medicare EHR Incentive Programs eCQM Library webpage to obtain the *2014 eCQM Specifications for EP Release*, June 2013 and supporting documentation. EPs and group practices reporting PQRS via the EHR-based reporting method are required to use the June 2013 version of the eCQMs with the exception of CMS140, which is to be reported using the December 2012 version (CMS 140v1).

By satisfactorily reporting eCQMs using Direct EHR or EHR Data Submission Vendor Products, an EP or group practice will earn the 2014 PQRS incentive as well as avoid the 2016 PQRS payment adjustment. EPs and group practices must report 9 measures covering at least 3 of the National Quality Strategy (NQS) Domains. The group practice should report the 9 measures over 3 domains as a group. If an eligible professional's or group practice's CEHRT system does not contain patient data for at least 9 measures covering at least 3 domains, then the EP or group practice must report the measures for which there is Medicare patient data. An EP or group practice must report on at least 1 measure for which there is Medicare patient data.

Additionally, EPs and group practices may meet the Clinical Quality Measure (CQM) component for the Medicare EHR Incentive Program if they participate via the PQRS EHR-based reporting method.

For 2014 and beyond, CMS will discontinue the PQRS qualification requirement for Data Submission vendors and Direct EHR vendors. The EHR products will have to be certified (CEHRT) under the program established by ONC. This program will provide adequate checks to ensure that CEHRT utilized is able to submit clinical quality data. Although CMS is discontinuing qualifying EHR products, vendors will be able to continue to submit test files. Allowing submission of test files is an important tool for providers and provides an adequate check to determine whether the vendor products are able to successfully submit data to CMS.

Direct EHR Vendor

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

Data submitted to CMS via a Direct EHR vendor EHR product must be transmitted using the Quality Data Model (QDM)-based Quality Reporting Documentation Architecture (QRDA) Category I or QRDA Category III formats. Although products must be able to transmit data using the QDM-based QRDA Category I and III formats, for

purposes of reporting PQRS quality measures data to CMS, EPs and group practices need only submit data via their EHR using one of these formats (either the QDM-based QRDA Category I or III).

If EPs and group practices are submitting quality measure data directly from an EHR system, they must register for an IACS account. For more information about how eligible professionals register for an IACS account, visit the "Physician and Other Health Care Professionals Quality Reporting Portal" (Portal) at https://www.qualitynet.org/portal/server.pt/community/pqri_home/212.

- Request the appropriate Submitter Role when registering for an IACS account – either Individual PQRS Submitter and PQRS Representative, or PQRS Submitter.
- If you already have an IACS account, you will need to request adding the role to your account.
- Refer to the *IACS Quick Reference Guides* document on the Portal home page

EHR Data Submission Vendor (DSV)

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

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

Submission of Clinical Quality Measures (CQMs)

EPs and group practices must submit final EHR reporting files with quality measure data, or ensure that their EHR Data Submission Vendor submits files by the data submission deadline of February 28, 2015, to be analyzed and used for 2014 PQRS EHR measure calculations.

- If reporting QDM-based QRDA Category I files, a single file must be uploaded/submitted for each patient. Files can be batched but there will be file upload size limits. It is likely that several batched files will need to be uploaded to the Portal for each eligible provider.
- Following each successful file upload, notification will be sent to the IACS user's e-mail address indicating the files were submitted and received.
- Submission reports will then be available to indicate file errors, if applicable.
- Reporting via EHR using the QRDA Category III format is one of three reporting methods (Qualified Registry, EHR, and QCDR) that provide calculated reporting and performance rates to CMS.

Reporting via Qualified Registry

Beginning with the 2008 Physician Quality Reporting System (PQRS) program year, EPs could qualify to earn a PQRS incentive by reporting quality measures data to a qualified registry. Reporting via registry is one of three reporting methods (Qualified Registry, EHR, and Qualified Clinical Data Registry) that provides calculated reporting and performance rates to CMS. This data must be submitted by the registry to CMS via defined .xml specifications.

Registry Vendors

A qualified registry is an entity that collects clinical data from an eligible professional or group practice and submits it to CMS on behalf of the participants. EPs and group practices should work directly with their chosen registry in order to submit data satisfactorily on the selected measures or measures groups. The 2014 PQRS data submission window will be in the first quarter of 2015. To select a registry vendor, refer to the *2014 Participating Registry Vendors* list on the Registry Reporting page of the CMS PQRS website.

Reporting Criteria for Individual EPs

EPs can *earn a 2014 PQRS incentive* by meeting one of the following criteria for satisfactory reporting:

1. Report on at least 9 measures covering 3 National Quality Strategy (NQS) domains for at least *50% of the EP's* Medicare Part B FFS patients.
    - EPs that submit quality data for only 1 to 8 PQRS measures for at least 50% of their patients or encounters eligible for each measure, OR that submit data for 9 or more PQRS measures across less than 3 domains for at least 50% of their patients or encounters eligible for each measure will be subject to Measure-Applicability Validation (MAV). (See http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html)
2. Report at least 1 measures group on a *20-patient sample*, a majority of which (at least 11 out of 20) must be Medicare Part B FFS patients.
    - For more information, see *2014 Physician Quality Reporting System (PQRS) Getting Started with Measures Groups*.

EPs can *avoid the 2016 PQRS payment adjustment* by meeting one of the following criteria:

1. Satisfactorily report and earn the 2014 PQRS incentive.
2. Report at least 3 measures covering one NQS domain for at least 50% of the EP's Medicare Part B FFS patients.
    - EPs that submit quality data for 1 or 2 PQRS measures for at least 50% of their patients or encounters eligible for each measure will be subject to MAV.

EPs opting to report via qualified registry are allowed to report on individual measures or measures groups. The *2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures* and the *2014 Physician Quality Reporting System (PQRS) Measures Groups Specifications Manual* are to be used for this option of reporting and can be found on the Measures Codes page of the CMS PQRS website at http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

Reporting Criteria for Group Practices

A group practice *must* have registered to report via qualified registry under the GPRO for 2014 PQRS. Group practices can *earn a 2014 PQRS incentive* by meeting the following criteria for satisfactory reporting:

1. Report on at least 9 measures covering 3 NQS domains for at least *50% of the group's* Medicare Part B FFS patients.
    - Group practices that submit quality data for only 1 to 8 PQRS measures for at least 50% of their patients or encounters eligible for each measure, OR that submit data for 9 or more PQRS measures across less than 3 domains for at least 50% of their patients or encounters eligible for each measure will be subject to MAV.

Group practices can *avoid the 2016 PQRS payment adjustment* by meeting one of the following criteria:

1. Satisfactorily report and earn the 2014 PQRS incentive.
2. Report at least 3 measures covering one NQS domain for at least 50% of the group's Medicare Part B FFS patients.
    - Group practices that submit quality data for 1 or 2 PQRS measures for at least 50% of their patients or encounters eligible for each measure will be subject to MAV.

Those group practices electing to report via registry will use the *2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures*. These specifications are located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

Participation via Qualified Clinical Data Registry (QCDR) - New for 2014

New for 2014, the Qualified Clinical Data Registry (QCDR) provides a new standard for individual EPs to satisfy PQRS requirements based on satisfactory participation. A QCDR is a CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients. The data submitted to CMS via QCDR covers quality measures across multiple payers and is not limited to Medicare. Reporting via QCDR is one of three reporting methods (Qualified Registry, EHR, and QCDR) that provides calculated reporting and performance rates to CMS.

A list of CMS-designated QCDRs will be available on the CMS PQRS website in the spring of 2014.

Note: The measures that may be submitted to a QCDR are not limited to the measures found in the PQRS measure set but *are* limited to submission of no more than 20 non-PQRS measures.

Reporting Criteria for Individual EPs

EPs can earn a *2014 PQRS incentive* by meeting the following criteria:

- Report on a minimum of 9 measures covering 3 National Quality Strategy (NQS) domains for at least 50% of the eligible professional's applicable patients seen during the 2014 reporting period.
    - At least 1 of the 9 measures submitted must be an outcome measure (containing denominator data fulfilling both exceptions and exclusions, as well as numerator data).

EPs can avoid the *2016 payment adjustment* by meeting one of the following criteria:

1. Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50% of the eligible professional's applicable patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted. Of the measures reported via a qualified clinical data registry, the EP must report on at least 1 outcome measure.
2. Report at least 3 measures covering at least 1 NQS domain AND report each measure for at least 50% of the EP's applicable patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.

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

Participants should also refer to *2014 Qualified Clinical Data Registry (QCDR) Participation Made Simple.* This document serves as educational resources to assist professionals and their staff with accurately reporting measures. The Fact Sheets provide helpful information on how to get started with PQRS and are available as downloadable documents in the Educational Resources section of the CMS PQRS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.

Group practices wanting to report measures under the Group Practice Reporting Option (GPRO) in the 2014 PQRS program year need to register. Registered group practices may report measures via the GPRO Web Interface, qualified registry, EHR direct, EHR data submission vendor, or CMS-certified survey vendor. They must elect their reporting method by September 30, 2014. The method chosen is the only PQRS submission method available to the group and all individual NPIs that bill Medicare under the group's TIN.

Incentive payment for PQRS is based on satisfactory reporting of quality data. Refer to Appendix B: *2014 PQRS Participation for Incentive Payment Decision Tree* for further information on the satisfactory reporting criteria for the GPRO reporting methods. It is important to review these options to determine which methods of reporting are applicable to the group practice. Reporting methods available for a group practice is dependent on the size. It is also helpful to review the measure specifications associated with each reporting method as the measures and satisfactory reporting requirements are different for each method.

Those group practices electing to report via the GPRO Web Interface should utilize the *2014 GPRO Web Interface Narrative Measure Specifications* and other supporting documentation to ensure accurate reporting of the measures. Reporting via the Web Interface includes completion of a pre-filled beneficiary sample. These documents are located on the GPRO Web Interface webpage at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.

- 25-99 Eligible Professionals:
  Report on all measures included in the Web Interface; AND populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.

  OR

  Optional:
  Group practices of 25-99 individual eligible professionals may choose to have all 12 CG CAHPS summary survey modules reported on its behalf via a CMS-certified survey vendor in addition to reporting 6 measures covering at least 2 of the NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO Web Interface as a reporting mechanism. CMS will publicly report CY 2014 CG CAHPS data collected by groups of any size via a CMS-certified survey vendor on Physician Compare.

- 100+ Eligible Professionals:
  Report on all measures included in the Web Interface; AND populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries. In addition, the group practice must report all CG CAHPS summary survey modules via CMS-certified survey vendor.

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

CMS-Certified Survey Vendor - New for 2014

A CMS-certified survey vendor is a new reporting mechanism available to group practices taking part in PQRS under the GPRO beginning in 2014. This option is available to group practices of 25 or more EPs wishing to report the CG CAHPS summary survey modules. The data collected on these measures will be submitted on behalf of the group practice by the CMS-certified survey vendor, the results of which will subsequently be posted on the Physician Compare website.

The CG CAHPS summary survey modules 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. Group practices of 25 or more EPs that select to have the CG CHAPS summary survey modules reported on their behalf will also need to complete 6 measures covering at least 2 NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO Web Interface.

With respect to group practices of 100 or more EPs reporting under the GPRO and using the GPRO Web Interface, reporting of the CG CAHPS summary survey modules is a requirement of satisfactory reporting.

Please refer to the *GPRO Decision Tree* in Appendix B for additional details on the reporting requirements of this mechanism.

Note: CMS-certified survey vendor is optional for all group practices taking part in PQRS under the GPRO.

Summary Survey Modules

The 12 CG CAHPS summary survey modules will include the following:

- Getting timely care, appointments, and information
- How well providers communicate
- Patient's rating of provider
- Access to specialists
- Health promotion & education
- Shared decision making
- Health status/functional Status
- Courteous and helpful office staff
- Care coordination
- Between visit communication
- Helping you to take medication as directed
- Stewardship of patient resources

The *2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures* can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

Identify Eligible Cases

Ensure that the practice identifies and reports on all eligible cases for the measures selected by the practice. Consider implementing an edit on the billing software that will flag each claim every time a combination of codes listed in a measure's denominator is billed so the entry of quality-data codes (QDCs) is required prior to final submission. Additional PQRS educational resources are available as downloads at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Claims Reporting Criteria

EPs may *earn a 2014 PQRS incentive* by meeting one of the following criteria for satisfactory reporting:

- Report on at least 9 measures covering 3 National Quality Strategy (NQS) domains for at least *50% of the EP's* Medicare Part B FFS patients.
    - EPs that submit quality data for only 1 to 8 PQRS for at least 50% of their patients or encounters eligible for each measure, OR that submit data for 9 or more PQRS measures across less than 3 domains for at least 50% of their patients or encounters eligible for each measure will be subject to Measure-Applicability Validation (MAV).(See http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html)

Note: Measures with a 0% performance rate will not be counted.

To avoid the 2016 payment adjustment, EPs must meet one of the following criteria:

- Satisfactorily report and earn the 2014 PQRS incentive.
- Report at least 3 measures covering 1 NQS domain for at least 50% of the EP's Medicare Part B FFS patients satisfactorily.
    - EPs who satisfactorily submit valid QDCs for only 1 or 2 PQRS measures for at least 50% of their patients or encounters eligible for each measure will be subject to the MAV process to determine whether an EP should have submitted additional measures.

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

Use of Current Procedural Terminology (CPT) Category I Modifiers

PQRS measure specifications include specific instructions regarding inclusion of the CPT Category I modifiers. Unless otherwise specified, CPT Category I codes may be reported with or without CPT modifiers. Refer to each individual measure specification for detailed instructions regarding CPT Category I modifiers that qualify or do not qualify a claim for denominator inclusion.

Note that surgical procedures billed by an assistant surgeon(s) will be excluded from the denominator population so his/her performance rates will not be negatively impacted for PQRS. Analysis will exclude otherwise PQRS-eligible CPT Category I codes, when submitted with assistant surgeon modifiers 80, 81, 82, or AS. The primary surgeon, not the assistant surgeon, is responsible for performing and reporting the quality action(s) in applicable PQRS measures.

Eligible CPT Category I procedure codes, billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population for

applicable PQRS measure(s). Both surgeons taking part in PQRS will be fully accountable for the clinical action(s) described in the PQRS measure(s).

Quality-Data Codes

QDCs are non-payable Healthcare Common Procedure Coding System (HCPCS) codes comprised of specified CPT Category II codes and/or G-codes that describe the clinical action required by a measure's numerator. Clinical actions can apply to more than one condition and, therefore, can also apply to more than one measure. Where necessary, to avoid shared CPT Category II codes, G-codes are used to distinguish clinical actions across measures. Some measures require more than one clinical action and, therefore, have more than one CPT Category II code, G-code, or a combination associated with them. EPs should review numerator reporting instructions for each measure carefully.

CPT Category II Codes

CPT Category II or CPT II codes, developed through the CPT Editorial Panel for use in performance measurement, serve to encode the clinical action(s) described in a measure's numerator. CPT II codes consist of five alphanumeric characters in a string ending with the letter "F." CPT II codes are not modified or updated during the reporting period and remain valid for the entire program year as published in the measure specifications manuals and related documents for PQRS.

Use of CPT II Modifiers

CPT II modifiers are unique to CPT II codes and may be used to report measures by appending the appropriate modifier to a CPT II code as specified for a given measure. The modifiers for a code cannot be combined and their use is guided by the measure's coding instructions, which are included in the numerator coding section of the measure specifications. Use of the modifiers is unique to CPT II codes and may not be used with other types of CPT codes. Only CPT II modifiers may be appended to CPT II codes. Descriptions of each modifier are provided below to help identify circumstances when the use of a modifier may be appropriate. Note that reporting an exclusion or reporting modifier will alter an EP's performance rate. Accurate reporting on all selected measures will count toward incentive, whether the clinical action is reported as complete or not complete (or performance met or not met).

CPT II code modifiers fall into two categories; exclusion modifiers and the 8P reporting modifier.

Exclusion modifiers may be appended to a CPT II code to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. These modifiers serve as denominator exclusions for the purpose of measuring performance. Not all exclusions will apply to every measure, and some measures do not allow any performance exclusions. Reasons for appending a performance measure exclusion modifier fall into one of three categories:

- 1P Performance measure exclusion modifier due to *medical reasons* includes:
    - Not indicated (absence of organ/limb, already received/performed, other)
    - Contraindicated (patient allergy history, potential adverse drug interaction, other)
    - Other medical reasons

- 2P Performance measure exclusion modifier due to *patient reasons* includes:
    - Patient declined
    - Economic, social, or religious reasons
    - Other patient reasons

- 3P Performance measure exclusion modifier due to *system reasons* includes:
    - Resources to perform the services not available (e.g., equipment, supplies)
    - Insurance coverage or payer-related limitations
    - Other reasons attributable to health care delivery system

The 8P reporting modifier is available for use only with CPT II codes to facilitate reporting an eligible case when an action described in a measure is not performed and the reason is not specified. Instructions for appending this reporting modifier to CPT Category II codes are included in applicable measures. Use of the 8P reporting

modifier indicates that the patient is eligible for the measure; however, there is no indication in the record that the action described in the measure was performed, nor was there any documented reason attributable to the exclusion modifiers.

- 8P Performance measure reporting modifier - action not performed, reason not otherwise specified

The 8P reporting modifier facilitates reporting an eligible case on a given measure when the clinical action does not apply to a specific encounter. Eligible professionals can use the 8P modifier to receive credit for satisfactory reporting but will not receive credit for performance. Eligible professionals should use the 8P reporting modifier sensibly for applicable measures they have selected to report. The 8P modifier may not be used freely in an attempt to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

Note: Measures with a 0% performance rate and measures groups containing a measure with a 0% performance rate will not be counted.

For example, an EP has selected and submitted QDCs during the reporting period for 2014 PQRS Measure #6, Coronary Artery Disease (CAD): Antiplatelet Therapy. The EP sees a patient for whom he does not choose to prescribe oral antiplatelet therapy and the reason is not specified. However, the claim(s) for services for that encounter contains International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), and CPT codes that will draw the patient into the measures' denominator during analysis. The 8P modifier serves to include the patient in the numerator when reporting rates are calculated for PQRS.

Claims-Based Reporting Principles

Up to four diagnoses can be reported in the header on the current CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim. Beginning 4/1/2014, up to 12 diagnosis may be reported in the electronic claim.

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

All diagnoses reported on the base claim will be included in PQRS analysis, as some measures require reporting more than one diagnosis on a claim.

- For line items containing a QDC, only one diagnosis from the base claim should be referenced in the diagnosis pointer field.
- To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, all diagnoses on the claim(s) are considered in PQRS analysis.

If billing software limits the number of line items available on a claim, you should add a nominal amount such as a penny to one of the line items on that second claim for a total charge of one penny.

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

A sample CMS-1500 form can be found in Appendix E of this document.

Principles for Reporting QDCs via Claims

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

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

2. QDCs must be submitted with a line-item charge of one penny ($0.01) at the time the associated covered service is performed.
   - The submitted charge field cannot be blank
   - The line item charge should be $0.01 – the beneficiary is not liable for this nominal amount
   - Entire claims with a $0.01 charge will be rejected
   - When the $0.01 nominal amount is submitted to the Carrier or A/B Medicare Administrative Contractor (MAC), the PQRS code line will be denied but will be tracked in the National Claims History (NCH) for analysis
   - Important: In an effort to streamline reporting of QDCs across multiple CMS quality reporting programs, CMS strongly encourages all EPs and practices to begin billing 2014 QDCs with a $0.01 charge. EPs should pursue updating their billing software to accept the $0.01 charge prior to implementing 2014 PQRS. EPs and practices will need to work with their billing software or EHR vendor to ensure this capability is activated. Entering the nominal charge of $0.01 on claims will help ensure the QDCs are processed into the CMS claims database.

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

Note: Claims may NOT be resubmitted for the sole purpose of adding or correcting QDCs. If a denied claim is subsequently corrected through the appeals process to the Carrier or A/B MAC, with accurate codes that also correspond to the measure's denominator, then QDCs that correspond to the numerator should also be included on the resubmitted claim as instructed in the measure specifications.

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

The RA/EOB denial code N365 is your indication that the PQRS codes are valid for the 2014 PQRS reporting year.

- The N365 denial code is just an indicator that the QDC codes are valid for 2014 PQRS. It does not guarantee the QDC was correct or that reporting thresholds were met. However, when a QDC is reported satisfactorily (by the individual EP), the N365 can indicate that the claim will be used in calculating incentive eligibility.
  - Important: In an effort to streamline reporting of QDCs across multiple CMS quality reporting programs, CMS strongly encourages all EPs and practices to begin billing 2014 QDCs with a $0.01 charge. EPs should pursue updating their billing software to accept the $0.01 charge prior to implementing 2014 PQRS. EPs and practices will need to work with their billing software or EHR vendor to ensure this capability is activated.
  - Please Note: Effective on 4/1/2014, EPs who bill on a $0.00 QDC line item will receive the N620 code. It replaces the current N365, which will be deactivated effective 7/1/2014. EPs who bill on a $0.01 QDC line item will receive the CO 246 N572 code.
  - All submitted QDCs on fully processed claims are forwarded to the CMS warehouse for analysis by the CMS quality reporting program, so providers will first want to be sure they do see the QDC's line item on the RA/EOB, regardless of whether the new RA (N620) code appears.

- Keep track of all cases reported so that you can verify QDCs reported against the remittance advice notice sent by the Carrier or A/B MAC. Each QDC line-item will be listed with the N365 denial remark code.

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

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

- EPs who bill with $0.00 charge on a QDC line item will see N620 instead of N365.
- EPs will receive code N620 on the claim EOB form beginning 4/1/2014.
- N620 reads: *This procedure code is for quality reporting/informational purposes only.*
- EPs who bill with a $0.00 charge on a QDC line item will receive an N620 code on the EOB and may or may not receive any Group Code or CARC.

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

The new CARC 246 with Group Code CO or PR and with RARC N572 indicates that this procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.

- In addition to N572, the remittance advice will show Claim Adjustment Reason Code (CARC) CO or PR 246 (This non-payable code is for required reporting only).
- CARC 246 reads: *This non-payable code is for required reporting only.*
- EPs who bill with a charge of $0.01 on a QDC item will receive CO 246 N572 on the EOB.

Submission through Carriers or A/B MACs

QDCs shall be submitted to Carriers or A/B MACs either through:

- Electronic-based Submission:
  PQRS QDCs are submitted on the claim just like any other code; however, QDCs will have a $0.00 (or nominal) charge. Electronic submission, which is accomplished using the ASC X 12N Health Care Claim Transaction (Version 5010), should follow the current HIPAA standard version of the ASC x12 technical report 3.

OR

- Paper-based Submission
  Paper-based submissions are accomplished using the CMS-1500 claim form as described in the sample claims provided in Appendix E.

Group NPI Submission

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

Solo NPI Submission

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

CMS-1500 Claim Example

There are two examples of a claim in CMS-1500 format that illustrates how to report several PQRS measures is provided. See Appendix E for the current CMS-1500 claim form (version 08/05) effective through 03/31/2014 and the new updated CMS-1500 claim form (version 02/12) beginning 04/01/2014.

Timeliness of Quality Data Submission

Claims processed by the Carrier or A/B MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 27, 2015 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

Appendix A: Glossary of Terms

Terms	Definitions
Base Claim Diagnosis	PQRS refers to all diagnoses listed (Item 21 of the CMS-1500 claim form) associated with physician office, outpatient, and inpatient visits for reporting.
CMS-Certified Survey Vendor	A CMS-certified survey vendor is a new reporting mechanism for purposes of reporting CG CAHPS summary survey modules for group practices reporting via GPRO. The CMS-certified survey vendor is required to be certified for a particular program year by CMS in order to submit the CG CAHPS summary survey modules data.
Claim	For PQRS purposes, one or more claims will be reconnected based on TIN, NPI, beneficiary and date of service.
Claim Adjustment Reason Code (CARC)	Claim adjustment reason codes (CARC) communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.
CPT Category II Codes	A set of supplemental CPT codes intended to be used for performance measurement. These codes may be used to facilitate data collection about the quality of care rendered by coding certain services, test results or clinical actions that support nationally established performance measures and that the evidence has demonstrated to contribute to quality patient care.[2] For PQRS, CPT Category II codes are used to report quality measures on a claim for measurement calculation.
Denominator (Eligible Cases)	The lower part of a fraction used to calculate a rate, proportion, or ratio. The denominator is associated with a given patient population that may be counted as eligible to meet a measure's inclusion requirements. PQRS measure denominators are identified by ICD-9-CM (01/01/2014-09/30/2014), ICD-10-CM (10/01/2014-12/31/2014), CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc.), and place of service (if applicable). Note: ICD-10-CM diagnosis codes have been incorporated into the *2014 PQRS Measures Specifications*. These codes will become effective on 10/01/2014 and count towards satisfactorily reporting the measures within PQRS in the 2014 program year.
Denominator Statement	A statement that describes the population eligible for the performance measure. For example, "Patients aged 18 through 75 years with a diagnosis of diabetes."
Diagnosis Pointer	Item 24E of the CMS-1500 claim form or electronic equivalent. For PQRS, the line item containing the quality-data code (QDC) for the measure should point to one diagnosis (from Item 21) per measure-specific denominator coding. To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses are considered in PQRS analysis.
Electronic Health Record (EHR)	The Electronic Health Record (EHR) is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter - as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.

Terms	Definitions
Eligible Professional (EP)	Refer to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS for a list of professionals eligible to report in 2014 PQRS. Providers not defined as eligible professionals in the Tax Relief and Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to report in PQRS and do not qualify for an incentive. Services payable under fee schedules or methodologies other than the Medicare Physician Fee Schedule (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, rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for PQRS since DME is not paid under the PFS.
Encounter	Encounters with patients during the reporting period which include: CPT Category I E/M service codes, CPT Category I procedure codes, or HCPCS codes found in a PQRS measure's denominator. These codes count as eligible to meet a measure's inclusion requirements when occurring during the reporting period.
G-codes for PQRS	A set of CMS-defined temporary HCPCS codes used to report quality measures on a claim. G-codes are maintained by CMS.
Group Practice Reporting Option (GPRO)	The Group Practice Reporting Option (GPRO) was introduced in 2010 as a reporting method for group practices to qualify to earn a PQRS incentive. PQRS defines a group practice as a single Tax Identification Number (TIN) with 2 or more individual eligible professionals (as identified by Individual National Provider Identifier [NPI]) that have reassigned their billing rights to the TIN.
ICD-9-CM Diagnosis Codes	The International Classification of Diseases, 9th Revision, Clinical Modification[5] is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office visits for reporting in PQRS.
ICD-10-CM Diagnosis Codes	ICD-10-CM is a clinical modification of the World Health Organization's ICD-10, which consist of a diagnostics classification system. ICD-10-CM includes the level of detail needed for morbidity classification and diagnostics specificity in the United States.[9] ICD-10-CM diagnosis codes have been incorporated into the *2014 PQRS Measures Specifications*. These codes will become effective on 10/01/2014 and will count towards satisfactorily reporting the measures within PQRS in the 2014 program year.
Line-Item Diagnosis	Six service lines in Section 24 of the CMS-1500 claim form to accommodate submission of the rendering NPI and supplemental information to support the billed service, including the pointed diagnosis from Item 21. QDCs are submitted on the line item in section 24 for PQRS.
Measure	Performance Measure • A quantitative tool (e.g., rate, ratio, index, percentage) that provides an indication of performance in relation to a specified process or outcome. • See also process measure and outcome measure.[1,6] Measure Types • Process measure: A measure which focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome. [6] • Outcome measure: A measure that indicates the result of the performance (or non-performance) of a function(s) or process (es).[6] • Structure measure: A measure that assesses whether organizational resources and arrangements are in place to deliver health care, such as the number, type, and distribution of medical personnel, equipment, and facilities.[6]

Terms	Definitions
Measure Reporting Frequency (also referred to as Measure Tag)	• Patient-Process: Report a minimum of once per reporting period per individual eligible professional (NPI). o If the measure is reported more than once during the reporting period, performance rates are calculated using the most advantageous QDC submitted. o Reflect quality actions performed throughout the reporting period or other timeframe. • Patient-Intermediate: Report a minimum of once per reporting period per individual eligible professional (NPI). o If the measure is reported more than once during the reporting period, performance rates are calculated using the most recent QDC submitted. o Often reflects lab or other test value, so the most recent measurement is desired. • Patient-Periodic: Report once per timeframe specified in the measure for each individual eligible professional (NPI) during the reporting period. o Examples include once per month and three times per year. • Episode: Report once for each occurrence of a particular illness/condition by each individual eligible professional (NPI) during the reporting period. o Usually reflects a clinical episode, difficult to determine from a single Part B claim. o Requires specialized analytics to determine the episode. • Procedure: Report each time a procedure is performed by the individual eligible professional (NPI) during the reporting period. • Visit: Report each time the patient is seen by the individual eligible professional (NPI) during the reporting period.
MIPPA	Medicare Improvements for Patients and Providers Act of 2008.
MMSEA	Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007.
NPI	National Provider Identifier of the individual eligible professional billing under the Tax ID ("NPI within the Tax ID").
Numerator	The upper portion of a fraction used to calculate a rate, proportion, or ratio. A clinical action to be counted as meeting a measure's requirements (i.e., patients that received the particular service or obtained a particular outcome that is being measured). [6] PQRS measure numerators are CPT Category II codes and G-codes.
Numerator Statement	A statement that describes the clinical action that satisfies the conditions of the performance measure. For example, "Patients that were assessed for the presence or absence of urinary incontinence."
Performance Timeframe	A designated timeframe within which the action described in a performance measure should be completed. This timeframe is generally included in the measure description and may or may not coincide with the measure's data reporting frequency requirement.
Performance Measure Exclusion Modifiers	Modifiers developed exclusively for use with CPT Category II codes to indicate documented medical (1P), patient (2P), or system (3P) reasons for excluding patients from a measure's denominator.[2]
Performance Measure Reporting Modifier 8P	The 8P reporting modifier is intended to be used as a "reporting modifier" to allow the reporting of circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified. 8P performance measure reporting modifier - action not performed, reason not otherwise specified [2]

Terms	Definitions
Place of Service	References Place of Service Codes (POS) from the list provided in section 10.5 of the *Medicare Claims Processing Manual*.
Qualified Clinical Data Registry (QCDR)	A CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients.
Quality-Data Code (QDC)	Specified CPT Category II codes with or without modifiers and G-codes used for submission of PQRS data via claims-based or registry reporting methods. The *2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry* contains all codes associated with each PQRS measure and instructions for data submission through the administrative claims system.
Qualified Registry	An entity that collects clinical data from an eligible professional or group practice and submits it to CMS on behalf of the eligible professional or group practice.
Rationale	A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results.[4]
Remittance Advice (RA)	Means utilized by Medicare contractors to communicate to providers, submitting measures through the claims-based reporting method, of processing decisions such as payments, adjustments, and denials.[7]
Remittance Advice Remark Codes (RARC)	Remittance Advice Remark Codes (RARCs) are used to provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC) or to convey information about remittance processing. Each RARC identifies a specific message as shown in the Remittance Advice Remark Code List. There are two types of RARCs, supplemental and informational. The majority of the RARCs are supplemental; these are generally referred to as RARCs without further distinction. Supplemental RARCs provide additional explanation for an adjustment already described by a CARC. The second type of RARC is informational; these RARCs are all prefaced with Alert: and are often referred to as Alerts. Alerts are used to convey information about remittance processing and are never related to a specific adjustment or CARC.
Reporting Frequency	The number of times quality-data codes (QDCs) specified for a quality measure must be submitted on claims during the reporting period. The reporting frequency for each measure is described in the *2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry* posted on the CMS Web site at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.
Reporting Options	2014 reporting methods available for incentive payment: claims-based; registry-based; electronic health record (EHR); participation via qualified clinical data registry; or group practice reporting option (GPRO). Refer to the "2014 PQRS Participation Decision Tree (Appendix B)".
Reporting Period	The period during which PQRS measures are to be reported for covered professional services provided. 6-month (July 1, 2014 through December 31, 2014) or 12-month (January 1, 2014 through December 31, 2014) time periods are available depending upon the 2014 reporting option the eligible professional selects for submitting PQRS quality data.
TRHCA	Tax Relief and Health Care Act of 2006.

Sources:

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

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

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

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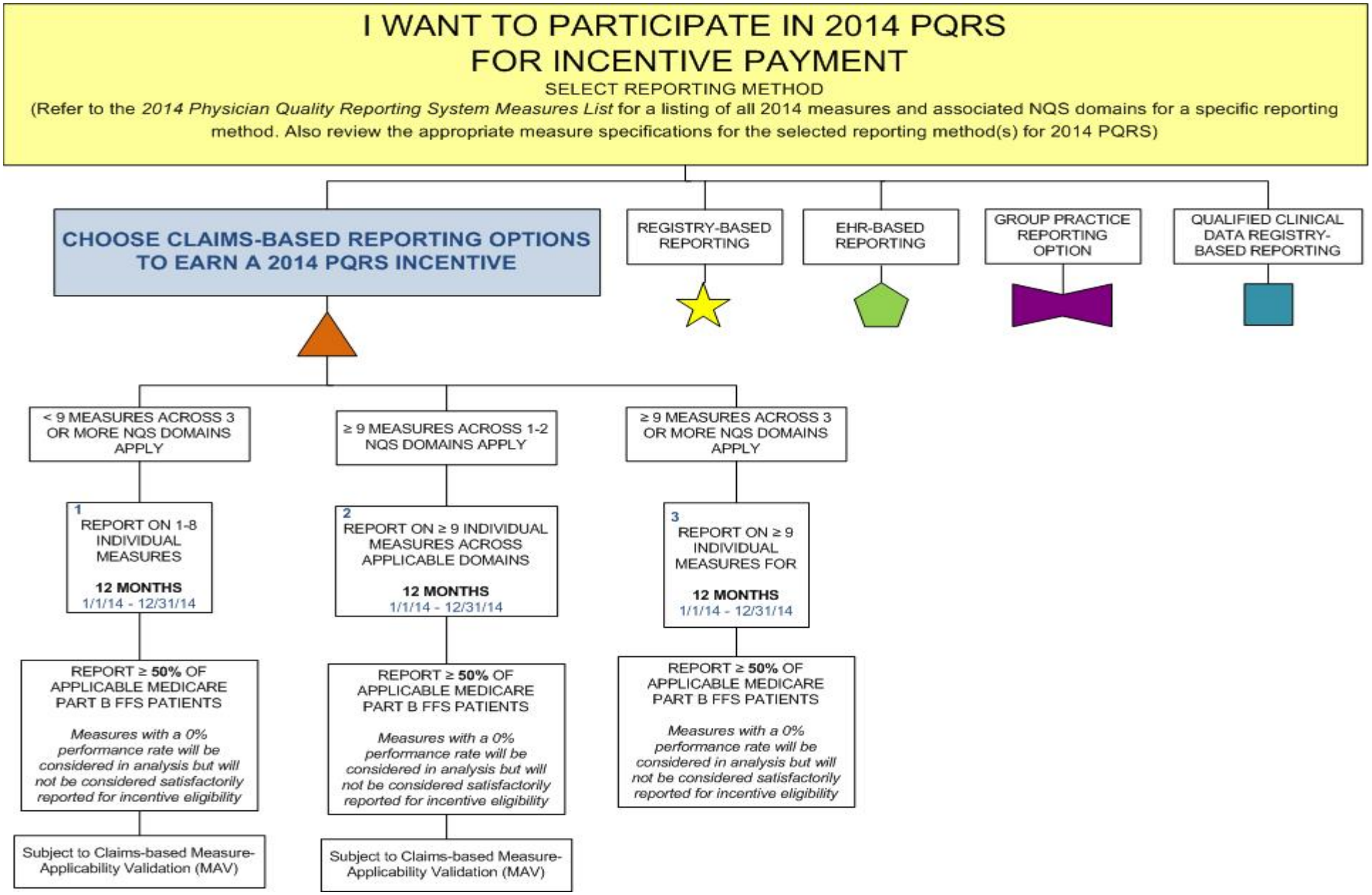
7. QualityNet, QMIS Specification Manual for National Hospital Quality Measures, Appendix D-3, Glossary of Terms version 2.3b, 9-28-2007

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

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

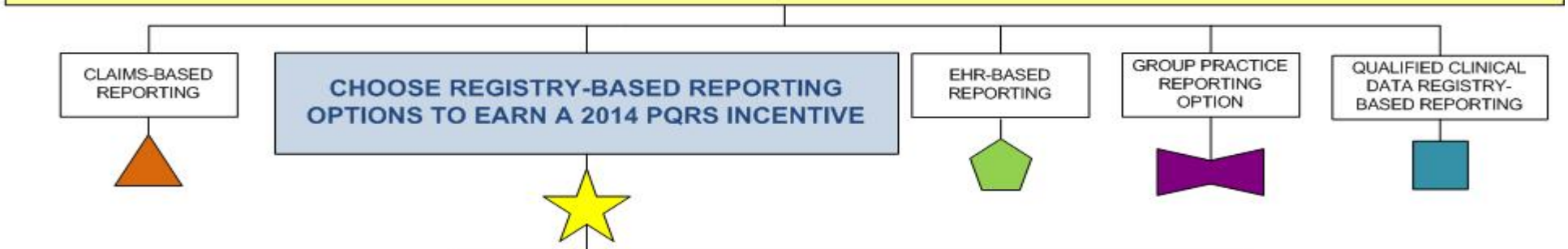
10. American Health Information Management Association (AHIMA), Understanding ICD-10, retrieved from official AHIMA website



I WANT TO PARTICIPATE IN 2014 PQRS FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

(Refer to the *2014 Physician Quality Reporting System Measures List* for a listing of all 2014 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) for 2014 PQRS)



INDIVIDUAL MEASURES

MEASURES GROUP(S)

< 9 MEASURES ACROSS 3 OR MORE NQS DOMAINS APPLY

4 REPORT ON 1-8 INDIVIDUAL MEASURES

12 MONTHS
1/1/14 - 12/31/14

REPORT ≥ **50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS

Measures with a 0% performance rate will not be counted

Subject to Registry-based Measure-Applicability Validation (MAV)

≥ 9 MEASURES ACROSS 1-2 NQS DOMAINS APPLY

5 REPORT ON ≥ 9 INDIVIDUAL MEASURES ACROSS APPLICABLE DOMAINS

12 MONTHS
1/1/14 - 12/31/14

REPORT ≥ **50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS

Measures with a 0% performance rate will not be counted

Subject to Registry-based Measure-Applicability Validation (MAV)

≥ 9 MEASURES ACROSS 3 OR MORE NQS DOMAINS APPLY

6 REPORT ON ≥ 9 INDIVIDUAL MEASURES ACROSS 3 NQS DOMAINS FOR

12 MONTHS
1/1/14 - 12/31/14

REPORT ≥ **50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS

Measures with a 0% performance rate will not be counted

SUBMIT ≥ 1 MEASURES GROUP FOR

12 MONTHS
1/1/14 – 12/31/14

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

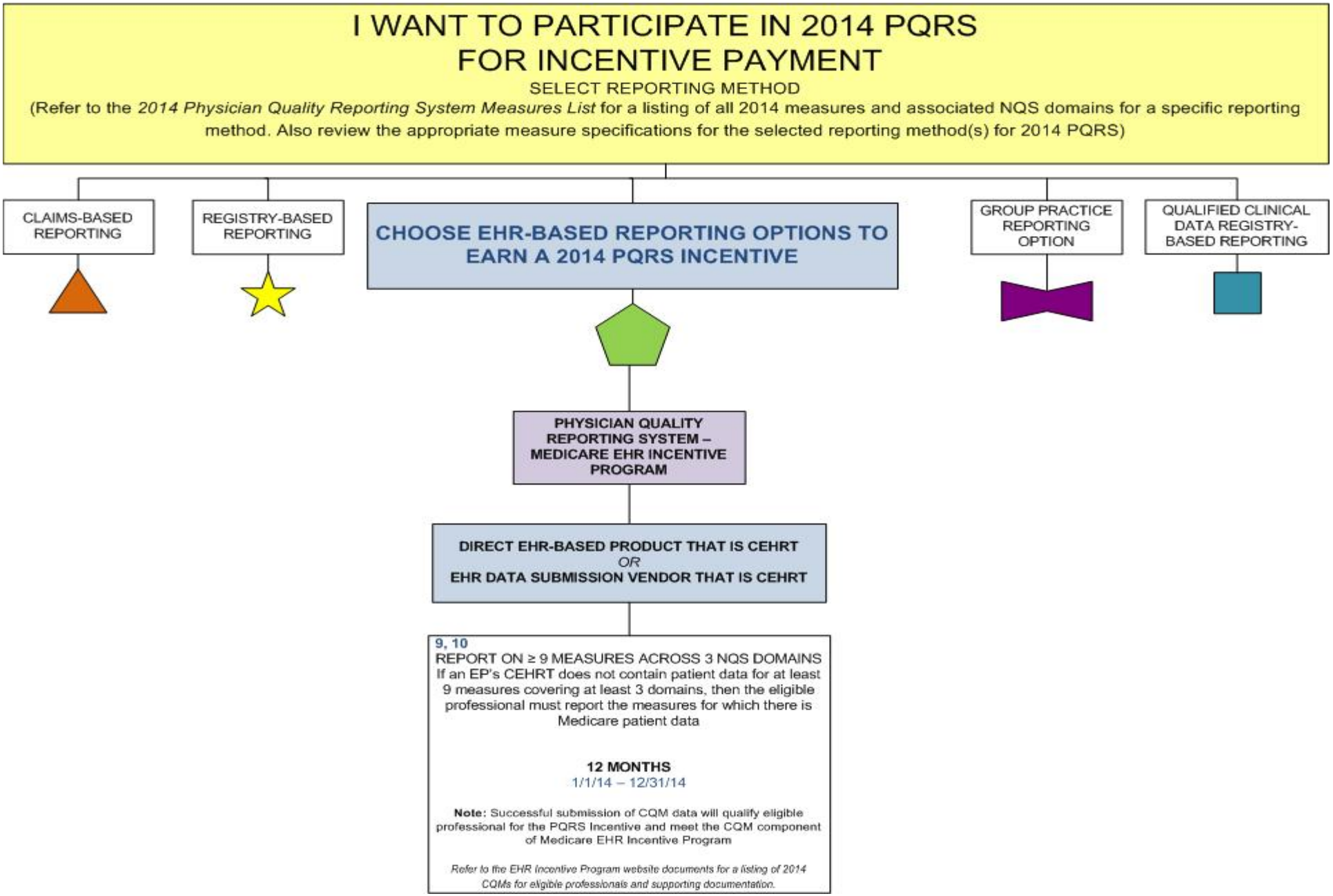
Measures Groups containing a measure with a 0% performance rate will not be counted

SUBMIT ≥ 1 MEASURES GROUP FOR

6 MONTHS
7/1/14 – 12/31/14

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

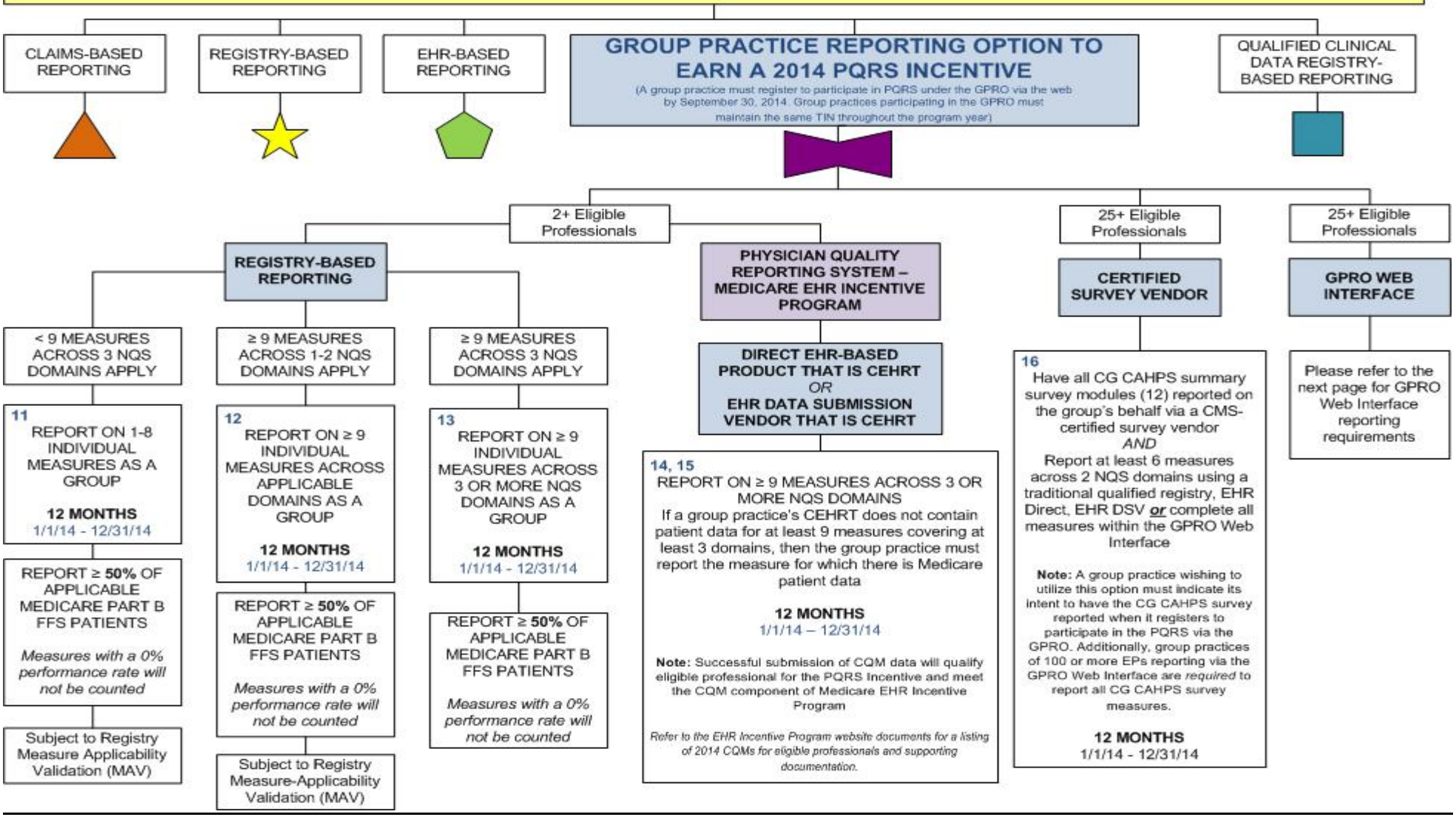
Measures Groups containing a measure with a 0% performance rate will not be counted



I WANT TO PARTICIPATE IN 2014 PQRS FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

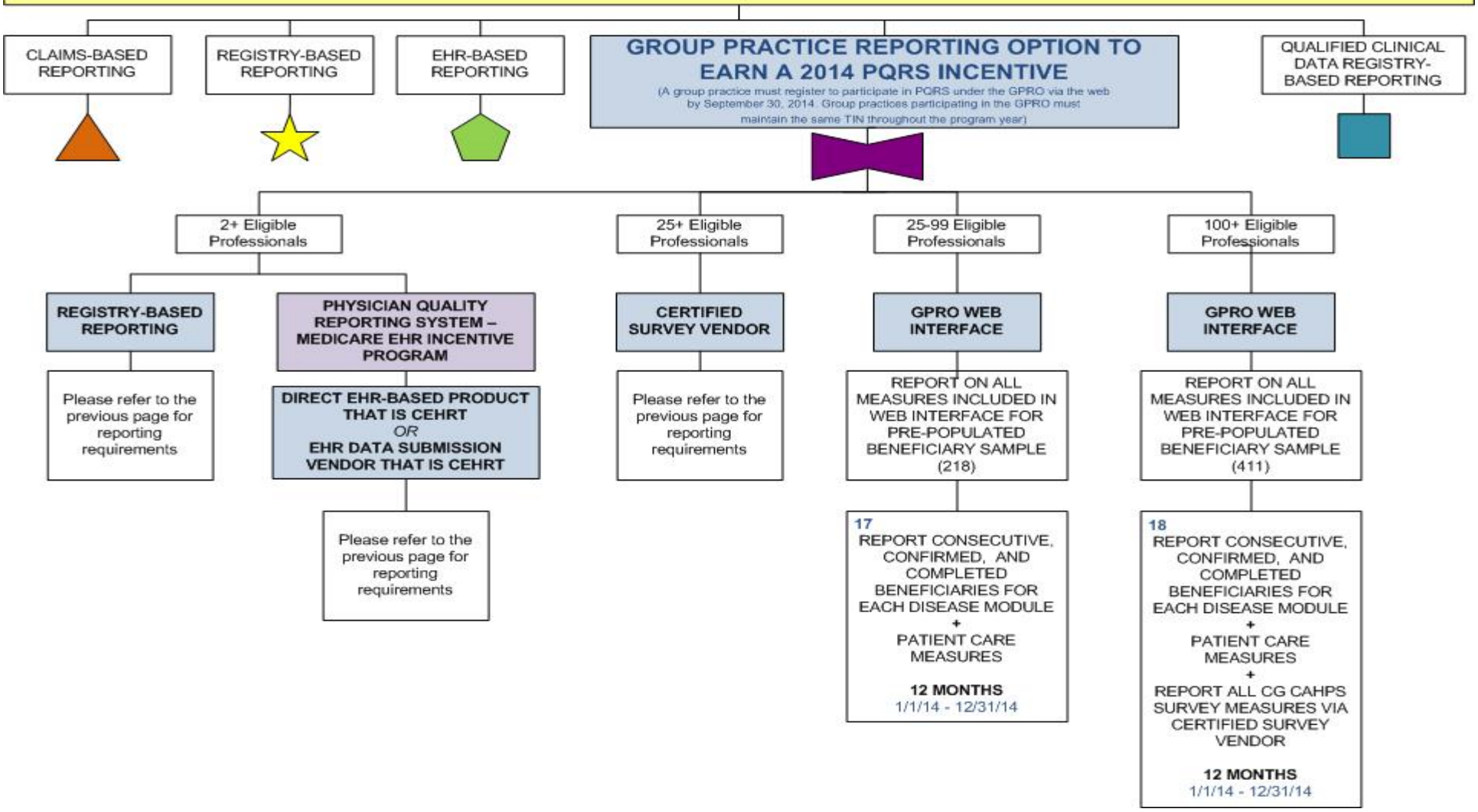
(Refer to the *2014 Physician Quality Reporting System Measures List* for a listing of all 2014 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) for 2014 PQRS)

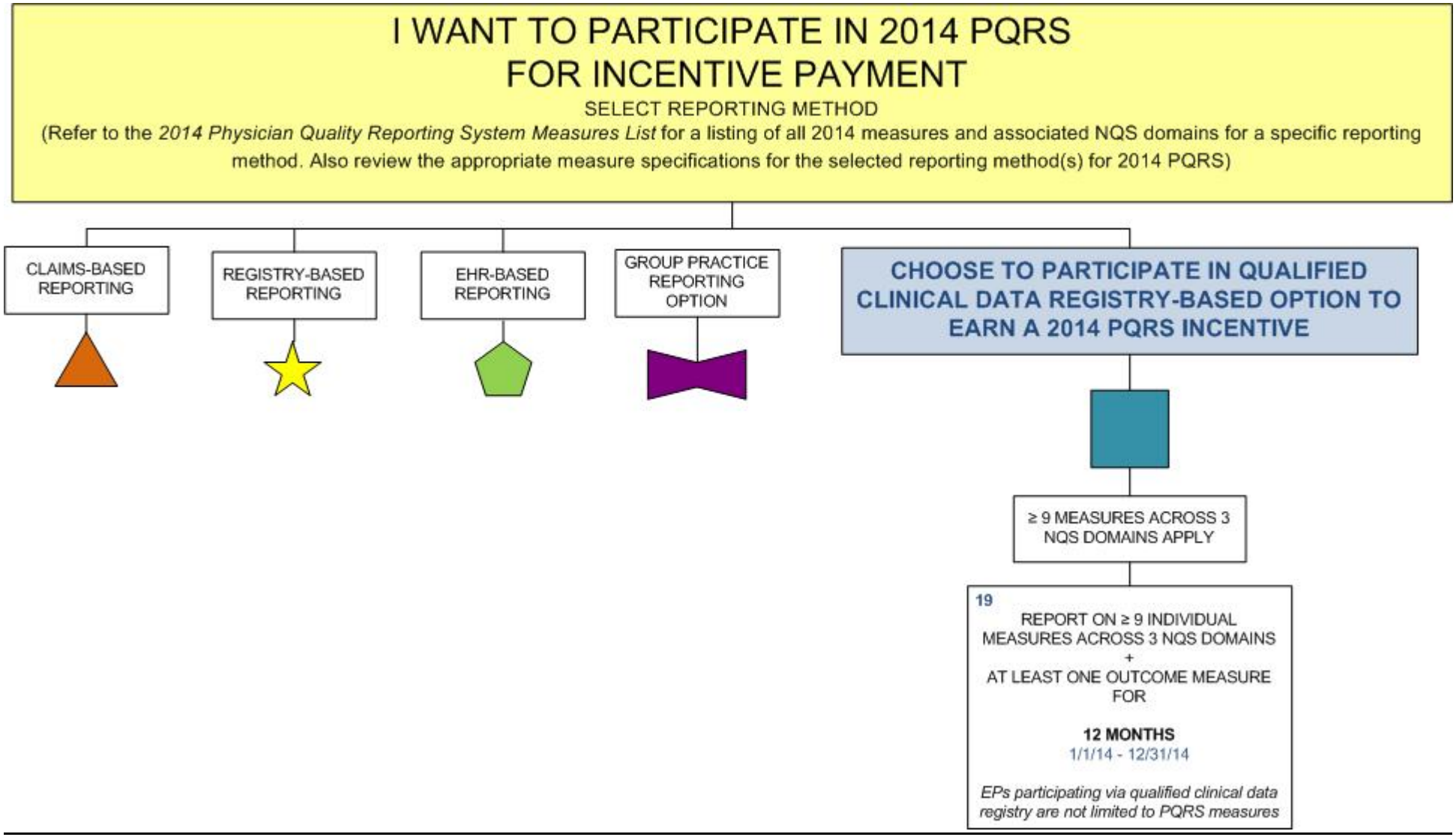


I WANT TO PARTICIPATE IN 2014 PQRS FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

(Refer to the *2014 Physician Quality Reporting System Measures List* for a listing of all 2014 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) for 2014 PQRS)

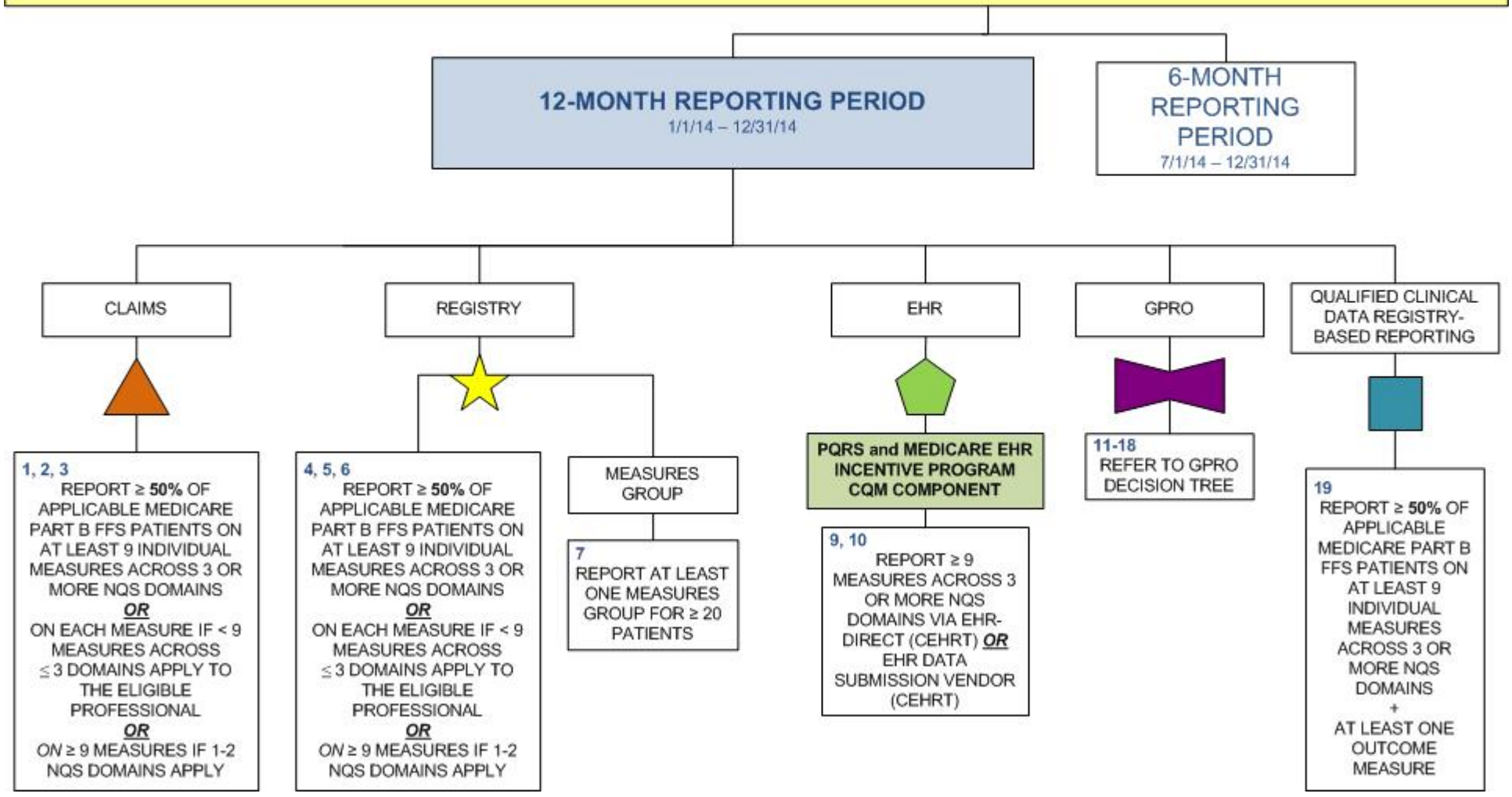




I WANT TO PARTICIPATE IN 2014 PQRS FOR INCENTIVE PAYMENT

SELECT REPORTING PERIOD

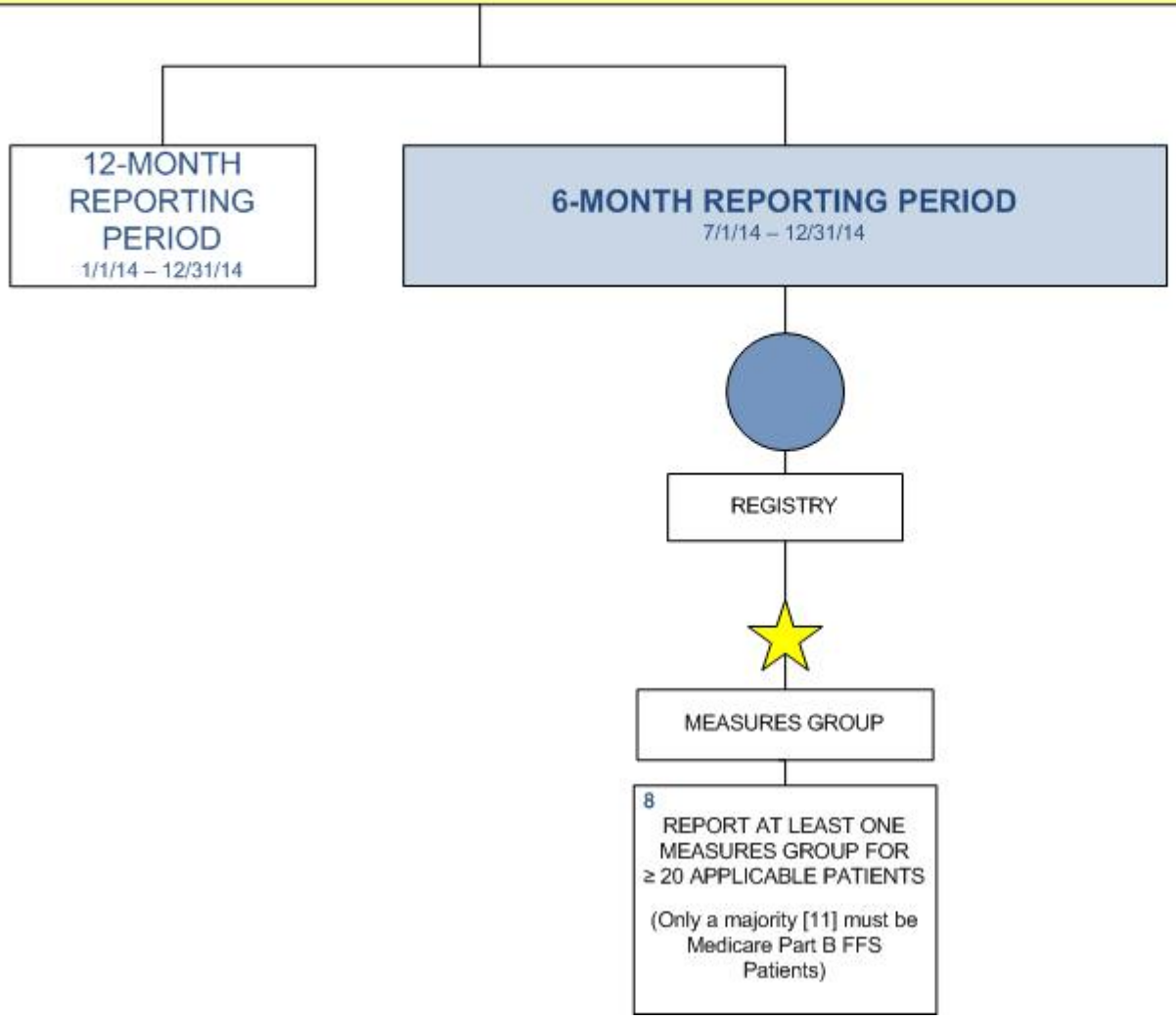
(Refer to the *2014 Physician Quality Reporting System Measures List* for a listing of all 2014 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) for 2014 PQRS)



I WANT TO PARTICIPATE IN 2014 PQRS FOR INCENTIVE PAYMENT

SELECT REPORTING PERIOD

(Refer to the *2014 Physician Quality Reporting System Measures List* for a listing of all 2014 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) for 2014 PQRS.)



2014 Program Reporting Options

Number assigned coordinates with appropriate box on the Appendix B: 2014 PQRS Participation for Incentive Payment Decision Tree.

1. Claims-based reporting of less than 9 individual measures across 3 or more NQS domains for 50% or more of an EP's applicable Medicare Part B FFS patients (12 months)
   Note: This reporting option is subject to Claims Measure-Applicability Validation (MAV)

2. Claims-based reporting of at least 9 individual measures across 1-2 NQS domains for 50% or more of an EP's applicable Medicare Part B FFS patients (12 months)
   Note: This reporting option is subject to Claims Measure-Applicability Validation (MAV)

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

4. Qualified registry-based reporting of less than 9 individual measures across 3 or more NQS domains for 50% or more of an EP's applicable Medicare Part B FFS patients (12 months)
   Note: This reporting option is subject to Registry Measure-Applicability Validation (MAV)

5. Qualified registry-based reporting of at least 9 individual measures across at 1-2 NQS domains for 50% or more of an EP's applicable Medicare Part B FFS patients (12 months)
   Note: This reporting option is subject to Registry Measure-Applicability Validation (MAV)

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

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

8. Qualified registry-based reporting of at least one measures group for 20 or more patients, the majority (11) of which must be Medicare Part B FFS patients (6 months)

9. Direct CEHRT EHR-based reporting of at least 9 individual measures across at least 3 NQS domains (12 months)

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

11. GPRO-based reporting (2+ eligible professionals) of 1-8 individual measures across 3 NQS domains via registry for 50% or more of a group's applicable Medicare Part B FFS patients
    Note: This reporting option is subject to Registry Measure-Applicability Validation (MAV)

12. GPRO-based reporting (2+ eligible professionals) of at least 9 individual measures across 1-2 NQS domains via registry for 50% or more of the group's applicable Medicare Part B FFS patients (12 months)
    Note: *This reporting option is subject to Registry Measure-Applicability Validation (MAV)*

13. GPRO-based reporting (2+ eligible professionals) of at least 9 individual measures across at least 3 NQS domains via registry for 50% or more of the group's applicable Medicare Part B FFS patients (12 months)

14. GPRO-based reporting (2+ eligible professionals) of at least 9 individual measures across at least 3 NQS domains via Direct CEHRT EHR-based reporting (12 months)

15. GPRO-based reporting (2+ eligible professionals) of at least 9 individual measures across at least 3 NQS domains via EHR Data Submission Vendor that is CEHRT (12 months)

16. A group practice taking part in GPRO (25 or more eligible professionals) may have all CG CAHPS summary survey modules reported on its behalf via a CMS-certified survey vendor AND report at least 6 measures across at least 2 NQS domains using a qualified registry, EHR Direct, EHR DSV, or complete all measures within the GPRO Web Interface (12 months)

17. GPRO-based reporting (25-99 eligible professionals) of all applicable measures included in the submission Web Interface provided by CMS for consecutive, confirmed, and completed patients for each disease module and preventive care measures (12 months)

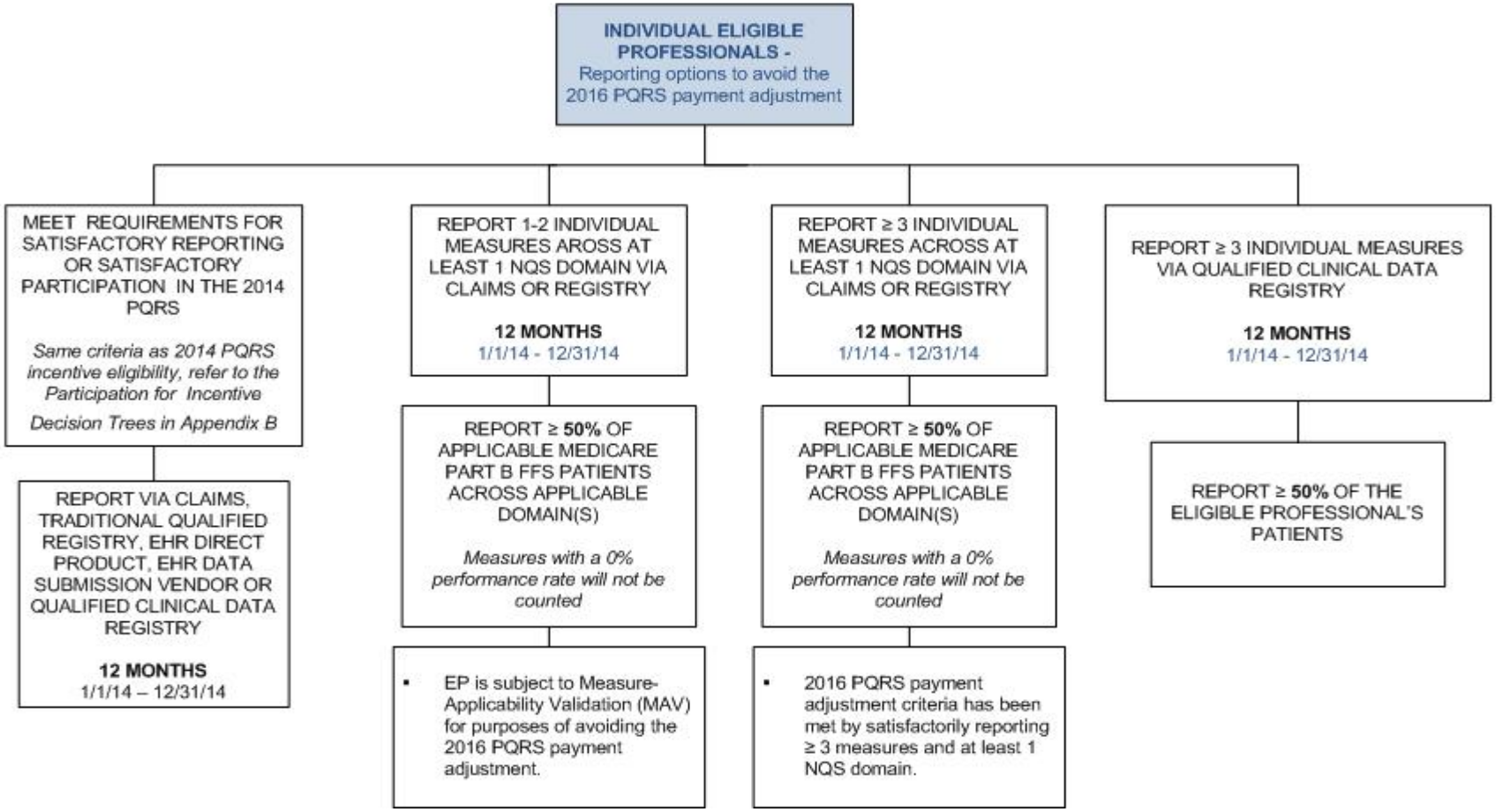
18. GPRO-based reporting (100+ eligible professionals) of all applicable measures included in the submission Web Interface provided by CMS for consecutive, confirmed, and completed patients for each disease module and preventive care measures AND report all CG CAHPS summary survey modules via CMS-certified survey vendor (12 months)

19. Qualified clinical data registry-based reporting of at least 9 measures across at least 3 NQS domains AND report at least 1 outcome measure for 50% or more of an EP's applicable Medicare Part B FFS patients (12 months)

I WANT TO PARTICIPATE IN 2014 PQRS TO AVOID THE 2016 PQRS PAYMENT ADJUSTMENT

SELECT REPORTING METHOD

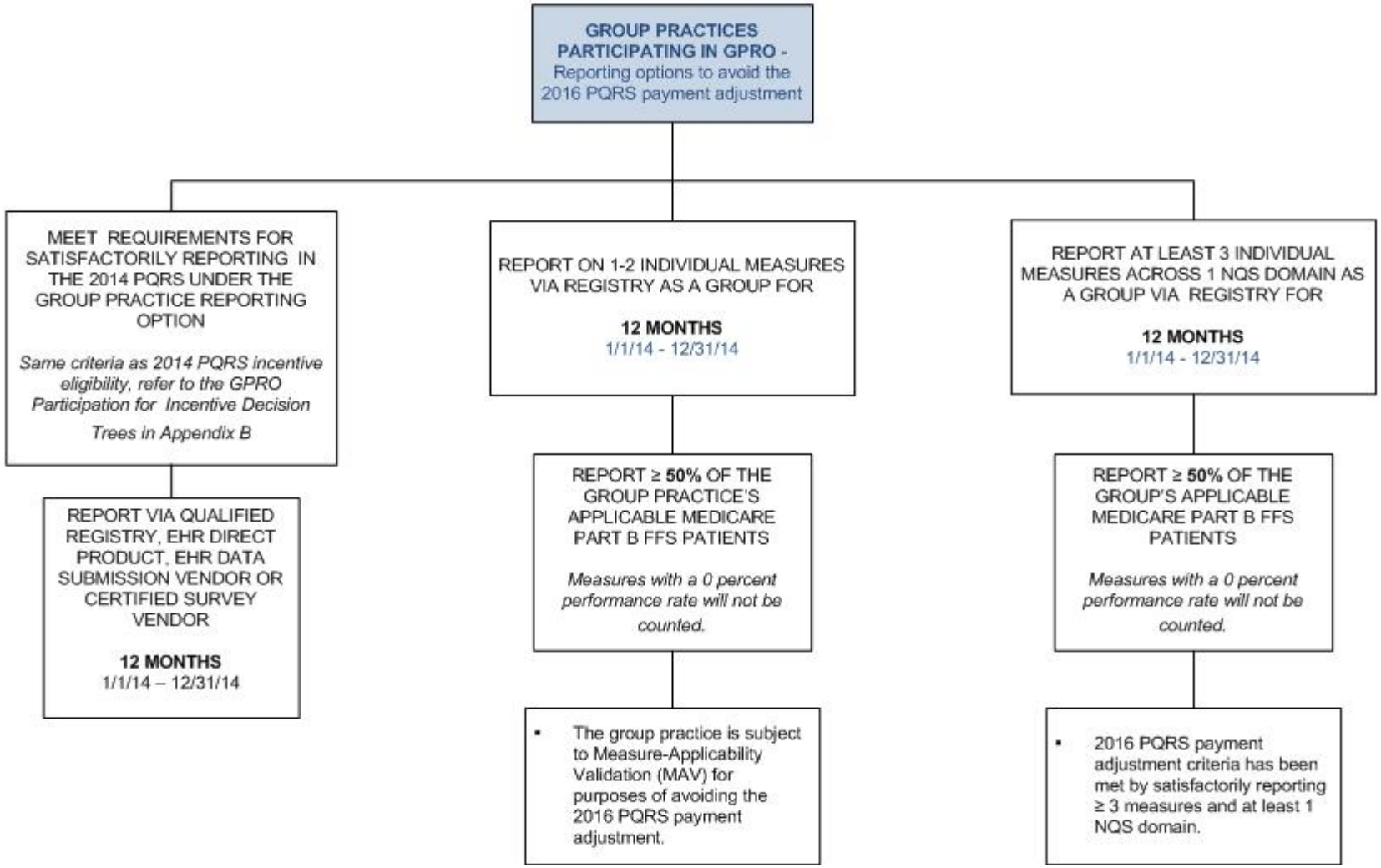
(Refer to the *2014 Physician Quality Reporting System Measures List* for a listing of all 2014 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) for 2014 PQRS)



I WANT TO PARTICIPATE IN 2014 PQRS TO AVOID THE 2016 PQRS PAYMENT ADJUSTMENT

SELECT REPORTING METHOD

(Refer to the *2014 Physician Quality Reporting System Measures List* for a listing of all 2014 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) for 2014 PQRS)



I WANT TO PARTICIPATE IN 2014 PQRS TO AVOID THE 2016 PQRS PAYMENT ADJUSTMENT

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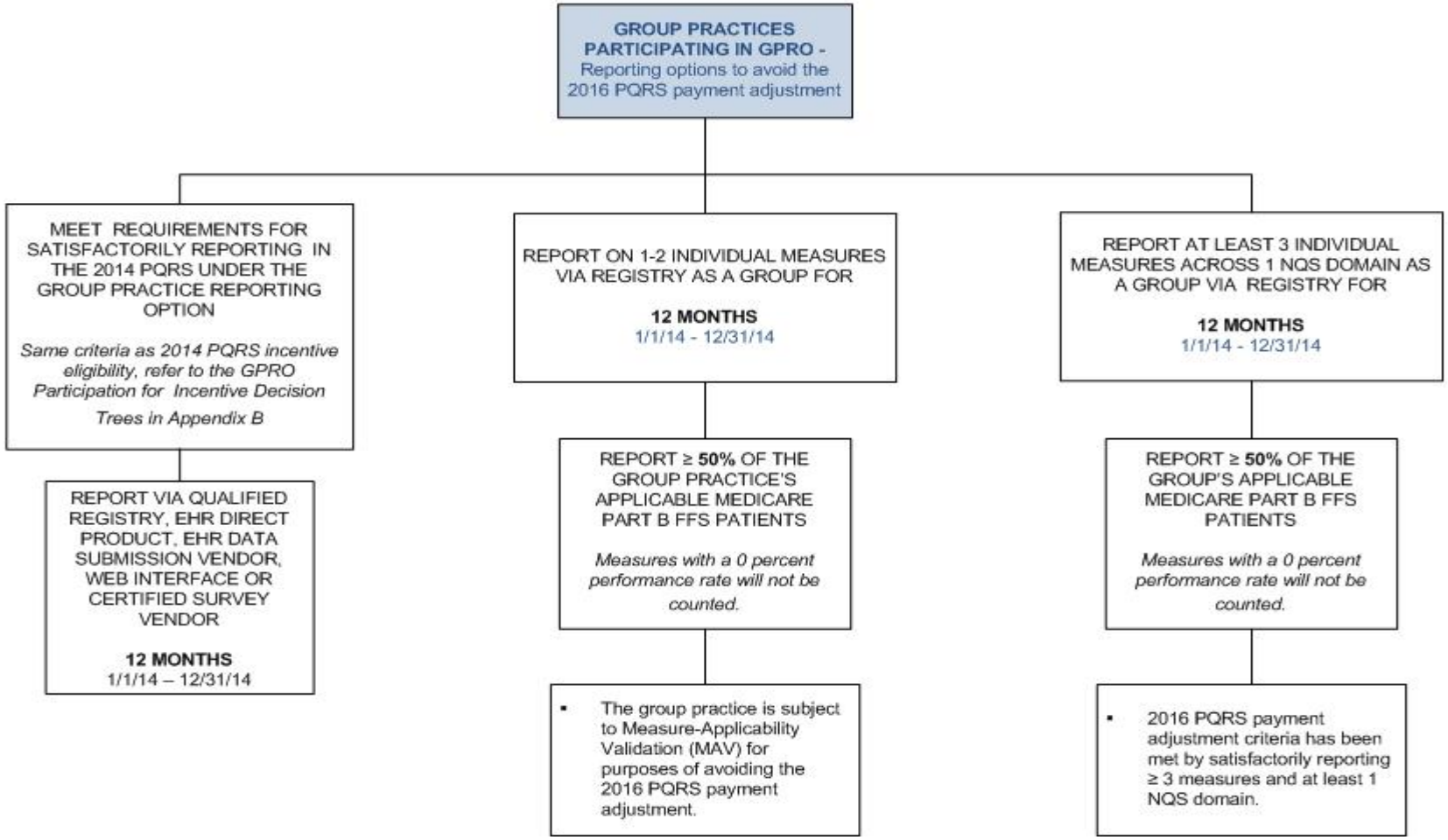


Satisfactorily Reporting Scenario

Measure #6: Coronary Artery Disease (CAD): Antiplatelet Therapy

Mr. Jones, age 65, presents for office visit (**99213**) with Dr. Thomas

Mr. Jones, has diagnosis of CAD (414.00)

Scenario 1

Dr. Thomas prescribes aspirin or clopidogrel

4086F

Scenario 2

Dr. Thomas does not prescribe aspirin or clopidogrel for Medical, Patient or System Reasons

4086F with 1P
4086F with 2P
4086F with 3P

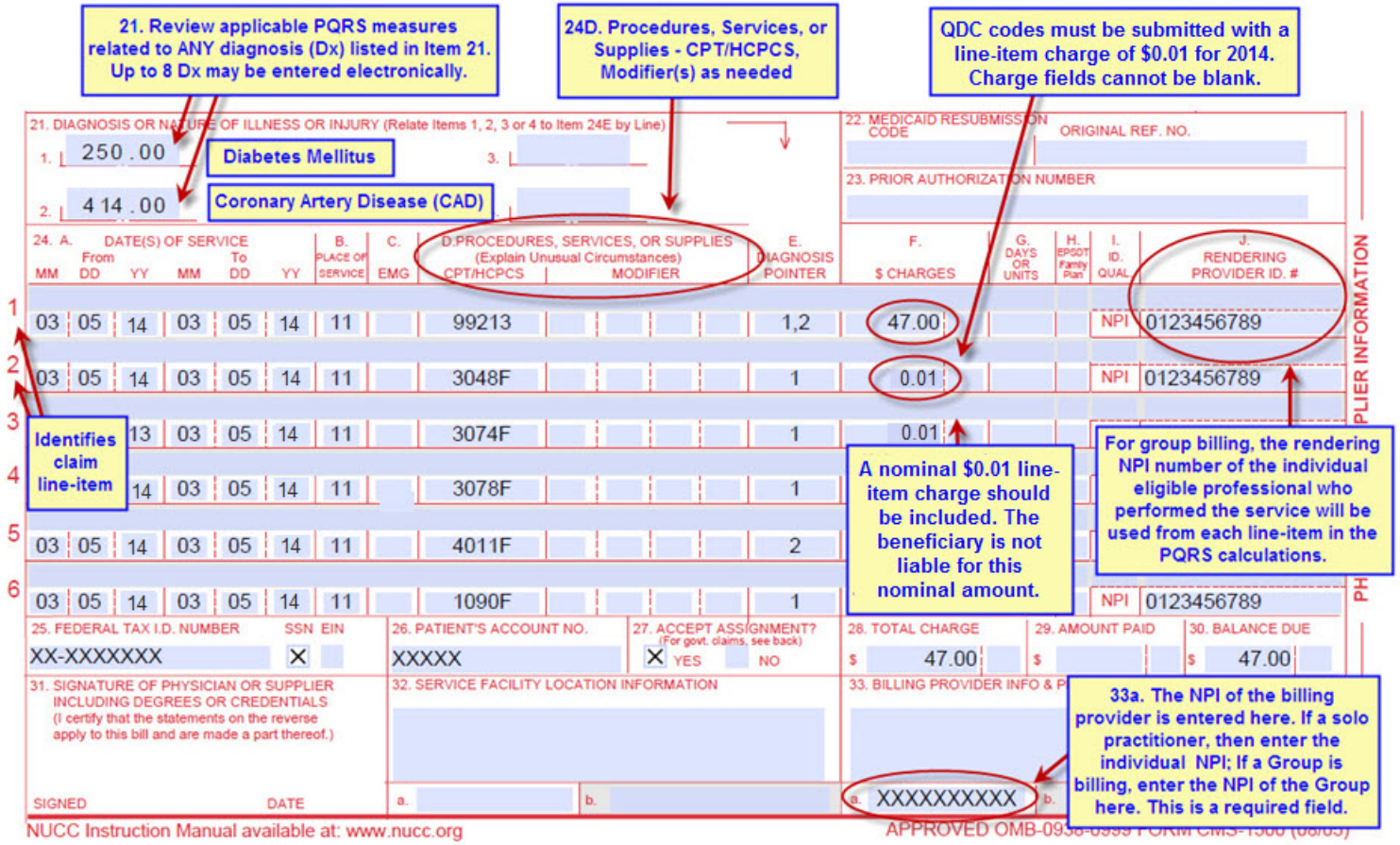
Scenario 3

Dr. Thomas does not prescribe aspirin or clopidogrel and does not specify the reason

4086F with 8P

Appendix E
CMS-1500 Claim PQRS Example (Through 03/31/2013)

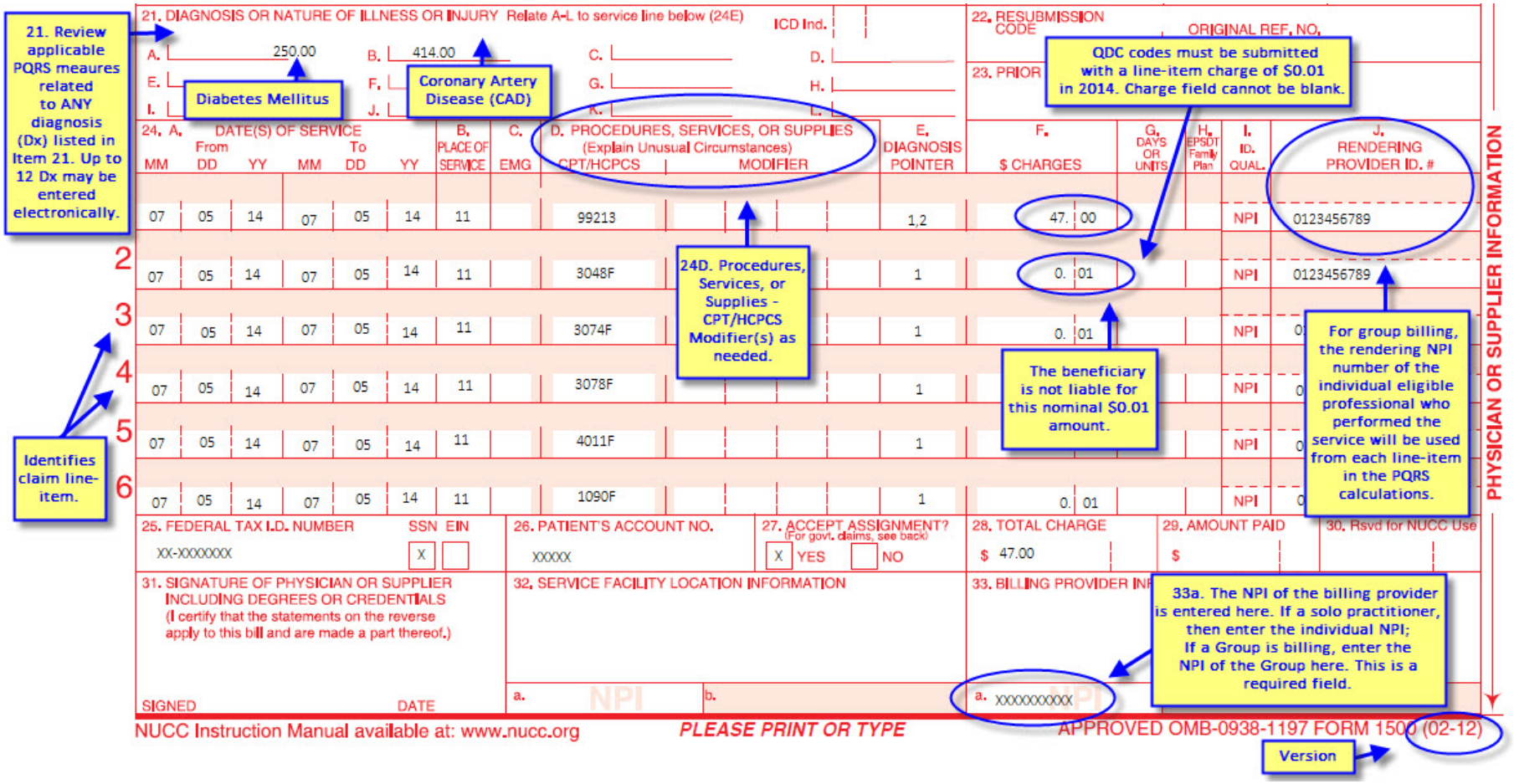
Examples of an individual NPI reporting on a single CMS-1500 claim. See http://www.cms.gov/manuals/downloads/clm104c26.pdf for more information.



The patient was seen for an office visit (**99213**). The provider is reporting several measures related to diabetes, coronary artery disease (CAD), and urinary incontinence:

- Measure #2 (LDL-C) with QDC 3048F + diabetes line-item diagnosis (24E points to DX 250.00 in Item 21);
- Measure #3 (BP in Diabetes) with QDCs 3074F + 3078F + diabetes line-item diagnosis (24E points to Dx 250.00 in Item 21);
- Measure #6 (CAD) with QDC 4011F + CAD line-item diagnosis (24E points to Dx 414.00 in Item 21); and
- Measure #48 (Assessment - Urinary Incontinence) with QDC 1090F. For PQRS, there is no specific diagnosis associated with this measure. Point to the appropriate diagnosis for the encounter.
- Note: All diagnoses listed in Item 21 will be used for PQRS analysis. Measures that require the reporting of two or more diagnoses on claim will be analyzed as submitted in Item 21.
- NPI placement: Item 24J must contain the NPI of the individual provider that rendered the service when a group is billing.
- If billing software limits the line items on a claim, you may add a nominal line-item charge of a penny to one of the QDC line items on that second claim. PQRS analysis will subsequently join both claims based on the same beneficiary, for the same date-of-service, for the same TIN/NPI and analyze as one claim.

New CMS-1500 Claim PQRS Example (Effective 04/01/2014)



The patient was seen for an office visit (**99213**). The provider is reporting several measures related to diabetes, coronary artery disease (CAD), and urinary incontinence:

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- Measure #6 (CAD) with QDC 4011F + CAD line-item diagnosis (24E points to Dx 414.00 in Item 21); and
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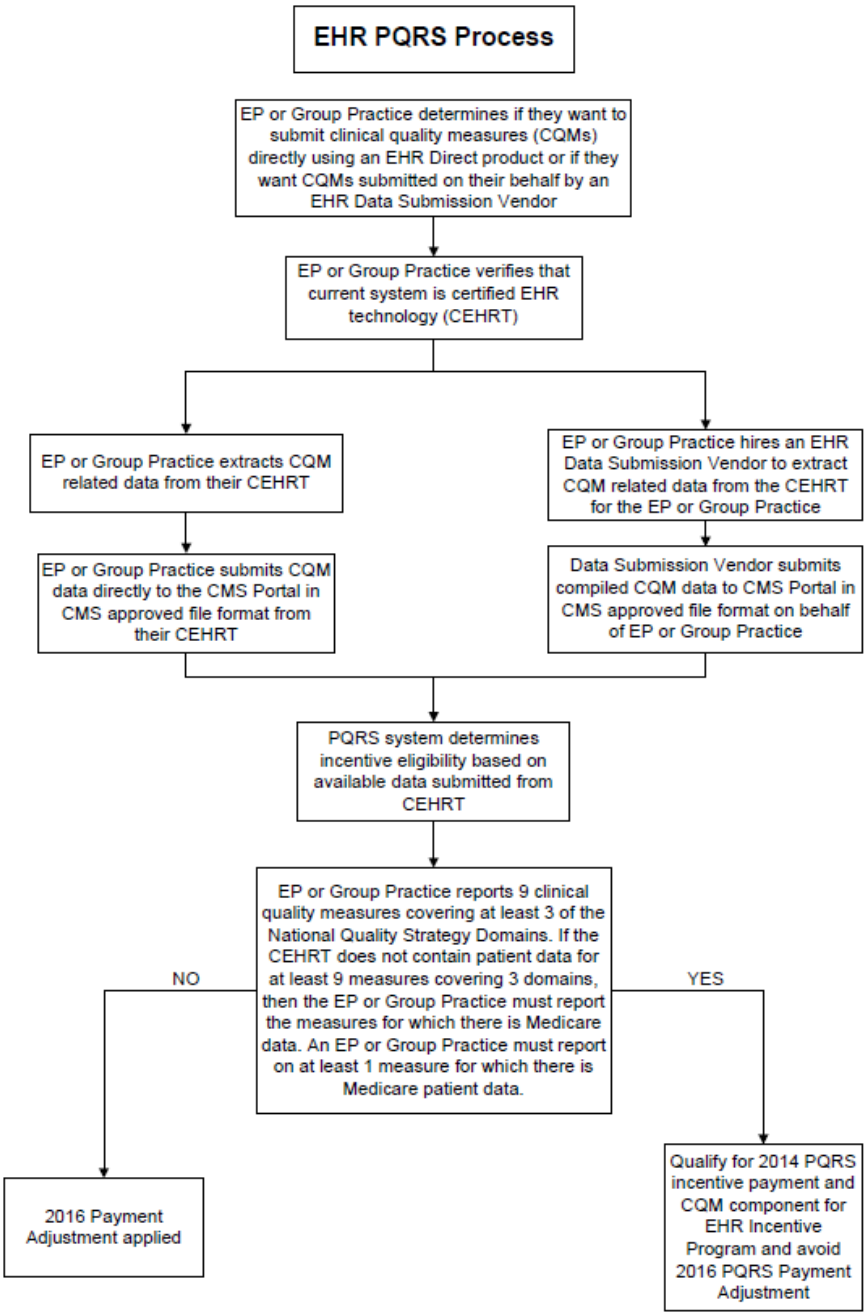
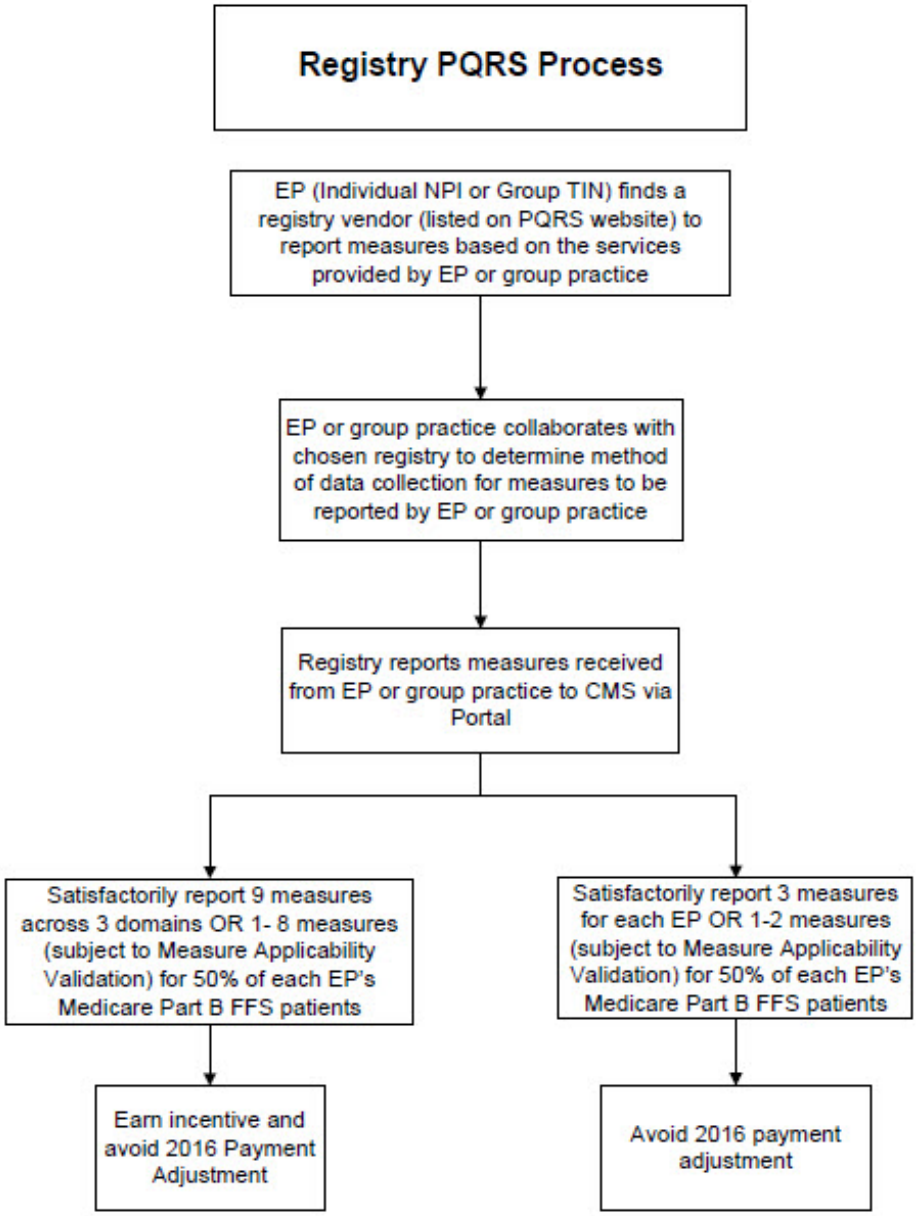
- Note: All diagnoses listed in Item 21 will be used for PQRS analysis. Measures that require the reporting of two or more diagnoses on claim will be analyzed as submitted in Item 21.
- NPI placement: Item 24J must contain the NPI of the individual provider that rendered the service when a group is billing.
- If billing software limits the line items on a claim, you may add a nominal line-item charge of a penny to one of the QDC line items on that second claim. PQRS analysis will subsequently join both claims based on the same beneficiary, for the same date-of-service, for the same TIN/NPI and analyze as one claim.

Appendix F: PQRS EHR Process



Appendix G: PQRS Registry Process



Appendix H: PQRS GPRO Web Interface Process