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2014 Physician Quality Reporting System (PQRS):
Registry Reporting Made Simple

Background

The Physician Quality Reporting System (PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals. The program provides an incentive payment to practices with individual eligible professionals (EPs) or group practices participating in the group practice reporting option (GPRO), who satisfactorily 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). Additionally, individual EPs and group practices that do not satisfactorily report in the 2014 PQRS program year will be subject to a payment adjustment in 2016.

Purpose

This document outlines the steps necessary in selecting a qualified registry for 2014 PQRS reporting and applies to:

- Individual EPs who wish to report via qualified registry
- Group practices that registered for qualified registry-based reporting under the Group Practice Reporting Option (GPRO)

Although this document briefly mentions the requirements for avoiding the 2016 PQRS payment adjustment, complete information is available on the CMS PQRS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

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 percent of the EP's* Medicare Part B FFS patients.
    - EPs or group practices that satisfactorily report for **only one to eight** PQRS measures across **one or more domains** for at least 50 percent of their eligible patients or encounters for each measure, **OR** EPs or group practices that satisfactorily report for nine or more PQRS measures across less than three domains for at least 50 percent of their eligible patients or encounters for each measure will be subject to Measure-Applicability Validation (MAV).
        - Please refer to the *2014 PQRS Measure Applicability Validation Process for Registry-Based Reporting of Individual Measures* document, available as a download on the Analysis and Payment page of the CMS PQRS website at 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.

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 percent of the EP's Medicare Part B FFS patients.
    - EPs that submit quality data for **one or two** PQRS measures for at least 50 percent of their patients or encounters eligible for each measure will be subject to MAV.

Reporting Criteria for Group Practices

A group practice *must* have registered to report via qualified registry under the Group Practice Reporting Option (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 percent of the group's* Medicare Part B FFS patients.
    - Group practices that submit quality data for **only one to eight** PQRS for at least 50 percent of their eligible patients or encounters for each measure, **OR** who submit data for **nine or more** PQRS measures across **less than three domains** for at least 50 percent 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 receive the 2014 PQRS incentive.
2. Report at least 3 measures covering one NQS domain for at least 50 percent of the group's Medicare Part B FFS patients.
    - Group practices that submit quality data for **one or two** PQRS measures for at least 50 percent of their patients or encounters eligible for each measure will be subject to MAV.

How to Get Started

STEP 1: Determine if you are eligible to participate

A list of eligible professionals who are able to participate as individuals is available on the PQRS web page at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Group practices participating in GPRO are analyzed at the TIN level; therefore, all providers under the group's TIN will be taken into account for the 2014 PQRS analysis.

STEP 2: Decide if you will report individual measures or measures groups

- Review the *2014 Physician Quality Reporting System (PQRS) Measures List*, a comprehensive resource that describes all PQRS measures including titles, descriptions, numbering, domain and the reporting option(s) for which the measure is available. This document is available on the Measures Codes page of the CMS PQRS website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.
- Determine which measures or measures group(s) may apply to your practice.

Note: *Measures groups reporting is not available to group practices.*

Individual Measures

- For measure details, reference the *2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry* under the "Downloads" section of the Measures Codes page on the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.
    - Group practices reporting via qualified registry should reference the claims and registry measure specifications manual and **not** attempt to report with *GPRO Narrative Specifications.*
- Choose applicable measures for submission that will impact clinical quality within the practice.

*Individual measures with a 0% performance rate will **not** be counted as satisfactorily reporting. The recommended clinical quality action must be performed on at least one patient for each individual measure reported. When a lower rate indicates better performance, such as Measure #1, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting). Performance exclusion quality-data codes are not counted in the performance denominator. If the registry submits all performance exclusion quality-data codes, the performance rate would be 0/0 (null) and the measure would be considered satisfactorily reported.*

Measures Groups (not available to group practices)

- Reference the *2014 Physician Quality Reporting System (PQRS) Measures Groups Specifications* at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html. *Measures group specifications are different from those of the individual measures that form the measures group.* Therefore, the specifications and instructions for measures group reporting are provided in a separate manual.
- Choose at least 1 measures group on which to report.
- A majority of the patients in the measures group, at least 11 out of 20, have to be Medicare Part B FFS patients.
- Review *Getting Started with 2014 PQRS Reporting of Measures Groups* at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html*.* This document outlines the different options for reporting measures groups and serves as a guide to implementing the 2014 PQRS measures groups.

*Measures groups **containing a measure** with a 0% performance rate will not be counted. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 (null) and the measure would be considered satisfactorily reported. Performance exclusion quality-data codes are not counted in the performance denominator. If the registry submits all performance exclusion quality-data codes, the performance rate would be 0/0 (null) and the measure would be considered satisfactorily reported.*

STEP 3: Choose your registry

Once you have selected the measures you would like to report, review the list of registries that report 2014 PQRS measures. This list will be made available late spring/early summer of 2014 on the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Registry-Reporting.html.

The list of participating registries includes:

- Registry name
- Registry contact information
- Cost information
- Which measures/reporting options the registry can report (i.e. measures groups or individual measures)

After you have selected your registry

Once you have selected a registry, you will be required to enter into and maintain an appropriate legal agreement. Such arrangements provide for the registry's receipt of the patient-specific data and allow the registry to release quality measure data on behalf of CMS.

Note for individual EPs: It is important that you provide the correct Tax Identification Number/National Provider Identifier (TIN/NPI) combination to your registry for incentive payment purposes. Below are some tips to help individuals submit the correct information:

- Report the TIN and individual NPI to which Medicare Part B charges are billed.
- CMS analyzes PQRS data strictly per the Federal Tax ID shown on the Part B claims you are submitting. On the CMS-1500 paper form, that is field 25 where you would enter a 9-digit number and then check whether it is a Social Security Number (SSN) or Employee ID Number (EIN).
- Use your ***individual*** rendering NPI, not the group NPI. The individual rendering provider ID field is 24J on a paper claim (not applicable to GPRO).

Note for group practices: It is important that you provide the correct Tax Identification Number (TIN) to your registry for incentive payment purposes. Below are some tips to help group practices submit the correct information:

- Report the TIN to which Medicare Part B charges are billed.

- CMS analyzes PQRS data strictly per the Federal Tax ID shown on the Part B claims you are submitting. On the CMS-1500 paper form, that is field 25 where you would enter a 9-digit number and then check whether it is a Social Security Number (SSN) or Employee ID Number (EIN).

Registries have a limited timeframe during the submission window to correct invalid TIN/NPI submissions. If CMS does not receive correct TIN/NPI information, you will not be able to receive an incentive payment, even if you report satisfactorily and you may be subject to a payment adjustment.

STEP 4: Work directly with your registry

Your registry will provide you with specific instructions on how and when to submit data for the selected measures or measures group on which you choose to report. The 2014 PQRS data submission window will be in the first quarter of 2015. You will work directly with your registry to ensure data is submitted appropriately for incentive purposes.

Additional Information

- For more information on reporting via qualified registry, go to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Registry-Reporting.html.
- For more information on what's new for 2014 PQRS, go to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.
- To find answers to frequently asked questions about PQRS, go to the CMS website at https://questions.cms.gov/.

Questions?

Contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or via email to Qnetsupport@sdps.org. They are available from 7:00 a.m. to 7:00 p.m. CST Monday through Friday.