PQRS Frequently Asked Questions

1. **What is the Physician Quality Reporting System (PQRS)?**
   Section 1848 (k) of the Social Security Act, as added by Division B, Title 1, Section 101, of the Tax Relief and Health Care Act of 2006 (TRHCA), mandates the establishment of a physician quality reporting system. CMS originally named this system the Physician Quality Reporting Initiative (PQRI) and renamed it the Physician Quality Reporting System (PQRS) in 2011. The PQRS is a voluntary program that provides a financial incentive to physicians and other eligible professionals (EPs) who successfully report quality data related to covered services provided under the Medicare Physician Fee Schedule (PFS).

2. **What can I do to avoid the Physician Quality Reporting System (Physician Quality Reporting) payment adjustment? When will the Physician Quality Reporting payment adjustment be applied?**
   Beginning in 2015, CMS will subject eligible professionals who are not successful reporters under Physician Quality Reporting to a payment adjustment. To avoid the 2015 Physician Quality Reporting payment adjustment, eligible professionals must successfully report during the 2013 reporting period (January 1, 2013 - December 31, 2013). More information regarding the 2013 Physician Quality Reporting System, and the 2015 Physician Quality Reporting payment adjustment will be available in future CMS Final Rules. The 2013 PFS Final Rule will set forth the requirements for reporting during the 2013 Physician Quality Reporting program year in order to avoid the 2015 payment adjustment. Updated program rules will be posted on the CMS Physician Quality Reporting System website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/StatuteRegulationsProgramInstructions.html

   If subject to the 2015 Physician Quality Reporting payment adjustment, eligible professionals will be paid 1.5% less than the Medicare Physician Fee Schedule (PFS) amount for services rendered in 2015. In 2016 and each subsequent year, the payment adjustment increases to 2.0%. The payment adjustment will be applied to all of the eligible professional's Part B-covered professional services under the Medicare PFS. CMS encourages eligible professionals to participate in the 2012 Physician Quality Reporting program in order to gain the needed experience to prepare for the 2013 program year. Additional information about how to get started in participating in the Physician Quality Reporting System is available on CMS website at http://www.cms.gov/PQRS under the "How to Get Started" section

3. **What are the financial benefits of participation in the Physician Quality Reporting System (Physician Quality Reporting, formerly called PQRI)?**
   A Physician Quality Reporting participant who reports satisfactorily will earn a financial incentive based on a percentage of the Medicare Part B Physician Fee Schedule (PFS) total estimated allowed charges for covered services provided during the longest or most advantageous reporting period for which the professional satisfied criteria for at least one reporting option. Incentive payments will end at the conclusion of the 2014 reporting period.

4. **How does the Physician Quality Reporting System (PQRS) work? What do providers have to do?**
   To participate in the Physician Quality Reporting System (PQRS), a physician or other eligible professional (EP) should begin by reviewing the detailed PQRS Quality Measure Specifications and related informational materials available on the CMS PQRS website. EPs will be required to select from the over 300 available measures applicable to their patient panels and the professional services furnished to his or her patients. The EP should then choose a reporting method. A list of available PQRS measures can be

found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

5. How do you participate?

By reporting on a minimum of 3 measures on a specified group of patients or 20 consecutive patients, a physician can earn a bonus payment of 0.5% on all of their Medicare billing for one year. For 2013, there are individual measures and measures groups in the PQRS, which can be reported to CMS by physicians and other caregivers in hospitals or physician practices. There are four methods for submitting PQRS data to CMS:

a. Claims Reporting Method: This requires providers to select specially created CPTII codes and submit them along with your routine bills. Successful reporting requires 50% reporting of 3 measures or 100% reporting on 20 consecutive patients.
b. Registry Reporting Method: This requires providers to select a registry which has been approved by CMS as a qualified registry for data collection and once or twice per year data submission. This method is expected to become the preferred method for many providers since they can review the data and add key clinical information regarding the patient at anytime. Additionally, providers DO NOT need to select CPTII codes for registry reporting since the registry performs the measure calculations and performance data is submitted separately from the billing process. Successful reporting requires 80% reporting of patients seen during reporting year or 20 consecutive patients
c. EHR Reporting Method: This requires submitting PQRS data straight from your EHR in the two months following the reporting year. Successful reporting requires reporting on 80% of eligible patients
d. Data Submission Vendor: This method requires the same criteria as the EHR reporting method but allows a data submission vendor to submit on behalf of the EP.

6. What simple steps can I take to submit Physician Quality Reporting System (PQRS) quality measures data on claims?

Take the following steps to begin claims-based reporting for Physician Quality Reporting:

1. Use the measure specifications to identify measures applicable for professional services you routinely provide.
2. Select those measures that make sense based upon prevalence and volume in your practice as well as your individual or practice performance analysis and improvement priorities.
3. Review the measures that you have selected to become familiar with how to apply and correctly code the measures.
4. Refer to the Physician Quality Reporting System Implementation Guide for more detailed information and reporting tips at http://www.cms.gov/PQRS/15_MeasuresCodes.asp.
5. Access data collection worksheets on the American Medical Association's (AMA) website (http://www.ama-assn.org/ama) to help you implement Physician Quality Reporting in your practice.
6. Ensure that your billing software and clearinghouse can correctly submit Physician Quality Reporting quality-data codes (QDCs) on your behalf to the carrier.
7. Regularly review the Remittance Advice Notice you receive from the Carrier/Medicare Administrative Contractor (MAC) to ensure the denial remark code N365 is listed for each QDC submitted.

7. Is PQRS applicable to Medicare Advantage or to Medicaid patients?

For most providers the answer is **NO**. Medicare claims-based submission was the only method available for 2007 Physician Quality Reporting Initiative (PQRI) so it was not feasible to include Medicaid only patients. Beginning in 2008, it is possible to report on Medicare Advantage and non-Medicare (including Medicaid and commercial patients), **but only for reporting measures groups through a registry**. For all other reporting options, PQRS will collect quality data and calculate incentive eligibility and Part B Fee-

For-Service payment amounts solely on covered professional services that are furnished to Medicare beneficiaries enrolled in the Part B Fee-For-Service plan. In other words, the incentive payment will be based only on the Medicare Part B covered professional services that are furnished to Medicare beneficiaries during the reporting period.

8. **My billing software limits the number of line-items available on a claim and this cannot be changed. How can I bill multiple Physician Quality Reporting System (PQRS) measures for an office visit without going into a second claim, which would then contain only quality-data code (QDC) line-items, each with a zero dollar charge, for a total charge of zero dollars? The Carrier/MAC would then reject this second claim and the QDCs would not get passed into the National Claims History file for PQRS analysis.**
   Although CMS does not impose line-item limits on claims, CMS claims processing systems cannot accept an entire claim with total charge of $0 and, therefore, will reject the claim. As your software limits the line-items on a claim, you may 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 and eRx analysis will subsequently join both (split) claims based on the same beneficiary, for the same date-of-service, for the same TIN/NPI and analyze as one claim. CMS will look across all claims data for common occurrences of Carrier claims control numbers, equated beneficiary claim numbers (HIC), and Carrier numbers. Note: Claims submitted with only QDCs will not be counted in the analysis of PQRS and eRx reporting or performance rates.

   Providers need to work with their clearinghouses/vendors regarding line limitations for claims. Make sure your clearinghouse or billing software vendor does not drop QDCs. See the CMS-1500 Claim Sample in the PQRS Implementation Guide on the Measures Codes section of the CMS PQRS website at LINK

9. **What are the reportable PQRS measures?**
   The eligible quality measures under PQRS are listed on the CMS Website and are not specialty-specific, i.e., a provider does not have to be a cardiologist to report on giving aspirin to a patient with acute myocardial infarction (AMI). In addition, CMS will allow more than one participating provider to report on quality codes on the same patient. The 2013 PQRS System Measures List identifies over 300 quality measures.

10. **What are the PQRS reporting periods for 2013?**
    There are two reporting periods available for eligible professionals: a) 12-month reporting period from January 1 through December 31 OR b) a 6-month reporting period from July 1 through December 31. The 6-month reporting period only applies to registry submission of measures groups. Providers usually submit individual measures and the reporting period is 12 months for both claims and registry.

11. **What is the methodology for PQRS scoring?**
    CMS has defined a numerator and a denominator that permit the calculation of the percentage of patient visits that achieve appropriate reporting of quality measures. There are 4 elements that must be extracted from the record to determine if the encounter qualifies for a PQRS measure: insurance status, patient age, ICD-9 code(s) and CPT code(s).

12. **Is registration required to participate in the Physician Quality Reporting System (PQRS)?**
    No. There are no registration requirements for a practice or professional to participate in Physician Quality Reporting System (PQRS). However, EPs who wish to participate in the EHR direct reporting must register an IACS Security Official at https://idm.cms.hhs.gov/idm/user/newregistration.jsp