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AdvantEdge Healthcare Solutions

2013 Physician Quality Reporting System (PQRS) Resource Guide

January 24, 2013

AdvantEdge Healthcare Solutions
2013 Physician Quality Reporting System (PQRS)
January 3, 2013

We have created this PQRS Resource Guide so that the most pertinent PQRS information for 2013 can be found in one document. Links have been provided for you to access the more detailed information provided on the CMS website. This Guide does not contain information on the Physician Value-Based Modifier Program, a mandatory program for group practices of 100+ eligible professionals.

This newsletter contains the following information:

DEFINITIONS

For the purposes of this manual, the following abbreviations will be used to be in sync with the CMS' manuals and for simplification purposes:

EP – Eligible professional
QDC (Quality Data Code) – PQRS Code
GP – Group Practice
FFS – Fee for Service

The following are descriptions of terms frequently used when describing quality measures;

- Numerator – the PQRS (or QDC) code used to describe the measure(s) reported
- Denominator – Qualifying CPT codes used for the measure(s) reported

WHAT IS PQRS?

PQRS or the "Physician Quality Reporting System" is a voluntary individual reporting program to report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Medicare C (Medicare Advantage) beneficiaries are not included in claim-based reporting of individual measures or measure groups, GPRO reporting or EHR Reporting.

ELIGIBLE PROFESSIONALS (Providers) (EPs)

A listing of all providers eligible to participate in 2013 is located in Addendum A at the end of this newsletter. Included with physicians are PA's, NPs, psychologists, social workers, therapists and other non-physician professionals.

PQRS measures are analyzed by the individual NPI number even if the member is part of a group. The exception is if a group practice of 2 EPs or more reports their measures through the ***Group Practice Reporting (GPRO)*** method, in which case the group's NPI number would be used in analyzing measure data.

2013 PQRI BASICS

- 2013 Incentive Payments will be ***0.5% of a provider's total Medicare allowable*** charges for successful reporting
  - 2012 was 0.5%
  - 0.5% will be applied to incentive payments for year 2014
- All claims for service dates of January 1, 2013 – December 31, 2013 must be received at CMS by February 24, 2013, to be included in the analysis for an incentive payment.
- Beginning in 2015, a payment adjustment will apply under the PQRS Incentive Program if the EP does not satisfactorily submit data on quality measures for his/her services for the quality reporting period. The fee schedule amount for services furnished by such EPs will be ***reduced*** by the following percentages:
  - 1.5% for 2015;
  - 2.0% for 2016 and each subsequent year

2013 PQRS Summary

- There are a total of 259 measures
- NEW MEASURES FOR 2013 - 10 new measures plus 3 GPRO individual measures were introduced for 2013 (See Addendum B)
- MEASURES RETIRED FOR 2013– 15 measures were retired in 2013 – See Addendum B

2013 PQRS REPORTING OPTIONS

There are 3 methods of reporting:

A. Individual Measure Reporting
B. Measures Groups Reporting
C. Group Practice Reporting Option (GPRO)

Reporting Periods

In 2013, there is only one reporting period of 12 months. The 6-month reporting period is only available for reporting "measures groups" via a registry.

1. 12 months – Service dates of January 1, 2013 – December 31, 2013
2. 6 months – Service dates of July 1, 2013 – December 31, 2013 *(for reporting "measures groups" via a registry only)*

If a provider participated in the 2012 PQRS program and wants to report the same measures for the 2013 program, the provider must:

- Determine if the measures are still available
- Check the Release Notes to determine if the criteria for these measures changed in 2013.

The "Release Notes" manuals are specifically written to show ***only the changes from 2012 to 2013***. To access the Release Notes, see ***Addendum F***:

For Individual Measures – Page 20
For Measures Groups and GPRO reporting – Page 21
For Registry & EHR Reporting – Page 22

REPORTING OF MEASURES – Individual EPs

To participate in the 2013 PQRS Incentive Program, individual EPs may choose to report information for **individual PQRS quality measures** or **measures groups**.

A. INDIVIDUAL QUALITY MEASURES REPORTING

Individual quality measures may be reported to CMS via:

1. Claim-based reporting - on Medicare Part B claims
2. A qualified PQRS Registry
3. A qualified electronic health record (EHR) product, or
4. Administrative Reporting (to avoid the 2015 payment adjustment only)

Claims-based individual measures reporting remains similar to last year.

- EPs must report a minimum of 3 measures for at least ***50%*** of their Medicare Part B FFS patients eligible for each measure in order to qualify for the incentive payment unless the provider only performs less than 3 measures.
- Providers who report less than 3 measures will be subject to the measure-applicability validation (MVA) process. Should Medicare find that the provider submitted CPT and diagnosis codes that would qualify him/her for a 3rd measure, the provider will not be paid for the 2 measures or less submitted.
- Measures with a 0% performance rate will not be counted

For more information on how the measure-applicability validation process is calculated, see

Section 5 "Measure Applicability Validation" of this Guide.

Registry Reporting

- EPs must report at least 3 measures for at least ***80%*** of their Medicare patients eligible for each measure in order to qualify for the incentive payment.
- Measures with a 0% performance rate will not be counted

EHR Reporting (Both EHR Direct Product and EHR Data Submission Vendor

- Option 1: Report on ALL three PQRS EHR Measures that are also Medicare EHR Incentive Program Core measures. If the denominator for one or more of the Medicare EHR Incentive Program core measures is 0, report on up to three PQRS EHR measures that are also Medicare EHR Incentive Program alternate core measures; AND Report on three additional PQRS EHR measures that are also measures available for the Medicare EHR Program
- OPTION 2 : Report at least 3 measures, AND report each measure for at least 80 percent of the EPs Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted.

Administrative Claims Reporting Method

The Administrative Claims Reporting Method is a method where an individual or a group practice reports Medicare Part B claims data for CMS to determine whether the EP/Group practice has performed services applicable to certain individual PQRS quality measures. CMS will analyze the practice's Medicare claims to determine if providers have met any quality measures. EP/group practices would not have to submit quality data codes on their claim forms.

EPs/Group Practices may use the administrative claims reporting method for 2015 payment adjustment purposes only. This reporting method may not be used for the 2013 incentive payments.

Those electing to report via the administrative claims method must submit their administrative claims election statement via the web by October 15, 2013. The ability to elect the administrative claims-based reporting mechanism will not be available until the summer of the applicable reporting period.

B. "MEASURES GROUPS" REPORTING

There are 22 measures groups available for reporting in 2013. 21 Measures from 2012 will be available for reporting in 2013.

- One Retired Measure Group – Community-Acquired Pneumonia
- One New Measure Group – Oncology

ADDENDUM E - lists all the Measures Groups, the measures within each group, the Intent Code, Composite Code and how the measures may be submitted.

With the "measure groups" option, providers may report on a group of clinically-related measures either through

- claims-based reporting, or,
- registry-based reporting

Providers only need to report ONE measures group to qualify for PQRS payment. More than one group measure may be reported but the EP will only earn a maximum of one incentive payment equal to 0.5% of the total estimated allowed charges furnished during the longest reporting period for which he or she satisfied reporting criteria.

- Each measures group has an **Intent G Code.** This code is used once to inform Medicare that the provider will be submitting via the Measures Group reporting method and will indicate which measures group will be reported.
- Each measures group has a **Composite Code**. This code is used if the EP is reporting on ALL measures within the measures group. This code is used instead of reporting each measure separately.

Claims-based submission

- The "intent G code" must be submitted only once. This alerts Medicare that the provider has chosen "measure group submission" of PQRS. As an example, intent code G8485 means: "I intend to report the *Diabetes Mellitus* Measures Group."
- The PQRS analysis will be initiated when the intent G code is first submitted on a claim. However, all claims meeting the group measures criteria will be considered in the analysis regardless of the date of service the intent G code is initially submitted. As an example, if you submitted several claims with a measures group for service date of 1/1/2013 but you did not submit an intent G code claim until service date 1/8/13; the payment analysis will begin with the service dates of 1/1/2013 that were submitted before the intent G code was actually submitted to Medicare.

Registry-based submission – The "intent G" code does not have to be submitted when reporting through a Registry unless the Registry will report via claims data. The Registry will inform the provider the appropriate way to submit measures groups through their system.

In 2013 there is only one method of submitting measures groups, the 20 Patient Sample. ***The Percentage Patient Sample Method has been removed for 2013.***

- **20 Patient Sample Method via Claims** – An EP must report on all applicable measures within the selected measures group when billing measure-eligible claims for a minimum sample of 20 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group (includes Medicare Secondary Payer claims and claims for Railroad Retirement beneficiaries; excludes Medicare Advantage beneficiaries)
- **20 Patient Sample Method via Registry** – An EP must report on all applicable measures within the selected measures group for a minimum sample of 20 unique patients, a majority of which must be Medicare Part B FFS patients, who meet patient sample criteria for the measures group. If the EP does not have at least 11 unique Medicare part B FFS patients who meet patient sample criteria for the measures group, the EP will need to choose another measures group or choose another reporting option.

Measure groups containing a measure with a 0% performance rate will not be counted

For **both claims-based** and **registry-based** reporting, all applicable measures within the measures group must be reported ***at least once*** for each patient within the sample population seen by the EP during the reporting period.

Individual measures within the Measures groups may have different criteria and specifications than the same measure reported individually. Individual measures within the measures groups may have also changed since 2012. Therefore, it is important that the requirements for each measure are reviewed within the specifications and instructions for ***measures group reporting***. These requirements are provided in a separate manual from the individual measures.

For more information, see ***ADDENDUM F*****,** Page 21, under the "Measures Group" heading.

C. GROUP PRACTICE REPORTING (GPRO)

CMS changed the definition of a group practice for the intent of GPRO reporting from 25 or more EPs to 2 or more EPs. A GPRO practice is now defined as a single TIN with 2 or more EPs, as identified by their NPI, who have reassigned billing rights to the TIN.

There will be 17 measures available for GPRO reporting including 2 composites for a total of 22 measures. 12 Measures were either retired or replaced by another measure.
See ***ADDENCUM C*** for new and deleted GPRO measures on page 14.

Methods for submitting:

- GPRO options can only submit through the GPRO web interface provided by CMS, Registry, and Administrative Claims (for the 2015 PQRS payment adjustment only)
- CMS will assign patients to participate by using Medicare Part B claims data for service dates on or after January 1, 2013 and claims submitted and processed by the last Friday in October 2013 (October 25). All patients will be Original Medicare patients and Medicare must be their primary payer.
- Submission requirements depend on the size of the Group Practice. For Registry reporting, measures with a 0 percent performance rate will not be counted.
    - Groups 2-24 EPs
        - Must report through a *REGISTRY* only
        - Must report on at least 3 measures, AND
        - Report each measure for at least 80 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted.
    - Groups 25-99 EPs
        - *GPRO WEB INTERFACE* - Must report on all GPRO measures included in the GPRO Web Interface; AND Populate data field for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each disease module or

preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries
        - *REGISTRY* – Must report on 3 measures AND report each measure for at least 80% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies
    - Groups 100+ EPs
        - *GPRO WEB INTERFACE* - Must report on all GPRO measures included in the GPRO Web Interface; AND Populate data field for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries
        - *REGISTRY* - Must report on 3 measures AND report each measure for at least 80% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies

- 12 month reporting period (Jan. 1, 2013 – Dec. 31, 2013)

GPRO Eligibility Criteria

- Individual EPs who are members of a GP selected to participate in the PQRS GPRO program are not eligible to separately earn a PQRS incentive payment as an individual EP under that same TIN. Once a GP's TIN is selected to participate in the GPRO; this is the only method of PQRS reporting available to the group and all individual NPIs who bill Medicare under the group's TIN number.
- As providers leave and join group practices through out the year, there could be a discrepancy between the number of EPs submitted by the practice during the self-nomination process and the number of EPs billing Medicare under the TIN.
    - If there are more or less NPIs in the Medicare claims than the number of NPIs submitted during self-nomination process, this could result in the practice being subject to different criteria for reporting. In this case, CMS will notify the practice of this finding as part of the self-nomination process. The practice will then have the option of:
        - either agreeing to being subject to the different criteria for satisfactory reporting. or
        - opting out of participation as a group practice.

Clients interested in participating as a GPRO ***for the first time*** must self-nominate themselves via a letter accompanied by an electronic file submitted in a format specified by CMS (such as Microsoft Excel) that includes the group practices' TIN(s) and name of the group practice, the name and email address of a single point of contact for handling administrative issues as well as the name and email address of a single point of contact for technical support purposes. (Once the CMS' web-tool is capable of accepting self-nomination statements, that will be the only available method to self-nominate. The web tool is expected to be ready for the 2013 PQRS.

The self-nomination statement must also indicate the group practice's compliance with the Medicare B's requirements which can be found in the GPRO Specifications.

CMS reserves the right to validate the data submitted by GPROs.

To be considered for 2013 GPRO reporting, all group practices must address the requirements in a self-nomination statement received via the web by October 15, 2013. Group practices must also select their reporting method at the time of self-nomination, and may change this method at any time prior to the October 15, 2013 deadline.

2013 REPORTING MECHANISMS

A. CLAIMS-BASED REPORTING

PQRS measures are reported on each claim submitted to Medicare when the CPT and diagnosis combination qualifies for the PQRS measures the provider has chosen. Instructions for billing via this method are contained in ***Addendum G*** at the end of this Guide. Submission of PQRS may be by:

- Individual Measures
- Measures Groups

B. REGISTRY REPORTING

Professionals may submit their measures through a Registry. A registry is a third-party database that many professionals already use to report data to researchers about common care processes for diabetes, kidney disease and preventive medicine. An EP or group practice would be required to enter into and maintain an appropriate legal arrangement with a qualified PQRS registry. The Registry would act as a HIPAA Business Associate and agent of the EP.

CMS will post a list of qualified registries on their PQRS website. However, CMS does not anticipate making this list available until the summer of 2013.

You may access the 2012 Qualified Registries by ***clicking below, scrolling to DOWNLOADS and picking 2012 Qualified Registries Posting Phase 2.***

2012 Qualified Registries

CMS web pages dedicated to Registry reporting may be found in ***ADDENDUM D***, page 22, under Alternative Reporting Methods, Registry Reporting.

C. EHR REPORTING (Electronic Health Records)

For 2013, EPs have the option of submitting quality measure data obtained from their PQRS qualified EHR to CMS either;

1. Directly from the EPs qualified EHR in the CMS-specified manner , or
2. Indirectly from a qualified EHR data submission vendor (on the EP's behalf), in the CMS-specified manner.

There are 51 measures available for EHR reporting and they are listed in ***ADDENDUM D***.

Direct EHR Reporting

EPs who choose this method must ensure their system is qualified to submit PQRS measures. *An EHR system certified for purposes of reporting under the Medicare and Medicaid EHR Incentive Programs may or may not be qualified for purposes of the 2013 PQRS program.*

EPs would submit PQRS quality measure data directly from their EHR system. EPs must report on a minimum of 3 measures for Medicare Part B beneficiaries at an 80% reporting rate

EHR Data Submission Vendors

EPs submit PQRS quality measure data extracted from their EHR to a qualified EHR Data Submission Vendor. The EHR submission vendor would then submit the PQRS measures data to CMS in the CMS-specified format(s). EPs must report on a minimum of 3 measures for Medicare Part B beneficiaries at an 80% reporting rate.

PQRS-Medicare EHR Incentive Program Pilot

Submit quality measure data through the PQRS-Medicare EHR Incentive Program Pilot which uses specific 2013 Physician Quality Reporting EHR measure specifications. Eligible professionals participating in the Pilot are required to submit information on three core measures. If the denominator for one or more of the core measures is zero, the eligible professional must report on up to three alternate core measures. Eligible professionals must also report on three additional measures available for the Medicare EHR Incentive Program.

CMS web pages dedicated to EHR reporting may be found in ***ADDENDUM F***, page 24, under Alternative Reporting Methods, EHR Reporting.

MAINTENANCE OF CERTIFICATION PROGRAM (MOCP)

EPs can earn another .5% of their allowed Medicare charges in addition to the .5% earned through the PQRS incentive program by participating in the Maintenance of Certification Program (MOCP). The MOCP is a continuous assessment program that advances quality and the life long learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism.

EPs interested in qualifying for this incentive must complete the following:

- Satisfactorily submit data on quality measures under the PQRS Incentive Program, for a 12-month reporting period either as an individual physician or as part of a group practice under one of the Physician Quality Reporting System group practice reporting options.

AND

The MOCP will need to submit to CMS, on behalf of the EP the following information:

- That the EP more frequently than is required to qualify for or maintain board certification status;
  - Participates in a MOCP for a year, and
  - Successfully completes a qualified Maintenance of Certification Program practice assessment for such year.
- Information on the survey of patient experience with care; and
- The methods, measures, and data used under the MOCP and the qualified MOCP practice assessment.

EPs will be required to participate more frequently than is required in at least one of the following two parts of the MOCP, as well as "more frequent successful completion of a qualified maintenance of program practice assessment:

- Participate in education and self-assessment programs that require an assessment of what was learned;
- Demonstrate through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge and clinical judgment to provide quality care in their respective specialty.

The phrase "more frequently" may be interpreted differently by different MOCPs. CMS is looking to see an attestation from a MOCP entity that both the MOCP itself and the practice assessment are completed once more by a physician than is required by a specific MOCP.

MOCP SELF-NOMINATION

New and previously approved MOCP entities who wish to enable their members to be eligible for the additional incentive need to complete the self-nomination process by January 31, 2013, and will need to be approved for participation by CMS.

Boards that were previously qualified as an MOCP entity or newly participating boards that utilize a previously qualified registry for their MOCP data, will not need to undergo the qualification process. However, these entities must still go through the self-nomination process each year they want to participate in the program.

CMS anticipates completing the qualification process for the MOCP entities by mid-2013 and will post the final list of qualified entities on the PQRS – Maintenance of Certification Program section of the CMS website at that time.

MOCP BASICS FOR EPs

- EPs who want to participate in the MOCP Program must only submit through a "qualified" MOCP entity and will need to work with their selected MOCP entity to ensure successful completion of the MOCP incentive requirements.
- The MOCP payment will be paid at the same time as the PQRS incentive payment for those physician(s) that qualify and will show as a separately identifiable payment on the PQRS Feedback Report for 2013.
- The 2013 PQRS will calculate the MOCP incentive payment based on allowed Medicare Part B PFS charges for their covered professional services furnished between January 1, 2013 and December 31, 2013.
- Physicians can not receive more than one additional 0.5% incentive even if they complete a MOCP in more than one specialty.
- The MOCP incentive will not be awarded to physician(s) who have not qualified for the PQRS incentive.

The following CMS DOWNLOADS provide more information on participating in this program and details the MOCPs' self-nomination process and obligations for submitting EPs' information. These downloads are also found in ***ADDENDUM F*** of this guide on page 25.

Maintenance of Certification Program

2013 Maintenance of Certification Program Requirements

Conditionally Qualified Maintenance of Certification Program Incentive Entities for 2013

VALIDATION OF SATISFACTORY REPORTING

When an EP reports on fewer that 3 measures, CMS will perform a review to determine whether there are other closely related measures (such as those that share a common diagnosis or those that are representative of services typically provided by a particular type of EP). If an EP who reports on fewer than 3 measures in 2013 and reports on a measure that is part of an identified cluster of closely related measures and does not report on any other measure that is part of that identified cluster, then the eligible professional will not qualify as a satisfactory reporter in the 2013 PQRS program. The EP will then NOT earn an incentive payment on the less than 3 measures reported.

Measure-applicability validation applies to providers:

- who submit QDC for only one or only two PQRS measures for at least 50% of their patients or encounters eligible for each measure and who do not submit any QDCs for any other measure – reports less than 3 measures
- who submit PQRS codes via ***claim-based submissions***

Those who fail the validation process will not earn the PQRS incentive payments.

Measures reported via REGISTRY, GPRO or EHR are NOT subject to MVA.

CMS will apply a two-step process to operationalize the MVA.

1. Clinical Relation Test
2. Minimum Threshold Test

Step 1: Clinical Relation Test.

This test is based on:

1. A presumption that if a provider submits data for a measure, then that measure applies to her/his practice and
2. The concept that if one measure in a cluster of measures related to a particular clinical topic or professional service is applicable to a provider's practice, then other closely-related measures (measures in that same *cluster*) may also be applicable.

The following is an example of how the clinical relation test will be applied:

A provider submitted PQRS codes for one of the PQRS measures related to pneumonia. (pneumonia has 4 separate measures) That EP's claims will then be analyzed using the minimum threshold test described below to determine whether another pneumonia measure (or two more pneumonia measures) could also have been submitted.

Step 2: Minimum Threshold Test.

The minimum threshold test is based on the concept that only if, during the 2013 reporting period, a provider treated more than a certain number of Medicare patients with a condition to which a certain measure applied, then that EP should be accountable for submitting the QDC(s) for that measure.

For the 2013 reporting period, the common minimum threshold, based on statistical and clinical frequency considerations, will not be less than 15 patients or encounters for the 12-month reporting period.

CMS examples of how the minimum threshold test will be applied:

An emergency department (ED) physician treated 20 Medicare patients with pneumonia during the 2013 12-month reporting period. If that ED physician is subject to validation and was found to have submitted a PQRS code for at least one of the pneumonia measures under the clinical relation test, then the physician would be deemed responsible for submitting PQRS codes for at least one other PQRS pneumonia measure. If the additional codes were not submitted, the provider will not earn the 2012 incentive payment.

Alternatively, if an internist was subject to validation and was found to have submitted a PQRS code for at least one of the pneumonia measures under the clinical relation test but treated only 2 Medicare patients with pneumonia during the same period, then the internist would not be responsible for submitting the additional pneumonia measures and would not be precluded from receiving an incentive payment.

During the reporting period, CMS will determine a minimum threshold for each individual PQRS measure based on analysis of Part B claims data. However, no threshold will fall below the common threshold of 15 patients or encounters described above.

CMS may determine that it is necessary to modify the measure-applicability validation process after the start of the reporting periods. However, any changes will result in the process being applied more leniently, thereby (1) allowing a greater number of professionals to pass validation and (2) causing no professional who would otherwise have passed to fail.

Information concerning the Validation Process along with a listing of the validation clusters can be found in ***ADDENDUM F***, under the heading, Applicability Validation.

ADDENDUM A - Eligible Professionals to report the 2013 PQRS Measures

1. Medicare physicians

Doctor of Medicine
Doctor of Osteopathy
Doctor of Podiatric Medicine
Doctor of Optometry
Doctor of Oral Surgery
Doctor of Dental Medicine
Doctor of Chiropractic

2. Practitioners

Physician Assistant
Nurse Practitioner
Clinical Nurse Specialist
Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant)
Certified Nurse Midwife
Clinical Social Worker
Clinical Psychologist
Registered Dietician
Nutrition Professional
Audiologists (as of 1/1/2009)

3. Therapists

Physical Therapist
Occupational Therapist
Qualified Speech-Language Therapist (as of 7/1/2009)

Eligible But Not Able to Participate

The following professionals are eligible to participate but are not able to participate for one or more reasons:

1. Providers paid under the Medicare PFS billing Medicare fiscal intermediaries/MACs. The FI/MAC claims processing systems currently cannot accommodate billing at the individual physician or practitioner level:

- Critical access hospital (CAH), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the regular FI for the professional services provided by the physician or practitioner.
- All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.

Providers not defined as eligible professionals in the Tax Relief Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRS and do not qualify for an incentive. Services payable under fee schedules or methodologies other than the PFS are not included in PQRS (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, portable x-ray suppliers, independent laboratories, hospitals [including critical access], rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for PQRS since DME is not paid under the PFS.

ADDENDUM B – 2013 Measure Changes

New Individual Measures

- 319 – GPRO DM-13 thry DM17 Diabetes Composite: Optimal Diabetes Care
- 320 - Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonscopy in Average Risk Patients - ***Claims, Registry***
- 321 - Participation by a Hospital, Physician, or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality Measures – ***Claims, Registry***
- 322 - Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients - ***Registry***
- 323 - Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI) - ***Registry***
- 324 - Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients - ***Registry***
- 325 - Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions - ***Registry***
- 326 - Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy Measure - ***Claims, Registry***
- 327 - Pediatric Kidney Disease: Adequacy of Volume Management - ***Claims, Registry***
- 328 - Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL - ***Claims, Registry***

Retired PQRS Measures

- 10 - Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports
- 57 - Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation
- 58 - Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status
- 92 - Acute Otitis Externa (AOE): Pain Assessment
- 105 - Prostate Cancer: Three Dimensional (3D) Radiotherapy
- 124 - Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)
- 158 - Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy
- 186 - Chronic Wound Care: Use of Compression System in Patients with Venous Ulcers
- 189 - Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear Within the Previous 90 Days
- 190 - Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss
- 196 - Coronary Artery Disease (CAD): Symptom and Activity Assessment
- 206 - HIV/AIDS: Screening for High Risk Sexual Behaviors
- 207 - HIV/AIDS: Screening for Injection Drug Use
- 235 - Hypertension (HTN): Plan of Care
- 253 - Pregnancy Test for Female Abdominal Pain Patients

ADDENDUM C – GPRO (Group Practice Reporting Option) Measures

2013 New Measures

- PREV-12 Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan

2013 Retired Measures

- COPD-1 Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy
- CAD-1 Coronary Artery Disease (CAD): Antiplatelet Therapy
- DM-3 Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus (replaced with DM-13)
- DM-5 Diabetes Mellitus: (LDL-C) Control in Diabetes Mellitus (replaced with DM-14)
- DM-7 Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
- DM-8 Diabetes Mellitus: Foot Exam
- DM-10 Diabetes Mellitus: Hemoglobin A1c Control (< 8%) (replaced with DM-15.)
- HF-1 Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment
- HF-2 Heart Failure (HF): Left Ventricular Function (LVF) Testing
- HF-5 Heart Failure: Patient Education
- HF-7 Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

ADDENDUM D – 2013 EHR MEASURES

- 1 - Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
- 2 - Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
- 3 - Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
- 5 - Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- 6 - Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
- 7 - Coronary Artery Disease (CAD): Beta-Blocker Therapy- Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40 percent)
- 8 - Heart Failure (HF): Beta-blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- 9 - Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment
- 12 - Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
- 18 - Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- 19 - Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- 39 - Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
- 47 - Advance Care Plan
- 48 - Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- 53 - Asthma: Pharmacologic Therapy for Persistent Asthma
- 64 - Asthma: Assessment of Asthma Control
- 66 - Appropriate Testing for Children with Pharyngitis
- 71 - Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
- 72 - Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

- 102 - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
- 110 - Preventive Care and Screening: Influenza Immunization
- 111 – Preventive Care and Screening: Pneumonia Vaccination for Patients ___ Years and Older
- 112 - Preventive Care and Screening: Screening Mammography
- 113 - Preventive Care and Screening: Colorectal Cancer Screening
- 117 - Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
- 119 - Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
- 128 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up
- 163 - Diabetes: Foot Exam
- 173 - Preventive Care and Screening: Unhealthy Alcohol Use – Screening
- 197 - Coronary Artery Disease (CAD): Lipid Control
- 200 - Heart Failure: Warfarin Therapy Patients with Atrial Fibrillation
- 201 - Ischemic Vascular Disease (IVD): Blood Pressure Management Control
- 204 - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- 226 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- 236 - Hypertension: Controlling High Blood Pressure
- 238 - Drugs to be Avoided in the Elderly
- 237 - Hypertension (HTN): Blood Pressure Measurement
- 239 - Weight Assessment and Counseling for Children and Adolescents
  Childhood Immunization Status
- 240 – Childhood Immunization Status
- 241 -Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low-Density (LDL-C) Control
- 305- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement
- 306 - Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
- 307 - Prenatal Care: Anti-D Immune Globulin
- 308 - Smoking and Tobacco Use Cessation, Medical Assistance: a. Advising Smokers to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies
- 309 - Cervical Cancer Screening
- 310 - Chlamydia Screening for Women
- 311 - Use of Appropriate Medications for Asthma
- 312 - Low Back Pain: Use of Imaging Studies
- 313 - Diabetes: Hemoglobin A1c Control (<8.0%)
- 316 - Preventive Care: Cholesterol-LDL test performed
- 317 - Preventive Care and Screening: Blood Pressure Measurement

ADDENDUM E – 2013 PQRS REPORTING OPTIONS FOR MEASURES GROUPS

(~~Strike-though~~ measures – 2012 measures eliminated as part of the measures grouping in 2013)

DIABETES MELLITUS MEASURES GROUP:
Intent Code: G8485 Composite Code: G8494 CLAIMS, REGISTRY
1. Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
2. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
3. Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
#117. Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
#119. Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
#163. Diabetes Mellitus: Foot Exam

ADULT KIDNEY DISEASE MEASURES GROUP: (Formerly called (Chronic Kidney Disease)
Intent Code: G8487 Composite Code: G8495 CLAIMS, REGISTRY
#110. Preventive Care and Screening: Influenza Immunization
#121. Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)
#122. Chronic Kidney Disease (CKD): Blood Pressure Management
#123. Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis - Stimulating Agents (ESA)

THE PREVENTIVE CARE MEASURES GROUP:
Intent Code: G8486 Composite Code: G8496 CLAIMS, REGISTRY
39. Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
48. Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
#110. Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
#111. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older
#112. Preventive Care and Screening: Screening Mammography
#113. Preventive Care and Screening: Colorectal Cancer Screening
#128. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
#173. Preventive Care and Screening: Unhealthy Alcohol Use – Screening
#226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (new)

CORONARY ARTERY BYPASS GRAFT (CABG) MEASURES GROUP:
Intent Code: G8544 Composite Code: G8497 REGISTRY ONLY
43. Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery
44. Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
#164. Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)
#165. Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate
#166. Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)
#167. Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency
#168. Coronary Artery Bypass Graft (CABG): Surgical Re-exploration
#169. Coronary Artery Bypass Graft (CABG): Anti-platelet Medications at Discharge
#170. Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge
#171. Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling

RHEUMATOID ARTHRITIS MEASURES GROUP:
Intent Code: G8490 Composite Code: G8499 CLAIMS, REGISTRY
#108. Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy
#176. Rheumatoid Arthritis (RA): Tuberculosis Screening
#177. Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
#178. Rheumatoid Arthritis (RA): Functional Status Assessment
#179. Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
#180. Rheumatoid Arthritis (RA): Glucocorticoid Management

ADDENDUM E **- 2013 PQRS REPORTING OPTIONS FOR MEASURES GROUPS (cont'd)**

PERIOPERATIVE CARE MEASURES GROUP:
Intent Code: G8492 Composite Code: G8501 CLAIMS, REGISTRY
#20. Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician
#21. Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin
#22. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)
#23. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
.

BACK PAIN MEASURES GROUP:
Intent Code: G8493 Composite Code: G8502 CLAIMS, REGISTRY
#148. Back Pain: Initial Visit
#149. Back Pain: Physical Exam
#150. Back Pain: Advice for Normal Activities
#151. Back Pain: Advice Against Bed Rest

HEPATITIS C MEASURES GROUP:
Intent Code: G8545 Composite Code: G8549 CLAIMS, REGISTRY
84. Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment
85. Hepatitis C: HCV Genotype Testing Prior to Treatment
86. Hepatitis C: Antiviral Treatment Prescribed
87. Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment
89. Hepatitis C: Counseling Regarding Risk of Alcohol Consumption
90. Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy
#183. Hepatitis C: Hepatitis A Vaccination in Patients with HCV
#184. Hepatitis C: Hepatitis B Vaccination in Patients with HCV

HEART FAILURE (HF) MEASURES GROUP:
Intent Code: G8548 Composite Code: G8551 REGISTRY ONLY
5. Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
8. Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
#198. Heart Failure: Left Ventricular Function (LVF) Assessment
#226. Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention

CORONARY ARTERY DISEASE (CAD) MEASURES GROUP:
Intent Code: G8489 Composite Code: G8498 REGISTRY ONLY
6. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
~~# 196. Coronary Artery Disease (CAD): Symptom and Activity Assessment~~
197. Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
#226. Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention
#242. Coronary Artery Disease (CAD): Symptom Management (added in 2013)

ISCHEMIC VASCULAR DISEASE (IVD) MEASURES GROUP:
Intent Code: G8547 Composite Code: G8552 CLAIMS, REGISTRY
#201. Ischemic Vascular Disease (IVD): Blood Pressure Management Control
#204. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
#226. Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention
#241. Ischemic Vascular Disease (IVD): Complete Lipid Panel – Low Density Lipoprotein (LDL-C) Control (Added in 2013)

ADDENDUM E - 2013 PQRS REPORTING OPTIONS FOR MEASURES GROUPS (cont'd)

HIV/AIDS MEASURES GROUP:
Intent Code: G8491 **Composite Code: G8500** **REGISTRY ONLY**
159. HIV/AIDS: CD4+ Cell Count or CD4+ Percentage
160. HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
161. HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy
162. HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy
205. HIV/AIDS: Sexually Transmitted Diseases – Chlamydia and Gonorrhea Screenings
208. HIV/AIDS: Sexually Transmitted Diseases – Syphilis Screening

COMMUNITY–ACQUIRED PNEUMONIA (CAP) MEASURES GROUP: ***RETIRED***

ASTHMA MEASURES GROUP
Intent Code: G8645 **Composite Code: G8646** **CLAIMS, REGISTRY**
#53. Asthma: Pharmacologic Therapy
#64. Asthma: Asthma Assessment
#231. Asthma: Tobacco Use: Screening – Ambulatory Care Setting
#232. Asthma: Tobacco Use: Intervention – Ambulatory Care Setting

COPD MEASURES GROUP
Intent Code: G8898 **Composite Code: G8757** **CLAIMS, REGISTRY**
#51. Chronic Obstructive Pulmonary Disease (COPD); Spirometry Evaluation
#52. Chronic Obstructive Pulmonary Disease (COPD); Bronchodilator Therapy #110. Preventive Care and Screening: Influenza Immunization
#110. Preventive Care and Screening: Influenza Immunization
#111. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older
#226. Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention

INFLAMATORY BOWEL DISEASE (IBD) MEASURES GROUP **REGISTRY ONLY**
Intent Code: G8899 **Composite Code: G8758**
#269. IBD: Type, Anatomic Location and Activity All Documented
#270: IBD: Preventive Care: Steroid Sparing Therapy
#271: IBD: Preventive Care: Steroid Related Iatrogenic Injury-Bone Loss Assessment
#272. IBD: Preventive Care: Influenza Immunization
#273: IBD: Preventive Care: Pneumoccocal Immunization
#274. IBD: Screening for Latent TB Before Initiating Anti-TNF Therapy
#275. IBD: Hepatitis B Assessment Before Initiating Anti-TNF Therapy
#226. IBD: Preventive Care: Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention

SLEEP APNEA MEASURES GROUP **REGISTRY ONLY**
Intent Code: G8900 **Composite Code: G8759**
#276. Assessment of Sleep Symptoms
#277: Severity Assessment at Initial Diagnosis
#278: Positive airway Pressure Therapy Prescribed
#279: Assessment of Adherence to Positive Airway Pressure Therapy

DEMENTIAL MEASURES GROUP
Intent Code: G8902 **Composite Code: G8760** **REGISTRY ONLY**
#280. Dementia: Staging of Dementia
#281. Dementia: Cognitive Assessment
#282. Dementia: Functional Status Assessment
#283: Dementia: Neuropsychiatric Symptom Assessment
#284. Dementia: Management of Neuropsychiatric Symptoms
#285. Dementia: Screening for Depressive Symptoms
#286. Dementia: Counseling Regarding Safety Concerns
#287 Dementia: Counseling Regarding Risks of Driving
#288. Dementia: Caregiver Education and Support

ADDENDUM E - 2013 PQRS REPORTING OPTIONS FOR MEASURES GROUPS (cont'd)

PARKINSON'S MEASURES GROUP **REGISTRY ONLY**
Intent Code:G8903 **Composite Code: G8761**
#289. Annual Parkinson's Disease Diagnosis Review
#290. Psychiatric Disorders or Disturbances Assessment
#291. Cognitive Impairment of Dysfunction Assessment
#292. Querying about Sleep Disturbances
#293. Parkinson's Disease Rehabilitative Therapy Options
#294. Parkinson's Disease Medical and Surgical Treatment Options Reviewed

HYPERTENSION MEASURES GROUP **REGISTRY ONLY**
Intent Code:G8904 **Composite Code: G8762**
#295. Aspirin or Other Anti-Platelet or anti-Coagulant Therapy
#296. Complete Lipid Profile
#297. Urine Protein Test
#298. Annual Serum Creatinine Test
#299. Diabetes Documentation or Screen Test
#300. Blood Pressure Control
#301. LDL Control
#302. Counseling for Diet and Physical Activity

CARDIOVASCULR PREVENTION MEASURES GROUP **CLAIMS, REGISTRY**
Intent Code: **Composite Code: G8763**
#2. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
#204. Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
#226. Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention
#236. Controlling High Blood Pressure
#241: Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control <100
#317. Preventive Care and Screening; Blood Pressure Measurement

CATARACTS MEASURES GROUP **REGISTRY ONLY**
Intent Code: G8906 **Composite Code: G8764**
#191. Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
#192. Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
#303. Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
#304. Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery

ONCOLOGY MEASURES GROUP **REGISTRY ONLY**
Intent Code: G8977 **Composite Code: G8953**
#71. Breast Cancer: Hormonal Therapy for Stage IC – IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
#72. Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
#110. Preventive Care and Screening: Influenza Immunization
#130. Documentation of Current Medications in the Medical Record
#143. Oncology: Medical and Radiation – Pain Intensity Quantified
#144. Oncology: Medical and Radiation – Plan of Care for Pain
#194. Oncology: Cancer Stage Documented
#226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

ADDENDUM F

LINKS TO THE CMS WEBSITE

This page is an index of the available CMS documents that reviews the PQRS program and its requirements in detail. The titles of the documents are listed with the CMS DOWNLOADS (links) below them. Some of the links contain several documents within a Zip File. Each section also has a link to the main CMS page for each category.

How to get Started
2013 PQRS Implementation Guide – guidance on how to select, read and understand a measure and outlines the reporting options available for 2012.
2013 Measures list – identifies and explains the measures used in PQRS, including available reporting options/methods, measure developers and their contact information.
2013 PQRS Measures List and Implementation Guide

Individual Measures
- 2013 Physician PQRS Specifications Manual for Claims and Registry Reporting of Individual Measures – includes codes and reporting instructions
- 2013 PQRS Measure Specification Release Notes – outlines 2012 changes from the 2011 PQRS specification manual
- 2013 PQRS Quality-Data Code (QDC) Categories – table that outlines, for each measure, each QDC that should be reported and clarifies those measures that require 2 or more QDCs to report satisfactorily.
- 2013 PQRS Single Source Code Master – numerical listing of all codes for individual claims and Registry measures for incorporation into billing software
CMS DOWNLOADS
MEASURES PAGE
2013 Physician Quality Reporting System Measure Specification Manual, Release Notes, Single Source Code Master and Quality-Data Code Categories [ZIP 4MB]

ADDENDUM F - Links to CMS Website (cont'd)

Measures Groups
- 2013 PQRS Measures Groups Specifications Manual – Measures groups specifications are different from those of the individual measures that form the group and are reported in this manual for claims and registry-based reporting.
- 2013 PQRS Measures Groups Release Notes - outlines 2012 changes from the 2011 PQRS specification manual
- Getting Started with 2012 Measures Groups – a guide to implementing 2012 PQRS measures groups
- 2013 Physician Quality Reporting Quality-Data Code (QDC) Categories - table that outlines, for each measure, each QDC that should be reported and clarifies those measures that require 2 or more QDCs to report satisfactorily.
- 2013 PQRS Measures Groups Single Source Code Master – numerical listing of all codes for included in the measures groups for incorporation into billing software
CMS DOWNLOADS:
2013 Physician Quality Reporting System Measure Groups Specifications and Release Notes, Getting Started with 2012 Measures Groups, 2012 Quality-Data Code Categories and 2012 Groups Single Source Code Master [ZIP 4MB]

GROUP PRACTICE REPORTING (GPRO)
- 2013 GPRO Requirements – Overview of the GPRO program
- 2013GPRO Measure Specifications and Release Notes - includes codes and reporting instructions and 2012 changes from the 2011 Measures Manual
- 2013 GPRO Measures List – table of PQRS and NQF codes
- 2013 GPRO Narrative Specifications – detailed description of all measures in the GPRO program
CMS DOWNLOADS:
2013 Group Practice Reporting Option (GPRO) Requirements [PDF 70 KB]
2013 Physician Quality Reporting GPRO I Measure Specifications and Release Notes [ZIP 352KB] (See Download Section)

ALTERNATIVE METHODS REPORTING – Registry & EHR Reporting
CMS DOWNLOADS:
ALTERNATIVE METHODS PAGE
Registry Reporting
- 2013 Registry Submission Qualifications – Vetting requirements for registries and measure specification for EPs
- **2012 Qualified Registries** – Listing of Registries approved in 2011. The 2012 approved registries should be published in the first quarter of 2012
2012 Registry Submission Qualifications Requirements [PDF106KB] (2013 not published)
2012 Qualified Registries
EHR Reporting
2013 PQRS EHR Measure Specifications – description of date element names and codes related to each of the 51 PQRS measures available for 2012
2013 PQRS EHR Measure Specification RELEASE NOTES – outlines 2012 changes from the 2011 PQRS EHR specification manual
2013 EHR Downloadable Resource Table
2013 EHR Downloadable Resource Table – Release Notes
2013 – EHR Qualified Vendors – List of qualified EHR vendors for 2013
2013 EHR Documents for Eligible Professionals [ZIP 3MB]
2013 EHR Direct Vendor Qualified Posting
MAINTENANCE OF CERTIFICATION PROGRAM (MOCP)
Maintenance of Certification Program 2013 Maintenance of Certification Program Requirements Conditionally Qualified Maintenance of Certification Program Incentive Entities for 2013

PQRS MEASURE - APPLICABILITY VALIDATION (MAV)
- 2013 PQRS MAV Process for Claims-based Reporting of Individual Measures – guidance for EPs who submit quality data codes for fewer than 3 PQRS measures
- 2013 PQRS MAV Process Release Notes - outlines 2013 changes from the 2012 PQRS EHR specification manual
- 2013 PQRS MAV Process Flow – chart that depicts the MAV Process
CMS DOWNLOADS:
PQRS Validation
Click above and go to DOWNLOAD - 2013 Physician Quality Reporting System Measure Applicability Validation Documents

ADDENDUM G - STEPS TO BILLING PQRS MEASURES for AHS CLIENTS

How to choose Measures

1. Review the listing of Measures for 2013 to see if they cover services provided by our clients
    a. 2013 PQRS QDC Categories
    b. 2013 List of Measures
2. Client/Provider must choose the measures applicable to their practice.
    a. Review the "Clusters Listing" in the MVA (Section 6) to ensure the provider, if reporting less than 3 measures, will not fail the measures validity test
    b. If a client is reporting the same measures as 2012, they must read the PQRS Measures Specifications **RELEASE NOTES** for any changes to the criteria for these measures (i.e., addition/deletion of CPT or DX codes, etc.)

Basics of Reporting

1. Print the pages of the measures that will be reported (PQRS Measures Specifications)
2. See 2013 PQRS implementation guide for instructions on how to interpret the measures
3. Each measure has:
    a. QDC (Quality Data code) – Non-payable HCPCS codes comprised of specified CPT Category II (CPTII) codes and/or G-codes that describe the clinical action associated with each measure
        i. CPTll codes consist of 5 alphanumeric characters with the string ending in the letter "F"
        ii. CPTll codes are not modified or updated during the reported period remaining valid for the entire year

    b. Each measure will have modifiers that are unique to CPTll codes. They describe <u>Performance Measure Exclusion modifier due to:</u>
        i. 1P –Medical reasons
            1. Not indicated (absence of organ/limb, already received/performed, other)
            2. Contraindicated (patient allergy history, potential adverse drug interaction, other)
            3. Other medical reasons
        ii. 2P –Patient reasons
            1. Patient declined
            2. Economic, social, or religious reasons
            3. Other patient reasons

iii. 3P – System reasons
   1. Resources to perform the services not available (e.g., equipment, supplies)
   2. Insurance coverage or payer-related limitations
   3. Other reasons attributable to health care delivery system

iv. 8P – Action not performed, reason not otherwise specified
   1. For use when an action described in a measure is not performed and the reason is not specified. Instructions of how to use this code are included in each measure.

c. Each measure will have a reporting frequency or timeframe requirement for each eligible patient seen during the reporting period by each eligible provider.
   i. Patient Process: Minimum of once per reporting period
   ii. Patient Intermediate: Minimum of once per reporting period
   iii. Patient Periodic: Report once per timeframe specified in the measure during the reporting period

ADDENDUM G **- STEPS TO BILLING PQRS MEASURES for AHS CLIENTS**

   iv. Episode: Report once for each occurrence of a particular illness/condition per reporting period
   v. Procedure: Report each time a procedure is performed during the reporting period
   vi. Visit: Report each time the patient is seen during the reporting period
   vii. All information must be captured in the clinical record

d. Other reporting requirements
   i. Some measures may not have associated diagnoses and will have to report the measure as specified in the measure (examples: 110- infuenza immunization, 154 - Falls risk assessment, 47 – Advance Care Plan, etc.
   ii. Settings of care: office, hospitals, nursing homes and home health agencies
   iii. Specified patient demographics, such as age parameters and sex

e. For measures that require more than one QDC, ensure that all codes are captured for the measure and reported on the claim form in the same encounter as the billed CPT code associated with the measures – See Measure 3

How to Read a Measure

1. Number and Narrative of the Measure
2. Reporting Options – Claims, Registry, EHR
3. DESCRIPTION – description of the patient and diagnoses of patients
4. INSTRUCTIONS – describes how often and criteria of patients (age) and who might report it

5. MEASURE REPORTING
    a. Via Claims – instructions for claims – CPT, DX, modifier
    b. Registry requirements
6. NUMERATOR – clinical action counted as meeting the measure's requirement (patients receive a particular service or obtained a particular outcome that is being measured) This are the CPT Category II and G-codes
    a. Communication
    b. Numerator Note
    c. Listing of Numerator Quality Data Code (QDC) for this measure (5010F type code or G code and possible modifiers to append
7. DENOMINATOR –
    a. Statement of diagnosis
    b. Acceptable Diagnosis codes
    c. Acceptable CPT codes
    d. Patient Demographics (age, gender) and POS (if applicable)
8. RATIONALE
    a. A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results
9. CLINICAL RECOMMENDATION STATEMENTS
    a. Summary of clinical recommendations based on best practices

ADDENDUM G **- STEPS TO BILLING PQRS MEASURES for AHS CLIENTS**

CLAIMS

1. If billable services on the claims are denied for payment, the QDCs will not be included in the PQRS analysis

    a. If the claim is corrected and paid through an adjustment, reopening, or the appeals process with accurate codes that correspond to the numerator and denominators specifications, the QDCs will now be counted

2. The ORIGINAL claim must have all the correct QDCs listed on the claim. A claim can not be resubmitted only to add or correct QDCs.

3. Claims with ONLY the QDCs on them (without the CPT code) may not be resubmitted to the carrier

4. EPs may submit multiple codes for more than one measure on a claim.

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

6. Up to 8 diagnoses can be reported in the header on electronic claims and 4 diagnoses on paper claims.

7. Appeals of denials must reach the Medicare claims system by February 24, 2010 to be included in the analysis

8. QDC codes should be submitted with $0 or $.01 as the fee depending on system requirements. The field can not be left blank.

9. All PQRS QDC lines will deny with denial code N365. This code indicates that the code has been passed on to the NCH file for use in calculating incentive eligibility. ***N365*** = ***This procedure code is not payable. It is for reporting/information purposes only."***

10. It is suggested that N365 denials are matched to claims submitted to ensure all QDCs were passed to the NCH system.

11. Group Billing – individual EP's NPI number must be on all claim lines including the QDC line.