HEALTH POLICY PERSPECTIVES

2015 Medicare Physician Quality Reporting System (PQRS)

OVERVIEW

Medicare's Physician Quality Reporting System (PQRS) is a voluntary program that uses payment adjustments to promote the reporting of quality information by eligible professionals through the use of PQRS measures and their correlating Quality Data Codes (QDC).

WHO IS ELIGIBLE TO REPORT?

Oral and maxillofacial surgeons and other professionals who render services for which PQRS measures exist are eligible to report those measures. (see list of measures applicable to OMSs at http://www.aaoms.org/docs/practice_mgmt/summary_of_pqrs_2012.pdf

WHAT ARE THE PQRS MEASURES?

Quality measures help quantify healthcare processes, patient outcomes and/or perceptions, and address various aspects of care, including prevention, chronic and acute care management, procedure-related care, resource utilization and care coordination. Providers may report either individual measures or measure groups. While 23 measure groups have been established for the 2015 Physician Quality Reporting System, there are no measure groups applicable to oral and maxillofacial surgery at this time.

Individual Measures: There are over 250 individual PQRS measures for claims or registry-based reporting, 17 of which are applicable to OMS. To avoid a payment adjustment, an applicable measure is to be reported each time a procedure is performed during the reporting period.

For example, when the OMS reports a mandibular fracture repair code (ie, 21461-21462) and documents the order for prophylactic parenteral antibiotics prior to the fracture repair in the patient's record, PQRS measure #20: Perioperative Care: Timing of Antibiotic Prophylaxis-Ordering Physician can be reported. This measure is to be reported each time the same procedure is performed during the reporting period.

For a complete list of the individual measures and instructions on their use and reporting, visit the Measure List Implementation Guidelines on the CMS Web site.

National Quality Strategy Domains: Quality measures selected must cover at least three of the six available National Quality Strategy (NQS) domains, which represent the Department of Health and Human Services' (HHS) NQS priorities for health care quality improvement.

The 6 NQS domains are:

1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population/Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Process/Effectiveness

Cross-Cutting Measures: Beginning in 2015, eligible professionals or group practices are also required to report at least 1 of 18 cross-cutting measures if they have a face-to-face encounter with at least one Medicare patient. The CMS defines a face-to-face encounter as an instance in which the Eligible Physician billed for services that are associated with face-to-face encounters under the Physician Fee Schedule (PFS). This includes general office visits, outpatient visits and surgical procedure codes. CMS does not

consider telehealth visits face-to-face encounters.

WHAT ARE PQRS PAYMENT ADJUSTMENTS?

PQRS payment adjustments are made two years after the reporting calendar year. For example, if an OMS failed to participate in the 2014 PQRS program, his/her Medicare payment in 2016 will reflect a 2% reduction.

In addition to the PQRS payment reduction of 2%, the Affordable Care Act established the "value-based payment modifier," which will also be applied to all doctors beginning with the 2015 PQRS program. Those who do not successfully report for PQRS during the 2015 calendar year will receive a value-based modifier payment reduction of 2% for solo practitioners and groups with two to nine EPs and for groups with 10 or more EPs in 2017. For more information on the Value Based Modifier, visit the CMS Web site.

REPORTING OPTIONS

Medicare providers may report quality measures as an individual or under the Group Practice Reporting Option (GPRO). Under the 2015 Physician Quality Reporting, a GPRO consists of a physician group practice using a single Tax Identification Number (TIN) with two or more individual eligible professionals (each identified by a different National Provider Identifier (NPI)) who have reassigned their billing rights to the group TIN. Group practices reporting via GPRO must register for their selected reporting method by June 30, 2015. For information on becoming a selected group practice, refer to the Group Practice Reporting Option section of the CMS PQRS Web site at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html.

Note: If the eligible professional or the GPRO changes the TIN, participation does not carry over to the new TIN.

An individual OMS may choose from the following methods to submit data to the CMS:

- Medicare Part B claims,
- Qualified registry,
- Qualified Electronic Health Record (EHR),
- Qualified PQRS data submission vendor (new for 2014),
- Qualified Clinical Data Registry (new for 2014), or
- The Group Practice Reporting Option (GPRO).

To report individual PQRS quality measures, submit the PQRS data via:

■ **Claims-based Reporting:** Professionals who choose to participate by reporting quality measures data through claims may report the appropriate quality-data codes on service lines of a Medicare Part B Physician Fee Schedule (PFS) claim form. See CMS examples at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_sampleCMS1500claim_12-19-2012.pdf.

- Under the 2015 reporting period an individual EP must report at least nine individual measures covering at least three NQS domains for at least 50% of Medicare Part B patients seen within the reporting period to avoid a payment adjustment in 2017, OR

  If fewer than nine measures apply, the eligible professional would report up to eight measures for at least 50% of Medicare Part B patients seen within the reporting period, AND
- Report one cross-cutting measure if they have at least one Medicare patient with a face-to-face encounter to avoid a payment adjustment in 2017

■ **Qualified Clinical Data Registry (QCDR):** The QCDR will collect an EP's medical and/or clinical data for patient and disease tracking, and submit it to CMS. The data submitted to CMS are not limited to Medicare. A list of CMS-approved registries is available on the CMS Web site.

- Under the 2015 reporting period, an individual eligible professional must report at least nine measures available for reporting under a QCDR covering at least three NQS domains for at least 50% of Medicare Part B patients seen within the reporting period to avoid the 2017 payment adjustment,
- Of these QCDR measures, the eligible professional must report on at least two outcome measures (or if less than two outcome measures, report on at least one outcome measure and at least one of the following types of measures: patient safety, resource use, patient experience of care, or efficiency/appropriate use).

Groups may report individual PQRS quality measures by submitting the PQRS data via:

■ GPRO Web Interface

■ Qualified PQRS Registry

■ EHR Direct Product that is certified electronic health record technology (CEHRT)

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■ EHR data submission vendor that uses CEHRT

■ CMS-certified survey vendor

■ **GPRO Web Interface:** Successful completion of the Web Interface measures for the required number of patients will determine PQRS incentive eligibility and performance rates for the measures. To avoid the 2017 PQRS payment adjustment, group practices taking part in PQRS GPRO via the Web Interface must meet the requirements for satisfactory reporting.

- Groups of 25-99 eligible professionals must report on all 18 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 number of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.

- Groups of 100+ eligible professionals must 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 number of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.

■ **CMS-Certified Survey Vendor:** A CMS-certified survey vendor is available to group practices of 25 or more EPs who would like to report the 12 Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) summary survey modules. CAHPS are patient experience surveys that ask respondents to evaluate their experience with providers.

- The CG CAHPS summary survey modules will be considered the equivalent of three individual measures and one NQS domain. Therefore, group practices that register for this method of reporting will need to report on at least six additional measures covering at least two additional NQS domains via qualified registry, direct EHR product, or EHR data submission vendor. Group practices of 25 or more eligible professionals that select to have the CG CHAPS summary survey modules reported on their behalf will need to complete six measures covering at least two NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO Web Interface.

Both an individual EP and a GPRO may report individual PQRS quality measures by submitting the PQRS data via:

■ **Qualified Registry-based Reporting:** Eligible professionals must select a qualified PQRS registry for reporting from the list of registries that can be found on the CMS Web site at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013ParticipatingRegistryVendors_05172013.pdf.

AAOMS has partnered with CECity to offer members and their staff the PQRSwizard to assist them in accurately participating in the PQRS program. CECity's PQRSwizard is an online portal customized for the specialty, which will allow members and their staff to submit the eligible quality measures directly to CMS. In doing so, OMSs will report using eligible measures and will avoid the payment reductions from their Medicare Part B reimbursement.

■ **Qualified EHR-based Reporting:** Eligible professionals will submit their PQRS data through an EHR product that is Certified EHR Technology (CEHRT) or through an EHR data submission vendor that uses CEHRT. A list of CEHRT vendors and their products is available on the CMS Web site.

	Individual EP	GPRO
Avoid Payment Adjustment	Report on at least 9 individual measures covering 3 NQS domains. If the EP's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report the measures for which there is Medicare patient data.	Report on at least 9 individual measures covering 3 NQS domains.

WHAT IS THE PQRS MEASURE APPLICABILITY VALIDATION (MAV)?

The MAV process is for those EPs who submit two or fewer PQRS measures across at least one NQS domain for at least 50% of their patients or encounters eligible for each measure, and who do not submit any other measure. Once the EP submits fewer than three PQRS measures, CMS will begin the MAV process. The MAV process will determine whether providers should have submitted additional measures. Eligible professionals who fail MAV may still avoid a payment adjustment if they reported at least one valid measure and if that measure is the only one that would apply to the EP. For more information on the MAV process, visit the Analysis and Payment page of the CMS Web site at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html.

	Individual EP	GPRO
Avoid Payment Adjustment	Report at least 9 measures covering 3 NQS domains for at least 50% of the Medicare Part B patients seen within the reporting period AND Report on at least 1 cross cutting measure if you see at least 1 Medicare patient in a face-to-face encounter	Report at least 9 measures covering 3 NQS domains for at least 50% of the group's Medicare Part B patients seen within the reporting period AND Report on at least 1 cross cutting measure if you see at least 1 Medicare patient in a face-to-face encounter

Complete details on the PQRS program can be found on the http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.

MEMBERSHIP MINUTE

All AAOMS fellows, members, resident members, and candidates will be listed in the *2015 AAOMS Membership Directory*, delivered to your door in late March. In addition to providing contact information for your colleagues, this informative resource includes AAOMS standing and special committee rosters, district trustee contacts, and OMS component society listings. Thanks to all members who completed the directory verification form notifying AAOMS of any changes to their contact information. All changes received by December 31, 2014 are included in the 2015 directory.

Updates received after December 31 will be reflected in the online member directory at AAOMS.org and in the Find a Surgeon listing on MyOMS.org. The online directories are updated weekly, so be sure to inform the Membership Department of any changes to your contact information to ensure that the most accurate information is always available.

Satellite office addresses may also be added to the Find a Surgeon feature on MyOMS.org. Members can list additional locations for a fee of $25 per address. Just contact the AAOMS Membership Department at 800/822-6637 or membership@aaoms.org for details.

AAOMS allied staff members may access their membership directory by logging into the aaoms.org members-only area and choosing the Allied Staff Directory. You may search by last name or location to check your listing or to network with colleagues. The Allied Staff Directory is updated weekly. If you don't see your name listed, contact the Membership Department to verify that your membership is current.