American Chiropractic Association

A Guidebook to the 2014 Physician Quality Reporting System

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Getting Started With PQRS

The Patient Protection and Affordable Care Act made participation in Medicare's Physician Quality Reporting System (PQRS) program mandatory beginning in 2015(based on 2013 reporting). The PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

Incentive Payments:
The 2014 reporting period (Jan. 1 – Dec. 31, 2014) is the last opportunity providers have to earn an incentive payment for participating in the PQRS program. Providers who successfully perform and satisfactorily report data to the Centers for Medicare and Medicaid Services (CMS) regarding quality measures related to their Medicare Part B patients can qualify to earn an incentive payment equal to 0.5% of their total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during that same reporting period. Incentive bonuses are usually paid in the month of November.

Payment Adjustments:
CMS finalized Calendar Year 2013 as the performance period for the 2015 PQRS penalties. Therefore, if CMS determines that an eligible professional did not successfully and satisfactorily report data on quality measures for covered professional services during last year's PQRS reporting period (Jan. 1 – Dec. 31, 2013), those providers will see their Medicare reimbursement decreased by 1.5% (98.5% of the fee schedule amount that would otherwise apply to such services) beginning in 2015.

Further, Calendar Year **2014 is the performance period that will affect a provider's 2016 Medicare reimbursement.** If CMS determines that an eligible professional has not successfully performed and satisfactorily reported on quality measures during the 2014 reporting period (Jan. 1 – Dec. 31, 2014), the provider will not qualify for the 0.5% payment incentive and they will see a **payment decrease of 2%** (98.0% of the fee schedule amount that would otherwise apply to such services) applied to their 2016 Medicare reimbursement.

If you have never participated in PQRS, the ACA encourages you to begin immediately. For those doctors of chiropractic who are continuing their participation in PQRS, please be advised that **significant updates and revisions have been made for 2014** that affect the number of PQRS measures applicable to chiropractic practices as well as the specific quality-data codes (G-codes) used to report these measures. To get started, follow the steps laid out below:

1) First, you should know that no registration is required to begin participating in PQRS.

2) It is best to start by familiarizing yourself with the **three (3)** quality measures doctors of chiropractic need to report in 2014. These measures are:

   - **Measure #131:** Pain Assessment and Follow-Up
   - **Measure #182:** Functional Outcome Assessment

   New for 2014

   - **Measure #317:** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

3) To receive an incentive bonus for participating in PQRS, and avoid the 2016 payment adjustment, you must report satisfactorily on **all three** measures applicable to DCs during the 12-month reporting

period in 2014. You must also successfully perform these measures at least once – measures with a zero percent performance rate will not be counted.

4) To report in PQRS, you will need to place G-codes on your claim. The G-codes will correlate to an action that was taken (or not taken) by the provider.

5) You should report Measures #131 and #182 on **every visit**, for every Medicare patient who is at least 18 years old **and** where you have reported a spinal CMT code (CPT® code 98940, 98941, or 98942). In 2014, you must satisfactorily report on **both** of these measures at least 50% of the eligible visits, and successfully perform each measure at least once, to qualify for the incentive bonus and avoid the 2016 payment adjustment.

6) In addition, you should report Measure #317 a minimum of **once per reporting period** (Jan. 1 – Dec. 31, 2014) for every Medicare patient who is at least 18 years old and where you have reported a spinal CMT code (CPT® code 98940, 98941, or 98942). Again, you must satisfactorily report on this measure at least 50% of the time, and successfully perform the measure at least once, to qualify for the incentive bonus and avoid the 2016 payment adjustment.

Information is provided on the following pages to assist you in reporting the appropriate G-code for each measure.

Measure #131
Pain Assessment and Follow-Up

- The purpose of this measure is for CMS to collect data on when a pain assessment is conducted, using a standardized tool, **and** a follow-up plan that includes a reassessment of pain is planned/documented when pain is present.
- A standardized tool is defined as an assessment tool that has been appropriately normalized and validated for the population in which it is used.
- Examples of standardized pain assessment tools include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).

  Note: The name of the standardized tool used to assess the patient's pain **must** be documented in the medical record *(exception: a provider may use a fraction such as 5/10 for the Numeric Rating Scale without documenting this actual tool name).*
- Providers are asked to report, for each visit, whether they provided a standardized pain assessment to the patient **and** whether they documented a follow-up plan which includes a reassessment of the pain (when pain is present). A clinical assessment of pain using a standardized tool may include characteristics of pain such as: location, intensity, description, and onset/duration.
- A follow-up plan **must** include a documented plan of care for a positive pain assessment, including a planned follow-up appointment to reassess the patient for pain, referrals, or notification of other care providers, as applicable, OR indicate the initial treatment plan is still in effect. The plan may also include educational interventions.
- The provider should report one of the quality data codes (G-codes) below on line 24 D of a paper claim or on service line 24 of an electronic claim.

The following chart depicts the situations in which each G-code should be reported for Measure #131:

Provider Action	G-Code Reported
Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented. The provider assessed the patient for pain using a standardized tool, documented a positive assessment (pain was present), and also documented a follow-up plan that specifically stated a planned reassessment of pain, a referral, or that the initial plan is still in effect..	**G8730**
Pain assessment using a standardized tool is documented as negative, no follow-up plan required. The provider assessed the patient for pain, documented a negative assessment (absence of pain), so no additional documentation was required.	**G8731**

Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool. The provider documented that the patient was not eligible for a pain assessment. Patients are not eligible only if one or more of the following reason(s) are documented: • Severe mental and/or physical incapacity where the patient is unable to express himself/herself in a manner understood by others; • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.	**G8442**
Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible. The provider assessed the patient for pain using a standardized tool, documented a positive assessment (pain was present), did not document a follow-up plan because the patient was deemed ineligible. Patients are not eligible only if one or more of the following reason(s) are documented: • Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others; • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.	**G8939**
No documentation of pain assessment, reason not given. The provider did not assess the patient for pain and there is no documentation the patient was not eligible (see G8939 or G8442 for non-eligibility reasons).	**G8732**
Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given. The provider assessed the patient for pain, documented a positive assessment (pain was present), but did **not** document a follow-up plan or a reason the patient was not eligible (see G8442 or G8939 for non-eligibility reasons).	**G8509**

Measure #182
Functional Outcome Assessment

- The purpose of this measure is for CMS to collect data on when functional outcome assessments are conducted, using a standardized tool, along with the creation of a treatment plan based on the functional deficiencies found.
- Examples of standardized functional outcome assessment tools include Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI) and Physical Mobility Scale (PMS).
    - ***Important:*** *Documentation of a current functional outcome assessment must include identification of the standardized tool used.*
    - ***Please Note:*** *A functional outcome assessment is multi-dimensional and quantifies pain and neuromusculoskeletal capacity; therefore the use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does* ***not*** *meet the criteria of a functional outcome assessment standardized tool.*
- Providers are asked to report whether they conducted a functional outcome assessment of the patient and whether they documented a care plan when functional outcome deficiencies were identified. A care plan describes expected/planned activities based on identified deficiencies (e.g., goals, services, appointments).
- The intent of the measure is for the functional outcome assessment tool to be **utilized** at a minimum of every 30 days, but **reporting** is required each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the code G8942 should be used for reporting purposes.
- The provider should report one of the quality-data codes (G-codes) below on line 24 D of a paper claim or on service line 24 of an electronic claim.

The following chart depicts the situations in which each G-code should be reported for Measure #182:

Provider Action	G-Code Reported
Functional outcome assessment documented as positive using a standardized tool <u>AND</u> a care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented. The provider performed a functional outcome assessment, using a standardized tool, and documented a care plan which included goals based on the deficiencies found.	**G8539**
Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required. The provider performed a functional outcome assessment, using a standardized tool, but a care plan is not required because no functional deficiencies were identified.	**G8542**
Functional outcome assessment using a standardized tool is documented within the previous 30 days and care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented. The provider has documented a functional outcome assessment, using a standardized tool, and a care plan which included goals based on the deficiencies found, within the last 30 days.	**G8942**

Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool. The provider documented the patient was not eligible for a functional outcome assessment. Patients are not eligible only if one or more of the following reason(s) are documented: • The patient refuses to participate • The patient is unable to complete the questionnaire • Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status	**G8540**
Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan. The provider performed a functional outcome assessment, using a standardized tool, and found functional deficiencies, did not document a follow-up plan because the patient was deemed ineligible. Patients are not eligible only if one or more of the following reason(s) are documented: • Patient refuses to participate • Patient unable to complete questionnaire • Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status	**G9227**
Functional outcome assessment using a standardized tool not documented, reason not given. The provider did not perform a functional outcome assessment and there is no documentation the patient was not eligible (see G8540 or G9227 for non-eligibility reasons).	**G8541**
Documentation of a positive functional outcome assessment using a standardized tool; care plan <u>not</u> documented, reason not given. The provider performed a functional outcome assessment, using a standardized tool, and found functional deficiencies, but did not document a care plan. In addition, there is no documentation the patient was not eligible (see G8540 or G9227 for non-eligibility reasons).	**G8543**

Measure #317
Preventive Care and Screening:
Screening for High Blood Pressure and Follow-Up Documented

- The purpose of this measure is for CMS to collect data on when screening for high blood pressure is conducted, and a follow-up plan is documented when a higher than normal blood pressure (120 / 80) is indicated.
- Providers are asked to report whether they screened a patient for high blood pressure and whether they documented an appropriate care plan when a higher than normal blood pressure has been identified.
- The intent of the measure is to screen patients for high blood pressure at a minimum of once per reporting period and provide recommended follow-up as indicated. Normal blood pressure follow-up is not recommended for patients with clinical or symptomatic hypotension.
- Blood Pressure (BP) is defined by four BP reading classifications as listed in the "Recommended Blood Pressure Follow-Up" table below, including Normal, Pre-Hypertensive, First Hypertensive, and Second Hypertensive readings.

Recommended Blood Pressure Follow-Up Table

BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up (*must include all indicated actions for each BP Classification)*
Normal BP Reading	< 120	AND < 80	• No Follow-Up required
Pre-Hypertensive BP Reading	≥ 120 AND ≤ 139	OR ≥ 80 AND ≤ 89	• Rescreen BP within a minimum of 1 year *AND* Recommend Lifestyle Modifications **OR** • Referral to Alternative/Primary Care Provider
First Hypertensive BP Reading	≥ 140	OR ≥ 90	• Rescreen BP within a minimum of ≥ 1 day and ≤ 4 weeks *AND* Recommend Lifestyle Modifications **OR** • Referral to Alternative/Primary Care Provider
Second Hypertensive BP Reading	≥ 140	OR ≥ 90	• Recommend Lifestyle Modifications *AND* 1 or more of the Second Hypertensive Reading Interventions ***(see definitions)*** **OR** • Referral to Alternative/Primary Care Provider

Definitions:

- **Lifestyle Modifications -** The current *Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure* (JNC) report outlines lifestyle modifications which **must** include one or more of the following as indicated: Weight Reduction, Dietary Approaches to Stop Hypertension (DASH) Eating Plan, Dietary Sodium Restriction, Increased Physical Activity, or Moderation in Alcohol (ETOH) Consumption.
- **Second Hypertensive Reading -** Requires a BP reading of Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg during the current encounter AND a most recent BP reading within the last 12 months of Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg.
- **Second Hypertensive Reading Interventions** - The current JNC report outlines interventions based on BP Readings shown in the "Recommended Blood Pressure Follow-Up" table and **must** include one or more of the following as indicated: Anti-Hypertensive Pharmacologic Therapy, Laboratory Tests, or Electrocardiogram (ECG).
- The provider should report one of the quality-data codes (G-codes) below on line 24 D of a paper claim or on service line 24 of an electronic claim.

The following chart depicts the situations in which each G-code should be reported for Measure #317:

Provider Action	G-Code Reported
Normal blood pressure reading documented, follow-up not required The provider performed a blood pressure screening and found that the patient had a normal blood pressure so no follow-plan was required.	**G8783**
Pre-Hypertensive or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented The provider performed a blood pressure screening, Pre-Hypertensive or Hypertensive Blood Pressure was indicated, AND appropriate follow-up is documented.	**G8950**
Blood pressure reading not documented, documentation the patient is not eligible. The provider documented the patient was not eligible for a blood pressure screening. Patients are not eligible only if one or more of the following reason(s) are documented: • Patient has an active diagnosis of hypertension • Patient refuses to participate (either BP measurement or follow-up) • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated	**G8784**
Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, documentation the patient is not eligible The provider performed a blood pressure screening, patient's blood pressure reading indicated a Pre-Hypertensive or Hypertensive blood pressure, but a follow up plan was not documented because the patient was not eligible. Patients are not eligible only if one or more of the following reason(s) are documented: • Patient has an active diagnosis of hypertension • Patient refuses to participate (either BP measurement or follow-up) • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated	**G8951**

Blood pressure reading <u>not</u> documented, reason not given The provider did not perform a blood pressure screening, a follow up plan was not documented, and there is no documentation the patient was not eligible (see G8784 or G8951 for non-eligibility reasons).	**G8785**
Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up <u>not</u> documented, reason not given The provider performed a blood pressure screening and a Pre-Hypertensive or Hypertensive blood pressure reading was documented, the indicated follow-up was not documented, and there was no documentation the patient was not eligible (see G8784 or G8951 for non-eligibility reasons).	**G8952**

2014 Criteria for Qualifying for the Incentive Bonus AND Avoiding the 2016 Payment Adjustment

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting *(NOTE: Claims-based reporting is the only reporting mechanism currently available to DCs.)*	Report both measures correctly for at least 50% of the eligible Medicare Part B FFS claims. Measures with a 0% performance rate will not be counted.	January 1, 2014 – December 31, 2014

How to Find Out if You Successfully Participated in PQRS

Each year, a Physician Quality Reporting System (PQRS) Final Feedback Report is issued for each provider based on their participation the previous year.

Interim feedback reports will be available quarterly for every Taxpayer Identification Number (TIN) under which at least one eligible professional (identified by his/her NPI) submitting Medicare Part B FFS claims reported at least one valid PQRS measure during the reporting period. This will be done through an "Interim Report Dashboard".

The Dashboard allows eligible professionals to log-in to a web-based tool and access interim PQRS data on a quarterly basis in order to monitor the status of claims-based individual measures. Please note the Dashboard does **not** provide final data analysis for full-year reporting or indicate PQRS incentive eligibility. The Dashboard will only provide claims-based data for interim feedback. Please take the time to download and read the "2014 Dashboard User Guide" once it is available (spring 2014).

How to Access your Final Feedback Report

If a PQRS feedback report is available for your National Provider Identifier (NPI), there are two (2) ways to access it.

1. A provider can simply call their A/B MAC to request the PQRS feedback report, which will contain information based on their individual NPI (if the provider is part of a group practice, each provider in the group practice must submit individually). To obtain a list of MAC Provider Contact Centers, visit the ACA website at:

   http://www.acatoday.org/pdf/AB_MACs_ByState.pdf

   In addition to PQRS information, these reports will provide individual providers with information on their Medicare Part B Physician Fee Schedule allowed charges upon which the incentive payment will be based, if applicable.

2. Providers can logon to the secure PQRS Portal on QualityNet at: https://www.qualitynet.org/portal to access their feedback report.

3. Users who have questions or need assistance should contact the Quality Net Help Desk at: 1-866-288-8912 (Monday-Friday 7:00 a.m.-7:00 p.m. CST) or email qnetsupport@sdps.org.

Timeline of Incentives/Payment Adjustments

- 2013 – 0.5% incentive bonus available*
- **2014 – 0.5% incentive bonus available***
- 2015 – 1.5% payment decrease *
- 2016 – 2.0% payment decrease *
- 2017 – 2.0% payment decrease *

** Starting in 2015, payment decreases will be implemented each year based on a provider's unsuccessful participation in PQRS two years prior.*

Frequently Asked Questions

Q. What is the Physician Quality Reporting System?

A. The Physician Quality Reporting System (PQRS) represents CMS' effort to implement a quality measure reporting program for Medicare providers.

Q. Is participation in PQRS mandatory?

A. The Patient Protection and Affordable Care Act (PPACA) made participation in PQRS mandatory, beginning in 2015. For clarification, CMS ruled in 2012 that, if a provider is not successfully participating in PQRS during the 2013 reporting period (Jan.1 – Dec. 31, 2013), their reimbursement will be decreased by 1.5% in 2015. In 2016 and beyond, reimbursement will be decreased by 2% and will be based on performance two years prior.

Q. To which Medicare providers does PQRS apply?

A. The program applies to:

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Oral Surgery
- Doctor of Dental Medicine
- **Doctor of Chiropractic**
- 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)
- Physical Therapist
- Occupational Therapist
- Qualified Speech-Language Therapist (as of 7/1/2009)

Q. When does the 2014 PQRS reporting period begin and end?

A. For 2014, the program begins on January 1, 2014 and concludes December 31, 2014.

Q. What are the requirements for participating in the PQRS program?

A. It is not necessary to register to participate in the PQRS program, but participants must have a National Provider Identifier (NPI) number in order to participate and must treat Part B beneficiaries.

Q. How does the incentive bonus payment work?

A. You can receive up to a 0.5% bonus, based on all Medicare allowed charges for dates of service January 1, 2013 through December 31, 2014. This includes deductibles and co-insurance as well as, where Medicare is the secondary payor, the total allowed charges and not just the portion paid by Medicare.

Q. What is meant by the 50 percent threshold for satisfactory PQRS Reporting?

A. This means that, during the 12-month reporting period, you have satisfactorily reported the measure for at least 50 percent of the Medicare Part B eligible visits (i.e., where the patient is at least 18 years old and a spinal CMT code was billed). That said, the ACA strongly recommends that you report PQRS measures on every visit to increase the chances of meeting the satisfactory reporting requirements for the incentive and to avoid the payment adjustment.

Q. What are considered appropriate assessment tools for Measure #131, the pain assessment measure?

A. An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment include, but are not limited to, Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).

Q. What are considered appropriate assessment tools for Measure #182, the functional assessment measure?

A. An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for the functional outcome assessment measure include, but are not limited to, Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), and Neck Disability Index (NDI) and Physical Mobility Scale (PMS).

Please Note: *The use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does* ***not*** *meet the criteria of a functional outcome assessment standardized tool.*

Q. Why do the CMS regulations say that provider have to report on a minimum of nine (9) measures?

A. For 2014, CMS increased the number of individual measures a provider must report on from three (3) to nine (9), if they want to qualify for a PQRS incentive payment. However, because DCs only have three measures available for reporting, we only have to report on those three.

Q. Is there a charge amount associated with reporting PQRS quality data codes (G-codes)?

A. CMS strongly encourages all eligible professional to submit quality data codes (PQRS G-codes) with a line item charge of one cent ($0.01). Please note that the beneficiary is **not** liable for this nominal amount. When the claim is submitted to the Medicare Administrative Contractor (MAC), the PQRS code line will be denied but will be tracked in the National Claims History (NCH) for analysis.

Please note: *Effective April 1, 2014, PQRS will issue different Remittance Advice (RA) codes for providers that bill on claims using $0.01 vs. $0.00.*

Q. What is the Remittance Advice (RA)/Explanation of Benefits (EOB) denial code N365?

A. N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." This remark code is your indication that the PQRS codes were received into the National Claims History file. The N365 code is just an indicator that the quality-data codes (QDCs/G-codes) were received; it does not guarantee the code chosen was correct or that reporting thresholds were met. However, when a QDC is reported satisfactorily, the N365 can indicate that the claim will be used in calculating incentive eligibility. The ACA recommends that you keep track of all cases reported so that you can verify QDCs reported against the RA/EOB sent by your Medicare Administrative Contractor (MAC). Each QDC line item should be listed with the N365 denial remark code. Additionally, you should regularly review the RA/EOB you receive from your MAC to ensure the N365 code appears.

Q. What happens if I don't see RA/EOB denial code N365?

A. If the RA/EOB remark code N365 does not appear on your RA/EOB, it is likely that you are not reporting the quality-data codes (G-codes) correctly and the transmission of this data was unsuccessful. For those claims where RA/EOB remark code N365 does not appear, ACA recommends that you review the claims submitted to ensure you inserted the G-codes on the claim form and that you also billed 98940, 98941 or 98942 on the same date of service. Additionally, the ACA has been informed that some MACs have begun providing a "shortened version" of the RA/EOB which does not include the N365 denial code.

If you believe your G-codes were submitted correctly, you have several options. You can contact your MAC and request that they provide you with the full version of your RAs/EOBs or that they provide you with your PQRS reporting success rate. Another option is to visit the PQRS Dashboard. This is a web-based tool that allows providers to log-in and access interim PQRS data on a quarterly basis and monitor the status of claims-based reporting. The Dashboard is available at: https://www.qualitynet.org/portal.

*Please Note: The Dashboard should **not** be used to determine final data analysis for full-year program reporting, or final determination of PQRS incentive eligibility.*

Q. I have read that there are five methods available for providers to report PQRS quality measures. Which method(s) can I use?

A. The claims-based reporting method (on your Medicare Part B claims) is the **only** available method to the chiropractic profession. DCs do not qualify to report PQRS using the other four methods [registry-based, qualified Electronic Health Record (EHR), Qualified Clinical Data Registry (QCDR) or the Group Practice Reporting Option (GPRO)].

Additional Resources

ACA webpage dedicated to PQRS: www.acatoday.org/PQRS

CMS webpage dedicated to PQRS: www.cms.gov/PQRS

ACA's Government Relations Department: Phone 703-812-0242 Email: Medicare@acatoday.org

CMS PQRS Helpdesk: Phone: 1-866-288-8912 Email: Qnetsupport@sdps.org

In addition, CMS regularly holds calls dedicated to PQRS and allows for open question and answer sessions. Look for announcements of these calls on the www.cms.gov/PQRS website under "CMS Sponsored Calls" and in ACA publications.

Glossary of Terms

Centers for Medicare and Medicaid Services (CMS): The nation's federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program.

Denominator: The denominator is associated with a given patient population that may be counted as eligible to meet a measure's inclusion requirements. PQRS measure denominators are identified by ICD, CPT, and HCPCS codes (e.g., 98940, 98941, 98942), as well as patient demographics (e.g., 18 years of age or older) and place of service (if applicable).

Eligible Professional (EP): Under PQRS, covered professional services are those paid under or based on the Medicare Physician Fee Schedule (MPFS). To the extent that eligible professionals are providing services which get paid under or based on the MPFS, those services are eligible for physician quality reporting. Providers not defined as EPs in the Tax Relief and Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRS and do not qualify for incentives. Refer to www.cms.gov/PQRS for a list EPs eligible to participate in PQRS.

Measure:

- **Outcome Measure** – A measure that provides information on how health care affects patients.
- **Performance Measure** – A measure used to assess the performance of a process or function.
- **Process Measure** – A measure associated with the practice of health care or the furnishing of a service that is known to be effective.
- **Structure Measure** – A measure that assesses whether organizational resources and arrangements are in place to deliver healthcare, such as number, type, and distribution of medical personnel, equipment, and facilities.

Numerator: A clinical action to be counted as meeting a measure's requirements (i.e., patients who were assessed for the presence or absence of pain or functional deficiency). PQRS measure numerators are identified by G-codes.

Pay-for-Performance (PFP): A model based on rewarding quality health care by setting different payment levels for health care providers based on how well they meet benchmarks of quality and efficiency (e.g., PQRS).

Physician Quality Reporting System (PQRS): Mandated by Congress through the Tax Relief and Health Care Act of 2006 (TRHCA), CMS developed the Physician Quality Reporting Initiative (PQRI). PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. To recognize that the PQRI was no longer an initiative and the program was made permanent, in 2011 CMS renamed the program the Physician Quality Reporting System (PQRS).

Reporting Period: The period during which PQRS measures are to be reported for covered professional services. Satisfactory reporting of PQRS measures are for dates of service that fall within the calendar year – January 1 through December 31.