

## PQRS Overview

Interested in participating in the Physician Quality Reporting System? Below is an overview to assist you every step of the way. We want all of our eligible professionals to benefit from this program as much as possible, so we are here to help!

### *What You Need to Know:*

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PQRS was established as part of The Tax Relief and Health Care Act of 2006 ([TRHCA](#)). It started as a voluntary bonus payment for eligible professionals for reporting Physician Quality Reporting Initiatives (PQRI) to Medicare beginning July 1, 2007, through 2014. The recently passed Patient Protection and Affordable Care Act ([PPACA](#)) will **require** mandatory reporting in 2015 (and into the future) and also changes the name to the Physician Quality Reporting System ([PQRS](#)).

### *Incentive Payments and Penalties:*

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- Eligible professionals who successfully report on measures in 2011 will qualify to earn an incentive payment of **1.0%** of their total estimated allowed charges for Medicare Part-B PFS covered professional services furnished during that same period
  - For 2012 – 2014, successful reports may earn an incentive payment of 0.5%
- Beginning in 2015, eligible professionals who do not successfully report on the measures may be subject to a payment adjustment or penalty of 1.5% in 2015 and 2.0% for 2016 and each subsequent year

PQRS		
Year	Successful	Not Successful
2009	2.0%	--
2010	2.0%	--
2011	1.0%	--
2012	0.5%	--
2013	0.5%	--
2014	0.5%	--
2015	No Incentive	-1.5%
2016 +	No Incentive	-2.0%

### *Who is Eligible?*

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Under PQRS, covered professional services are those paid under or based on the Medicare Physician Fee Schedule (PFS). To the extent that eligible professionals are providing services which get paid under or based on the PFS, those services are eligible for PQRS.

Most rheumatologists are eligible to participate in the PQRS program and may have additional clinical staff in their practice (including nurse practitioners, physician's assistants and physical therapists) that may be eligible to participate and collect bonus payments.

### Reporting Mechanics (Using the [Rheumatology Clinical Registry](#)):

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The RCR allows you to submit data to CMS by reporting on rheumatology-related individual PQRS quality measures or the RA measures group. Most RCR users opt to report using the RA measures group, as it requires significantly less data entry (reporting on 30 unique Medicare Part B patients as opposed to 80% of the applicable Medicare Part B population which is required for the individual measures).

#### **Measures Group:**

The RCR supports reporting for the RA measures group. To successfully submit to CMS for the RA measures group, RCR users must complete a Patient Registration Form and the required PQRS data fields (as indicated by *maroon italics* in the RCR) in the RA form for a total of 30 Medicare Part B patients who have had at least one office visit during the 2011 calendar year.

Note that not all clinical actions to meet quality measures must be performed on the same date, but should be performed at least once during the calendar year to be concordant with the measure.

Since the registry allows for retrospective data entry of PQRS data, RCR users have until Dec 31, 2011 to collect data on these 30 patients for entry into the RCR. So, eligible professionals can select a reporting period of 12 months\*, even if all of the data was collected and entered during the latter half of the year.

***\*Selection of the full year as the reporting period is recommended for maximum incentive payment.***

See the 'Getting Started' section for more resources on reporting the RA measures group through the RCR.

#### **Individual Measures:**

The RCR supports reporting of select individual PQRS measures that are relevant to the practice of rheumatology. These measures include:

- Measure #24: Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older
- Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
- Measure #40: Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older
- Measure #41: Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older
- Measure #109: Osteoarthritis (OA): Function and Pain Assessment
- Measure #142: Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications

To successfully submit to CMS for the PQRS program using individual measures, RCR users must select three applicable measures and complete a Patient Registration Form and the required PQRS data fields in the Osteoporosis and/or Osteoarthritis form for **80%** of applicable Medicare Part B patients who have had at least one office visit during the 2011 calendar year.

The measures can be submitted based on a 12-month or a 6-month (July 1 – Dec 31) reporting period, yielding bonus payments of 1.0% of the Medicare FFS payments during that timeframe. Note that the 80% rule applies to both timeframes, so if reporting on the 12-month period, you must

enter data for 80% of all applicable Medicare Part B patients you have seen during the year. If reporting on the 6-month period, you must enter data for 80% of the applicable Medicare Part B patients that you have seen during that time.

See the 'Getting Started' section for more resources on reporting individual measures through the RCR.

**Note that there are two important changes to the data submission and reporting requirements for the 2011 PQRS program:**

- **Patient sample requirements: all patients must be Medicare Part B patients**  
Unlike last year, the 2011 PQRS program requires that all patients included for reporting be Medicare Part B patients.
- **Data submission and performance requirement: measures submitted with a 0% performance rate will not be counted**  
CMS will disregard and not count measures reported with a 0% performance rate, meaning that of all patients submitted for the measure, the clinical quality action must be performed on at least one patient.

So, in order to successfully submit for the RA measures group, the data submitted to CMS must show each of the following:

- At least one patient of the 30 reported must have documentation of a functional status assessment during the 2011 calendar year
- At least one patient of the 30 reported must have documentation of a disease activity assessment using a standardized tool and have that score translated to a classification of 'low,' 'moderate,' or 'high' disease activity during the 2011 calendar year
- At least one patient of the 30 reported must have documentation of an assessment of prognosis and have prognosis classified as either 'good' or 'poor' during the 2011 calendar year
- At least one patient of the 30 reported must have documentation of a DMARD prescribed, administered, or issued during the 2011 calendar year.
- At least one patient of the 30 reported must have documentation of a TB test performed and interpreted if that patient was on a first course biologic DMARD during the 2011 calendar year
- At least one patient of the 30 reported must have documentation of a glucocorticoid management plan – if required – during the 2011 calendar year

If you have questions about any of these measures or how to incorporate these clinical actions into your practice, please contact ACR Registries and Health IT staff at [rcr@rheumatology.org](mailto:rcr@rheumatology.org).

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***Public Reporting:***

The Affordable Care Act calls for the development of a 'physician compare website,' which will be populated with 2011 PQRS data. While CMS already makes the names of eligible professionals who participate/submit data for the PQRS program public, the new 'physician compare' site will make it easier to find this information.

When the site opens in 2012 it will make available the names of providers who:

- Submitted data on 2011 PQRS quality measures through one of the reporting mechanisms available for the 2011 PQRS program;
- Met one of the proposed satisfactory reporting criteria of individual measures for the 2011 PQRS program; and
- Qualified to earn a PQRS incentive payment for covered professional services furnished during the applicable 2011 PQRS reporting period.

CMS will only post the names of providers who were successful in the 2011 PQRS program, but will move in the following years to post performance information, including scores for measures collected under the 2012 PQRS program.

### *Feedback Reports:*

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Section 3002 (e) of the ACA requires CMS to provide timely feedback to eligible professionals on the performance of that eligible professional with respect to satisfactorily submitting data on quality measures. CMS believes that the requirement for ‘timely’ feedback is met by providing the feedback reports on or about the time of issuance of incentive payments, consistent with current practice.

#### **How do I access my report for last year’s PQRS program?**

QualityNet Help Desk:

7:00 AM – 7:00 PM, CT

Phone: (866) 288-8912

E-mail: [Qnetsupport@sdps.org](mailto:Qnetsupport@sdps.org)

This service will help you with:

- General CMS PQRS and e-prescribing information
- PQRS portal password issues
- PQRS feedback report availability and access

Practices also may use a ‘[quality reporting portal](#)’ to confirm whether a feedback report exists for their Tax Identification Number (TIN) or a National Provider Identifier (NPI). If a report exists, there are two ways to access it:

1. Individual eligible professionals may call their local Medicare contractor and request that the contractor e-mail the report based on the individual NPI. Individual physicians in a group practice may individually use this option. For further information on this process, see [CMS MLN educational article SE0922](#).
2. Group practices that want to access feedback reports at the TIN level must once again use the [quality reporting portal](#), which also requires a user ID and password to the Individuals Authorized Access to CMS Computer Services (IACS) system. Use the [CMS IACS account management page](#) to verify access to your IACS account.

### *Informal Appeals Process:*

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Section 302 (f)(2) of the ACA requires CMS to establish an informal review process for eligible professionals to seek a review of the determination that s/he did not satisfactorily submit data on quality measures under PQRS

In order to appeal CMS's decision, an eligible professional must request an informal review, in writing, within 90 days of the feedback reports becoming available. Upon receiving the request for review, CMS will provide a written response within 60 days and, if found that the eligible professional did satisfactorily report, CMS will provide the applicable incentive payment.

We will post further information about the review process upon release from CMS.