2016 Physician Quality Reporting (PQRS): FREQUENTLY ASKED QUESTIONS

Q: What is the Physician Quality Reporting System?
A: The Physician Quality Reporting System (PQRS), formerly known as PQRI, is a program developed by the Centers for Medicare and Medicaid Services (CMS) that applies a payment reduction to eligible professionals (EPs) who do not satisfactorily report data on quality measures for the **Medicare Part B** patients they treat.

Q: Are non-physician clinicians subject to the same payment reductions?
A: Yes, any non-physician clinician that bills Medicare under his or her own NPI number is subject to the same reductions as the physician.

Q: Which non-physician clinicians (physician assistant (PA), nurse practitioner (NP), clinical nurse specialists (CNS), and advanced practice registered nurse (APRN)) are eligible to report PQRS measures?
A: Non-physician clinicians that are eligible to report PQRS measures are those that bill Medicare under their own NPI number. If the clinician bills under the doctor's NPI number, then he or she does not have to report.

Q: Can I report as a group practice?
A: Yes, Medicare allows practices of 2 or more eligible providers to report PQRS as a group (known as the Group Practice Reporting Option, or GPRO). To participate, registration with CMS must be completed during the registration period (TBA). More information about participating as a group is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html.

Q: The physician I work for told me that I need to submit his/her information through a registry. What does that mean?
A: A registry is an electronic system that is built by an outside company (vendor) that allows physician practices to enter quality information online. All vendors have to be registered on a qualified list with CMS.

Q: Does the AAD have a registry for members to use? Does it support group reporting?
A: Yes, the AAD's registry is run through DataDerm. DataDerm is a web-based system – all you need is an internet connection to use it. Additionally, DataDerm will support group reporting. DataDerm registration will launch in March 2016.

Q: If I have multiple Tax Identification Numbers (TINs) for a single practice location, under which do I report?
A: CMS analyzes your PQRS data strictly per the TIN shown on the Part B claims you are submitting. On the CMS 1500 paper form, that is field 25 where you enter a nine digit number and then check whether it is a SSN (Social Security Number) or EIN (Employee ID Number).

Q: If the provider works, or has worked, at multiple locations during 2016, does he or she have to report for each one?
A: Yes, CMS expects eligible providers to report under each TIN that they work under.

Q: What is the potential payment reduction for not participating in PQRS?
A: The potential payment reduction for not reporting PQRS in 2016 is 4-6% of Medicare charges, depending on the size of the practice (to be applied in 2018). This amount is comprised of the 2% PQRS payment reduction, and the 2-4% Value

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Based Payment Modifier (VBM) reduction. For solo practitioners and groups of 2-9 physicians, the potential payment reduction is 2% of Medicare charges for PQRS and a 2% VBM payment reduction. Groups of 10 or more physicians will automatically receive a 4% VBM payment reduction, in addition to a 2% reduction. There is no longer an incentive available to eligible providers who satisfactorily report PQRS measures.

Q: What is the Value Based Payment Modifier?
A: The Value Based Payment Modifier (VBM) provides incentives and levies payment reductions based on the quality of care and cost of care that eligible professionals provide under the Medicare Physician Fee Schedule. All eligible professionals, including solo practitioners, who have not successfully reported PQRS measures during the 2016 reporting period, will be automatically assessed a 2% to 4% VBM reduction, depending on the size of the practice. The additional VBM payment reduction can be avoided by successfully participating in PQRS.

Q: How many measures do I have to report to avoid the payment reductions?
A: The payment reductions will occur in 2018, and will be based on your participation in 2016. To avoid these payment reductions, you have to report at least 9 measures, on at least 50% of patients that apply to each measure, across at least three National Quality Strategy (NQS) domains. Additionally, providers must report at least one cross-cutting measure. The dermatology-specific measures can only be reported via registry.

Q: Do I really have to report 9 quality measures?
A: If you are unable to find 9 measures to report, Medicare encourages eligible professionals to report measures that are relevant to them and that work within the flow of their practice. Only you can consider a measure applicable or relevant to your practice. However, some measures may require clinic flow adjustments that are more efficient and effective, in order to accurately reflect the measure. By reporting less than 9 measures, you will be subject to the MAV process, but you can still avoid the same penalties as a provider who does have 9 measures to report.

Q: How many quality measures are there for dermatologists?
A: You can download a list of the dermatology-specific and dermatology appropriate measures at https://www.aad.org/practice-tools/pqrs-reporting.

Q: What is a cross-cutting measure and why do I have to report one?
A: Cross cutting measures are broadly applicable measures that are meant to drive quality and improvement. Cross-cutting measures are required for all eligible professionals that have a face to face encounter (likely excluding dermatopathologists from this requirement). You should choose the most applicable cross-cutting measure to your practice, but per PQRS requirements, at least one cross-cutting measure must be reported in order to satisfactorily report. For example, if you already ask whether your patients are tobacco users, then measure 226, Tobacco Use; Screening and Cessation Intervention, may be a good cross-cutting measure to report. The complete list of cross-cutting measures can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS-Crosscutting.pdf.

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Q: What are "National Quality Strategy (NQS) domains?"
A: The domains are in which certain quality measures fall. If electing to report nine measures you must choose nine measures that span at least three of these domains. The domains are: 1) Patient Safety, 2) Person and Caregiver-Centered Experience and Outcomes, 3) Communication and Care Coordination, 4) Effective Clinical Care, 5) Community/Population Health, 6) Efficiency and Cost Reduction.

Q: Which patients do I actually have to report?
A: You are only reporting on Medicare Part B patients for PQRS. This can be confusing because the measure specifications often say "regardless of age" in reference to which patients need to be reported. However, this language exists only to account for younger patients (e.g. people with disabilities) who may be on Medicare.

Q: Sometimes, multiple different providers in a practice will treat a single patient. Who should report that patient?
A: A provider will report a patient only if that patient is billed under his or her individual NPI. If the provider's individual NPI is not on the Medicare claim, then the patient should not be entered into the registry for that provider. This would only apply if you are not reporting as a GPRO (group practice).

Q: How many measures do I have to *meet*?
A: You *must* have greater than a 0% performance rate for all reported measures in order to report successfully. However, not every reported patient needs to meet every measure. In addition, each of the quality measures must have at least one eligible instance in order for you to report that measure. For example, since the only applicable diagnosis for measure 138 is a new diagnosis of melanoma, you must see at least one patient with a new diagnosis of melanoma (that is also a Medicare patient) to report measure 138 successfully.

> *Example Scenario: "This year, I saw eleven Medicare patients with a personal history of melanoma (V10.82), and I diagnosed four Medicare patients with a new melanoma (172.X). How many of these patients do I report? How many times should I report each one?"*
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> *Answer: You would have to report at least six of your eleven patients (55%) with a history of melanoma, as well as at least two of your patients (50%) with a new diagnosis of melanoma. If all of your patients with a history of melanoma returned for follow-up appointments, you only have to enter one visit for that patient into the registry.*

Q: What is the difference between these percentages I keep hearing about? 50%? 0%?
A: The "50%" figure refers to the minimum percentage of patients, or patient visits (depending on the measure) that one must *report* per measure. This number of patients must be reported *whether you successfully perform the measure, or not.* For example, measure 138, Melanoma: Coordination of Care, only applies to patients with a new diagnosis of melanoma. Therefore, you would report at least 50% of however many patients you had with that diagnosis. Measure 226, Tobacco Use; Screening and Cessation Intervention, on the other hand, applies to all patients who had an office visit in 2016. If choosing to report that measure, you would still have to report at least 50% of those patients, even though it will inevitably be a larger number than for measure 138.

The "0%" figure you may have heard about is the measure performance rate that will not count as successful reporting. If reporting a measure, the measure must be successfully performed at least once.

Q: I understand that this program only applies to Medicare patients, but what if Medicare is a secondary or tertiary payer for this patient's care?
A: Patients who have Medicare as a secondary or tertiary payer should be included in your submission.

Q: Should I include patients covered under Medicare Advantage plans?
A: No, do not include Medicare Advantage patients in your PQRS submission.

Q: Should I include patients covered under Railroad Medicare?
A: Yes, you should include Railroad Medicare patients in your submission.