DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

Physician Quality Reporting System:
Updates for 2012

FACT SHEET **http://www.cms.gov/PQRS**

Background

The Physician Quality Reporting System (Physician Quality Reporting) is a voluntary reporting program. The program provides an incentive payment to practices with eligible professionals (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to **Medicare Part B Fee-For-Service (FFS) beneficiaries** (including Railroad Retirement Board and Medicare Secondary Payer).

Each eligible professional must satisfactorily report on at least **50 percent** of eligible instances when reporting through claims to qualify for the incentive.

A web page dedicated to providing all the latest news about Physician Quality Reporting is available at http://www.cms.gov/PQRS on the Centers for Medicare & Medicaid Services (CMS) website.

Purpose

This fact sheet includes important information about changes to Physician Quality Reporting for 2012, as authorized by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

Important Changes for 2012 Physician Quality Reporting

For 2012 Physician Quality Reporting, key changes included the following:

- Addition of several new quality measures for a total of 210 for claims- and/or registry-based reporting;
- Addition of eight new Physician Quality Reporting measures groups for a total of 22;
- Revisions to reporting requirements, including:
  - Deleting the 6-month reporting option, except when reporting measures groups via registry;

- Data submission vendors can submit on behalf of eligible professionals for Electronic Health Record (EHR) data;
- Adding a pilot program to align EHR-based reporting with the EHR Incentive Program;
- Adopting all 44 EHR Incentive Program measures for EHR-based reporting;
- Replacing Group Practice Reporting Option (GPRO) I and II with a single GPRO, with updated group sizes and reporting requirements;
- Posting GPRO performance information on the Physician Compare website in 2013;
- Adopting measures that align with the Medicare Shared Savings Program;
- Providing interim (in addition to annual) feedback reports; and
- Establishing 2013 as the reporting period for the 2015 Physician Quality Reporting payment adjustment.

2012 Physician Quality Reporting – Individual Measures

Several new quality measures reportable via claims, registry, and EHR were added for the 2012 program year. 2012 Physician Quality Reporting now consists of 210 quality measures. This includes 28 new measures for claims and registry. Nine measures from the 2011 program were retired for 2012.

Appendix A lists the nine 2011 measures retired for 2012. For more specific information, refer to the 2012 measures documents at http://www.cms.gov/PQRS on the CMS website.

NOTE: The 2012 Physician Quality Reporting measure specifications for any given individual quality measure may be different from specifications for the same quality measure used for 2011. **Eligible professionals should ensure that they are using the 2012 Physician Quality Reporting measure specifications.**

2012 Physician Quality Reporting – Measures Groups

For 2012, there are a total of 22 measures groups. Fourteen measures groups were retained from 2011 and eight new measures groups were added for 2012. The retirement of measures led to changes in the following measures groups:

- Chronic Kidney Disease (CKD),
- Ischemic Vascular Disease (IVD), and
- Heart Failure (HF).

For specific measures groups changes from 2011 to 2012 in the form of release notes, refer to the "2012 Physician Quality Reporting System Measure Groups Specifications and Release Notes" document at http://www.cms.gov/PQRS/15_MeasuresCodes.asp on the CMS website.

NOTE: The specifications for measures groups do not necessarily contain all the specification elements of each individual measure included in the measures group. Therefore, the specifications and instructions for measures groups will be provided separately from the specifications and instructions for the 2012 individual measures. In addition,

the 2012 Physician Quality Reporting measures groups specifications for any given measures group may be different from specifications for the same measures group used for 2011. **Eligible professionals should ensure that they are using the 2012 measures groups specifications.**

2012 Physician Quality Reporting Options and Criteria for Satisfactory Reporting for Individual Eligible Professionals

Key changes to the reporting requirements for individual eligible professionals included the following:

- Individual measures with a 0 percent performance rate will be considered in analysis but will not be considered satisfactorily reported for incentive eligibility.
- Measures groups containing a measure with a 0 percent performance rate will not be counted as satisfactorily reported.
- The 6-month reporting period beginning July 1, 2012, and ending December 31, 2012, is only available to those eligible professionals reporting measures groups via registry.
- A pilot program was added to align Physician Quality Reporting EHR-based reporting with the EHR Incentive Program. For more information on this program, please see the "Physician Quality Reporting System-Medicare EHR Incentive Pilot" section below.

As in previous years, an eligible professional who reports on fewer than three individual measures via claims may also be subject to the Measure-Applicability Validation process to make certain there are no additional measures on which the eligible professional could have reported. The criteria used to determine whether an eligible professional satisfactorily reports for 2012 Physician Quality Reporting are summarized in Tables 1 through 5 in **Appendix B**.

Physician Quality Reporting System-Medicare EHR Incentive Pilot

For the 2012 program year, CMS implemented the Physician Quality Reporting System-Medicare EHR Incentive Pilot.

- Successful participation in the pilot will allow receipt of the 2012 Physician Quality Reporting incentive payment and demonstrate meaningful use of the Clinical Quality Measure (CQM) component of the EHR Incentive Program.
- For additional details on the Physician Quality Reporting System-Medicare EHR Incentive Pilot, refer to the "2012 Physician Quality Reporting System: Medicare EHR Incentive Pilot: Quick Reference Guide" document at http://www.cms.gov/PQRS/20_AlternativeReportingMechanisms.asp on the CMS website.

GPRO

Beginning with 2012 Physician Quality Reporting, a single GPRO replaces GPRO I and GPRO II.

- Group practices must go through a self-nomination process and be selected by CMS to participate.
- 2012 self-nomination and reporting requirements can be found in the "Group Practice Reporting Option (GPRO) Requirements for Submission of 2012 Physician Quality

Reporting System and Electronic Prescribing (eRx) Incentive Program Data" document at http://www.cms.gov/PQRS/22_Group_Practice_Reporting_Option.asp on the CMS website.

- Group sizes, reporting mechanism, reporting criteria, and reporting period for satisfactory reporting under GPRO are summarized in Table 6 in **Appendix B**.

GPRO Performance Data on Physician Compare

- As a part of the self-nomination process for 2012 GPRO, group practices must agree to have their reporting performance results publicly reported on the Physician Compare Website in 2013 at http://www.medicare.gov/find-a-doctor/provider-search.aspx on the Internet.
- CMS will identify those eligible professionals associated with the group practice during the reporting period, but does not intend to post information regarding individual performance rates.

Aligning with Medicare Shared Savings Program

The following measures were added to 2012 Physician Quality Reporting GPRO in an effort to align with Accountable Care Organizations (ACOs):

- Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility,
- Falls: Screening for Future Fall Risk,
- Diabetes Mellitus: Hemoglobin A1c Control (< 8%),
- Diabetes Mellitus: Daily Aspirin Use for Patients with Diabetes and Ischemic Vascular Disease,
- Diabetes Mellitus: Tobacco Non Use,
- Ischemic Vascular Disease (IVD): Complete Lipid Profile and Low Density Lipoprotein (LDL-C) Control,
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic,
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up,
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, and
- Preventive Care and Screening: Screening for High Blood Pressure.

Interim Feedback Reports

In addition to annual feedback reports, interim feedback reports will be available in 2012.

- These reports will be a simplified version of the feedback reports CMS currently provides to eligible professionals. Reports will be based on claims for dates of service occurring on or after January 1, 2012, and processed by March 31, 2012.
- CMS expects to make interim feedback reports available to eligible professionals in the summer of 2012 for the 2012 program year.

Future Physician Quality Reporting System Payment Adjustments

Beginning in 2015, if the eligible professional or group practice does not satisfactorily submit data on Physician Quality Reporting quality measures, a 1.5 percent payment adjustment will apply. The adjustment (98.5 percent of the PFS amount that would otherwise apply to such services) applies to covered professional services furnished by an eligible professional or group practice during 2015 or any subsequent year.

To avoid the 2015 adjustment, an eligible professional must satisfactorily report Physician Quality Reporting quality measures during the 2013 reporting period (January 1 – December 31, 2013).

Resources

- For more information about what's new for 2012 Physician Quality Reporting, visit http://www.cms.gov/PQRS/30_EducationalResources.asp on the CMS website.
- For more information about reporting measures groups, refer to the "2012 Physician Quality Reporting System: Reporting the Preventive Care Measures Group Via Claims Made Simple" document at http://www.cms.gov/PQRS/30_EducationalResources.asp on the CMS website.
- For answers to frequently asked questions, visit https://questions.cms.hhs.gov/app/home on the CMS website.
- The Medicare Learning Network® (MLN) Educational Web Guides MLN Guided Pathways to Medicare Resources help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information applicable to you, refer to the section about your provider type in the "MLN Guided Pathways to Medicare Resources Provider Specific" booklet at http://www.cms.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website. For all other "Guided Pathways" resources, visit http://www.cms.gov/MLNEdWebGuide/30_Guided_Pathways.asp on the CMS website.

Appendix A

2011 Physician Quality Reporting Measures Retired for 2012

Measure Number	Measure Title
79	End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility
135	Chronic Kidney Disease (CKD): Influenza Immunization
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization
199	Heart Failure: Patient Education
200	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation (AF)
202	Ischemic Vascular Disease (IVD): Complete Lipid Profile
203	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control

Appendix B

2012 Reporting Requirements

Table 1. Criteria for Claims-Based Reporting of Individual Measures

Reporting Criteria	Reporting Period
At least 3 Physician Quality Reporting measures, or 1-2 measures if less than 3 apply to the eligible professional, for at least 50% of applicable Medicare Part B FFS patients of each eligible professional. **New: Measures with a 0% performance rate will be considered in analysis but will not be considered satisfactorily reported for incentive eligibility.**	January 1, 2012 – December 31, 2012
New/revised: 6-month reporting option via claims no longer available.	N/A

Table 2. Criteria for Claims-Based Reporting of Measures Groups

Reporting Criteria	Reporting Period
One measures group for 30 **unique** Medicare Part B FFS patients of each eligible professional. **New: Measures Groups containing a measure with a 0% performance rate will not be counted.**	January 1, 2012 – December 31, 2012
One measures group for 50% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients during the reporting period). **New: Measures Groups containing a measure with a 0% performance rate will not be counted.**	January 1, 2012 – December 31, 2012

Table 3. Criteria for Registry-Based Reporting of Individual Measures

Reporting Criteria	Reporting Period
At least 3 Physician Quality Reporting measures for 80% of applicable Medicare Part B FFS patients of each eligible professional. **New: Measures with a 0% performance rate will not be counted.**	January 1, 2012 – December 31, 2012
New/revised: 6-month reporting option via registry no longer available.	N/A

Table 4. Criteria for Registry-Based Reporting of Measures Groups

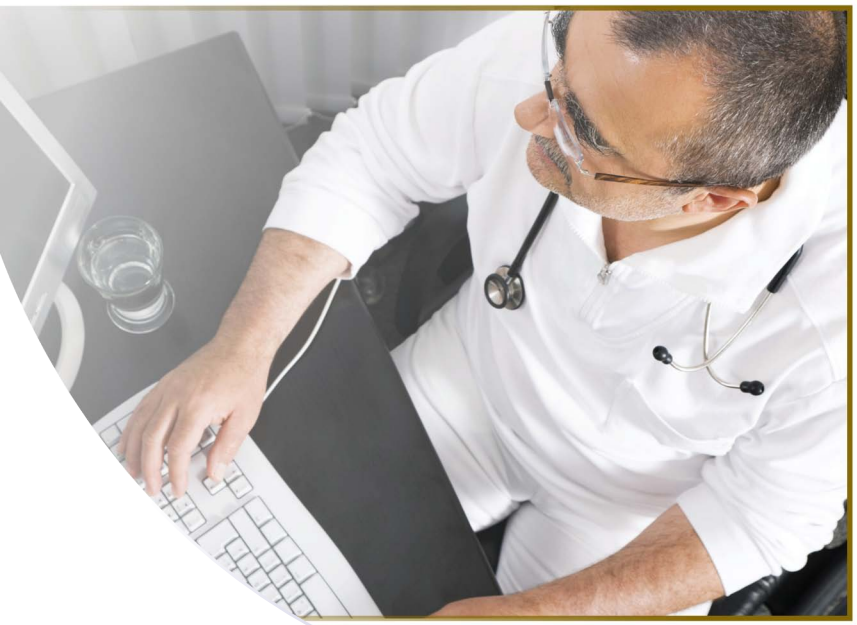
Reporting Criteria	Reporting Period
One measures group for 30 **unique** patients of each eligible professional. Patients must be Medicare Part B FFS patients. **New: Measures Groups containing a measure with a 0% performance rate will not be counted.**	January 1, 2012 – December 31, 2012
One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients during the reporting period). **New: Measures Groups containing a measure with a 0% performance rate will not be counted.**	January 1, 2012 – December 31, 2012
One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 8 patients during the reporting period). **New: Measures Groups containing a measure with a 0% performance rate will not be counted.**	July 1, 2012 – December 31, 2012

Table 5. Criteria for EHR-Based Reporting of Individual Measures

Reporting Criteria	Reporting Period
At least 3 Physician Quality Reporting measures, for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. **New: Measures with a 0% performance rate will not be counted.**	January 1, 2012 – December 31, 2012
New: EHR Aligning with the Medicare EHR Incentive Program Report on **all** 3 Medicare EHR Incentive Program core measures (as identified in Table 48 of Final Rule with Comment Period). If denominator for one or more of core measures is 0, report on up to 3 Medicare EHR Incentive Program alternate core measures (as identified in Table 48); **and** Report on 3 (of the 38) additional measures available for the Medicare EHR Incentive Program. Table 48 is on page 73364 of the Final Rule with Comment Period at http://www.gpo.gov/fdsys/pkg/FR-2011-11-28/pdf/2011-28597.pdf on the Internet.	January 1, 2012 – December 31, 2012

Table 6. Criteria for the Group Practice Reporting Option

Group Practice Size	Reporting Mechanism	Reporting Criteria	Reporting Period
25-99 eligible professionals	A submission web interface provided by CMS	Report on all measures included in the 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 (with an oversample of 327) for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.	January 1, 2012 – December 31, 2012
100+ eligible professionals	A submission web interface provided by CMS	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 (with an oversample of 616) for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.	January 1, 2012 – December 31, 2012



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