CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-22 Medicare Quality Reporting Incentive Programs	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10	**Date: July 27, 2012**
	Change Request 7879

SUBJECT: Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program Pub. 100-22 Medicare Quality reporting Incentive Programs Manual Update

I. SUMMARY OF CHANGES: This Change Request (CR) provides updates to the requirements established for the Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program described in the 2006 Tax Relief and Health Care Act (TRHCA), Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and Medicare Improvements for Patients and Providers Act (MIPPA).

EFFECTIVE DATE: October 29, 2012
IMPLEMENTATION DATE: October 29, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/Table of Contents
R	1/10/Background
R	1/20/Eligible Professionals
R	1/20.1/Eligible Professionals Not Able to Participate
R	1/20.2/Professionals Not Eligible to Participate in the Physician Quality Reporting System and Not Qualified to Earn an Incentive Payment
R	1/20.3/Participation by Group Practices
R	1/30/Payment for Reporting
R	1/40/Reporting Period
R	1/50/Form and Manner of Reporting
R	1/50.1/Claims-based Reporting Mechanism
R	1/50.1.1/Coding and Reporting Principles for Claims-based Reporting
R	1/50.2/Registry-based Reporting Mechanism
R	1/50.3/Electronic Health Record-based (EHR-based) Reporting Mechanism
R	1/60/Physician Quality Reporting System Measures
R	1/60.1/Reporting of Individual Physician Quality Reporting System Quality Measures
R	1/60.2/Reporting of Physician Quality Reporting System Measures Groups
R	1/70/Criteria for Determination of Satisfactory Reporting
R	1/70.1/ Criteria for Determination of Satisfactory Reporting of Individual Measures and Measures Groups for Individual Eligible Professionals
R	1/70.1.1/ Criteria for Determination of Satisfactory Reporting of Individual Measures for Claims-based Reporting
R	1/70.1.2/ Criteria for Determination of Satisfactory Reporting of Individual Measures for Registry-based Reporting
R	1/70.1.3/ Criteria for Determination of Satisfactory Reporting of Individual Measures for EHR-based Reporting
R	1/70.2/ Criteria for Determination of Satisfactory Reporting for Group Practices and Process for Reporting by Group Practices
N	1/70.2.1/ Criteria for Determination of Satisfactory Reporting for Group Practices and Process for Reporting under the GPRO
R	1/80/Limitations on Review
R	1/90/Confidential Feedback Reports
N	1/100/Direct Mailings

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	2/Table of Contents
R	2/10/Background
R	2/20/Eligibility
R	2/20.1/Individual Eligible Professionals
N	2/20.1.1/Professionals Eligible to Participate But Not Able to Participate
N	2/20.1.2/Professionals Not Eligible to Participate
N	2/20.1.3/Professionals Eligible to Participate But For Whom the Payment Adjustment Does Not Apply
R	2/20.2/Participation by Group Practices Using the eRx Group Practice Reporting Option (GPRO)
R	2/30/Reporting Period
N	2/30.1/Reporting Period for the Incentive Payments
N	2/30.2/Reporting Period for the Payment Adjustments
R	2/40/Payment for Reporting
R	2/50/Form and Manner of Reporting for the Purpose of Receiving Incentive Payments and Payment Adjustment
R	2/50.1/Claims-based Reporting Mechanism
R	2/50.1.1/Coding and Reporting Principles for Claims-based Reporting
R	2/50.2/Registry-based Reporting Mechanism
R	2/50.3/Electronic Health Record-based (EHR-based) Reporting Mechanism
R	2/60/Criteria for Determination of Successful Electronic Prescriber
R	2/60.1/Eligible Professionals
N	2/60.1.1/Criteria for Determination of Successful Electronic Prescriber for the Incentive Payments - Individual Eligible Professionals
N	2/60.1.2/Criteria for Determination of Successful Electronic Prescriber for the Payment Adjustments - Individual Eligible Professionals
R	2/60.2/Group Practices
N	2/60.2.1/Criteria for Determination of Successful Electronic Prescriber for the Incentive Payments - Group Practices
N	2/60.2.2/Criteria for Determination of Successful Electronic Prescriber for the Payment Adjustments - Group Practices
R	2/70/Significant Hardship Exemptions for the Payment Adjustments
N	2/70.1/Significant Hardship Exemptions for the Payment Adjustments - Individual Eligible Professionals and Group Practices

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	2/80/Confidential Feedback Reports
N	2/90/Direct Mailings
N	2/100/Public Posting of Program Performance

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-22	Transmittal: 10	Date: July 27, 2012	Change Request: 7879

SUBJECT: Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program – Pub 100-22 Medicare Quality reporting Incentive Programs Manual Update

Effective Date: **October 29, 2012**

Implementation Date: October 29, 2012

I. GENERAL INFORMATION

A. Background: The Physician Quality Reporting System previously known as the Physician Quality Reporting Initiative or PQRI is a voluntary reporting program that provides an incentive payment to identified individual eligible professionals. Section 131 of the Medicare Improvements for Patients and Providers Act (MIPPA), enacted on July 15, 2008, made the Physician Quality Reporting System, initially established under the Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006 MIEA-TRHCA permanent. Section 132 of the MIPPA required the Secretary to establish a new incentive program for individual eligible professionals who are successful electronic prescribers as defined by MIPPA beginning on January 1, 2009. This CR manualizes the information contained in existing CRs and MPFS legislation. This CR does not establish new requirements for the Physician Quality Reporting System and ERx Incentive Program. It manualizes existing requirements to the programs. Changes to the programs are described in the annual MPFS legislation.

B. Policy: This CR provides updates to the requirements established for the Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program described in the 2006 Tax Relief and Health Care Act (TRHCA), Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and Medicare Improvements for Patients and Providers Act (MIPPA).

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	FISS	MCS	VMS	CWF	
7879.1	Contractors shall be aware of the revisions made to Pub. 100-22 Chapters 1 and 2 which manualizes the Physician Quality Reporting System and ERx Incentive Program.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7879.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. .	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
7879.1	CR 6514: Coding and Reporting Principles for the Physician Quality Reporting Initiative (PQRI) and the Electronic Prescribing (E-Prescribing) Incentive Programs
7879.1	CR 6394: Program Overview: 2009 Physician Quality Reporting Initiative (PQRI) and the 2009 Electronic Prescribing (E-Prescribing) Incentive Program
7879.1	CR6187: 2008 Physician Quality Reporting Initiative Claims-Based Reporting of Measures Groups

Section B: For all other recommendations and supporting information, use this space: NA

V. CONTACTS

Pre-Implementation Contact(s): Diane Stern, diane.stern@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Quality Reporting Incentive Programs Manual

Chapter 1 – The Physician Quality Reporting *System*

Table of Contents
(Rev.10, Issued: 07-27-12)

Transmittals for Chapter 1

80 – Limitations on Review

90 - Confidential Feedback Reports

100 – Direct Mailings

10 - Background

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

The *Physician Quality Reporting System (formerly known as Physician Quality Reporting Initiative or PQRI)* is a reporting program that provides *a combination of incentive payments and payment adjustments* to identified individual eligible professionals *and* group practices who satisfactorily report data on quality measures for covered professional services (defined below) furnished by *eligible professionals* during a specified reporting period.

The *Physician Quality Reporting System* was first implemented in 2007*, then referred to as PQRI,* as a result of section 101 of Division B – Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006 (P.L. 109-432) (MIEA-TRHCA), which was enacted on December 20, 2006. Section 101(b) of the MIEA-TRHCA adds subsection (k) to section 1848 of the Social Security Act (the Act), which requires the establishment of a quality reporting system. Section 101(c) of the MIEA-TRHCA authorizes the Secretary to provide incentive payment*s to eligible professionals* who satisfactorily report data on quality measures under the quality reporting system for covered professional services furnished to Medicare beneficiaries during the second half of 2007. CMS named the quality reporting system*,* the incentive payment*, and the payment adjustment* the *Physician Quality Reporting System*. Section 1848(k)(3)(A) of the Act defines "covered professional services" as services for which payment is made under, or is based on, the Medicare Part B Physician Fee Schedule (PFS) and which are furnished by an *eligible professional*.

Section 101(b)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) (MMSEA), which was enacted on December 29, 2007, amends section 1848(k)(2)(B) of the Act (as added by the MIEA-TRHCA) and section 101(c) of the MIEA-TRHCA to extend the *Physician Quality Reporting System* through 2009 and to authorize the Secretary to make incentive payments for covered *Medicare* PFS services furnished to Medicare Part B fee-for-service (FFS) beneficiaries in 2008. In addition, the MMSEA amends section 101(c) of the MIEA-TRHCA by requiring the Secretary, for 2008 and 2009, to establish alternative reporting criteria and alternative reporting periods for reporting on measures groups, and for registry-based reporting.

Section 131of the Medicare Improvements for Patients and Providers Act (P.L. 110-275) (MIPPA), which was enacted on July 15, 2008, makes the quality reporting system initially established under MIEA-TRHCA permanent. In addition, section 131(b)(2) of the MIPPA redesignates section 101(c) of the MIEA-TRHCA, as amended by MMSEA, as subsection (m) of section 1848 of the Act. Section 1848(m) of the Act, as redesignated and amended by the MIPPA, authorizes the Secretary to make *Physician Quality Reporting System* incentive payments for covered *Medicare* PFS services furnished to Medicare Part B FFS beneficiaries in 2009 and 2010.

The Affordable Care Act (ACA) makes further changes to the Physician Quality Reporting System, including the following: authorizing incentive payments until 2014; requiring payment adjustments beginning in 2015 for eligible professionals who do not satisfactorily report data on quality measures during the applicable reporting period for the year; requiring timely feedback to participating eligible professionals; requiring the establishment of an informal review process whereby eligible professionals may seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures for purposes of qualifying for a Physician Quality Reporting System incentive payment; and making available an additional incentive payment for those eligible professionals satisfactorily reporting data on quality measures for a year and having such data submitted on their behalf through a Maintenance of Certification Program and participating in a Maintenance of Certification Program practice assessment more frequently than is required to qualify for or maintain board certification status.

The program requirements for the *Physician Quality Reporting System* are summarized in this chapter.

20 – Eligible Professionals

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

As defined in section 1848(k)(3)(B) of the Act, eligible professional means any of the following:

1. Physicians
    - Doctor of Medicine
    - Doctor of Osteopathy
    - Doctor of Podiatric Medicine
    - Doctor of Optometry
    - Doctor of Dental Surgery
    - Doctor of Dental Medicine
    - Doctor of Chiropractic

2. Practitioners
    - 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)

3. Therapists
    - Physical Therapist
    - Occupational Therapist
    - Qualified Speech-Language Therapist (began billing Medicare directly as of 7/1/09)

Audiologists were added to the definition of *"eligible professional"* beginning with the 2009 *Physician Quality Reporting System* as required by section 131(b)(4) of the MIPPA.

All Medicare-enrolled professionals in these categories are eligible to participate in the *Physician Quality Reporting System*, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims.

20.1 – *Eligible Professionals Not Able to Participate*

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Some professionals who are included in the definition of "*eligible professional*" above, although listed as eligible to participate in the *Physician Quality Reporting System*, are not able to participate for one or more reasons described below.

Eligible professionals in certain settings in which Medicare PFS billing is processed by Medicare FIs/AB MACs. The FI/AB MAC claims processing systems for the following settings currently cannot accommodate billing at the individual *eligible professional* level:

- Critical access hospitals (CAHs), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the regular FI or Part A MAC for the covered professional services furnished by the *eligible professional*.

- All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.

20.2 – Professionals Not Eligible to Participate in the *Physician Quality Reporting System* and Not *Qualified* to Earn an Incentive Payment

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Providers and professionals not defined as *eligible professionals* are not eligible to participate in *the Physician Quality Reporting System* and do not qualify for an incentive. Services payable under fee schedules or methodologies other than the *Medicare* PFS are not included in *the Physician Quality Reporting System* (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, portable x-ray suppliers, independent laboratories, hospitals [including critical access], rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for *the Physician Quality Reporting System* since DME is not based on or paid under the *Medicare* PFS.

20.3 – Participation by Group Practices

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Prior to 2010, the *Physician Quality Reporting System* was limited to *eligible professionals* and the determination of whether an *eligible professional* satisfactorily reported quality data was made at the individual professional level, based on the National Provider Identifier (NPI). No incentive payments were made to a group practice based on a determination that the group practice, as a whole, satisfactorily reported *the Physician Quality Reporting System* quality measure data. To the extent that individual *eligible professionals* (based on individuals' NPIs) are associated with more than one practice, or Tax Identification Number (TIN), the determination of whether an *eligible professional* satisfactorily reported *the Physician Quality Reporting System* quality measures data was made for each unique TIN/NPI combination. Therefore, the incentive payment amount was calculated for each unique TIN/NPI combination and payment was made to the holder of the applicable TIN (see §30 below).

As required by the MIPPA, group practices can qualify to earn a *Physician Quality Reporting System* incentive payment beginning with the 2010 *Physician Quality Reporting System* based on the determination that the group practice, as a whole, satisfactorily reports *Physician Quality Reporting System* quality measures data. The criteria for satisfactory reporting for group practices and the process for reporting by group practices under the *Physician Quality Reporting System* group practice reporting option (GPRO) are discussed in §70.3 below. *In 2010," group practice"* was defined as a TIN with at least 200 individual *eligible professionals* (as identified by NPIs) who have reassigned their billing rights to the TIN.

In 2011, the GPRO was expanded to include a second, smaller GPRO classification, GPRO II. Thus, whereas GPRO I consists of group practices comprised of a TIN with at least 200 individual eligible professionals, under GPRO II, a "group practice" is defined as a TIN with 2-199 eligible professionals. Therefore, in 2011, due to the addition of the GPRO II to the Physician Quality Reporting System, for purposes of this reporting option, "group practice" was defined as a TIN with at least 2 individual eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN.

In 2012, the definition of GPRO was further revised. First, the GPRO II option, along with its reporting requirements, was eliminated. In lieu of GPRO II, the GPRO (classified as GPRO I in 2011) was extended to group practices comprised of a TIN with at least 25 or more eligible professionals. Therefore, effective beginning January 1, 2012, "group practice" is defined as a TIN with at least 25 eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN.

In order to participate in the *Physician Quality Reporting System* GPRO, group practices are required to complete a self-nomination process and to meet *certain specified* requirements*, which include but are not limited to:*

- *Indicating group size to determine eligibility to participate in the GPRO*
- Agree*ing* to attend and participate in all mandatory training sessions;
- Have billed Medicare Part B *during a specified timeframe*;

- *Providing* CMS with an electronic file (such as, a Microsoft® Excel file) with the self-nomination *statement* that includes the group practice's TIN and *all rendering* individual NPI numbers, *and* name of the group practice;
- *Providing* a single point of contact for handling administrative issues as well as a single point of contact for technical support purposes; *and*
- *If desired, indicating the group practice's participation in the eRx Incentive Program for the applicable program year with either the intended reporting method or, if applicable, a request for a hardship exemption from the applicable eRx payment adjustment.*

The specific self-nomination requirements for the Physician Quality Reporting System GPRO for a particular program year can be found in the Group Practice Reporting Option section of the CMS Physician Quality Reporting System website at http://www.cms.gov/PQRS.

CMS assesses whether the participation requirements are met by each self-nominated group practice and notifies group practices of a decision. Under section 1848(m)(3)(C)(iii) of the Act, an individual *eligible professional* who is a member of a group practice selected to participate in the *Physician Quality Reporting System* GPRO for a particular program year is not eligible to separately earn a *Physician Quality Reporting System* incentive payment as an individual *eligible professional* under that same TIN (that is, for the same TIN/NPI combination) for that year. Once a group practice (TIN) is selected to participate in the GPRO for a particular program year, this is the only *Physician Quality Reporting System* reporting option available to the group and all individual NPIs who bill Medicare under that group's TIN for that program year.

30 – Payment for Reporting

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

A participating individual *eligible professional* or group practice (see §20 above) who satisfactorily reports data on *Physician Quality Reporting System* quality measures as described in §70 may earn an incentive payment *equal to the applicable quality percent of the Secretary's estimate of allowed part B charges for covered professional services furnished by the eligible professional or group practice* during a specified reporting period (see §40 below).

For 2007 and 2008, *the applicable quality percent is 1.5% incentive.*

For 2009, *the applicable quality percent is 2.0%*.

For 2010, *the applicable quality percent is 2.0%*.

For 2011, the applicable quality percent is 1.0%.

For 2012 through 2014, the applicable quality percent is 0.5%.

In addition, from 2011 through 2014, eligible professionals who are physicians may qualify to earn an additional Maintenance of Certification Program incentive (the applicable quality percent for each year is 0.5%). To earn this additional incentive payment, each year, a physician must:

- *Satisfactorily submit data on quality measures (i.e. meet the criteria for satisfactory reporting to earn a Physician Quality Reporting System reporting incentive) for the 12-month reporting that applies for the year;*
- *Have such data submitted on their behalf through a Maintenance of Certification Program that meets the criteria for registry (as specified by CMS) or an alternative form and manner determined appropriate by the Secretary;*
- *Participate in a Maintenance of Certification Program more frequently than is required to qualify for or maintain board certification status; and*
- *Successfully complete a qualified Maintenance of Certification Program practice assessment more frequently than is required to qualify for or maintain Board certification status.*

For each year, the *Physician Quality Reporting System* incentive payment is calculated based on an *eligible professional's* a group practice's total estimated Medicare Part B PFS allowed charges for all covered professional services: (1) furnished during the applicable reporting period, (2) received into the CMS National Claims History (NCH) file by no later than 2 months after the end of the reporting period, and (3) paid under or based upon the Medicare PFS. Because claims processing times may vary by time of the year and Medicare Carrier/AB MAC, participating *eligible professionals* or group practices should submit claims from the end of a reporting period promptly, so that if, for example, the reporting period ends on December 31st of a particular year, claims from the end of the reporting period will reach the NCH file by February 28th of the following year. *Physician Quality Reporting System* incentive payments are paid as a lump sum. *Physician Quality Reporting System* incentive payments are generally made in the middle of the year following the year in which the reporting period falls. There is no beneficiary co-payment or notice to the beneficiary regarding the *Physician Quality Reporting System* incentive payments.

The *Physician Quality Reporting System* incentive payment amount is calculated using estimated allowed charges for all covered professional services under the Medicare Part B PFS, not just those charges associated with reported quality measures. The term "allowed charges" refers to total charges. Note that the amounts billed above the Medicare Part B PFS amounts for assigned and non-assigned claims do not apply to the incentive payment. The statute defines *Physician Quality Reporting System* covered professional services as those paid under or based upon the Medicare Part B PFS only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a different methodology.

Other Part B services and items that may be billed by *eligible professionals* but are not paid under or based upon the Medicare PFS do not apply to the *Physician Quality Reporting System* incentive payment. In addition, any amounts owed to CMS, such as from overpayments or other withholds, are subtracted from the incentive payment amount.

The analysis of satisfactory reporting is performed at the individual *eligible professional* level using individual-level NPI data, and beginning in 2010, for group practices participating in the GPRO, the group practice level using TIN data. For both participating individual *eligible professionals* and group practices, CMS uses the TIN as the billing unit. Therefore, any

Physician Quality Reporting System incentive payments earned are paid to the TIN holder of record. For individual *eligible professional*, *Physician Quality Reporting System* incentive payments are paid to the holder of the TIN, aggregating individual incentive payments for groups that bill under one TIN. For *eligible professionals* who submit claims under multiple TINs, CMS groups claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the *Physician Quality Reporting System* incentive payment under more than one TIN would receive a separate *Physician Quality Reporting System* incentive payment associated with each TIN.

In situations where *eligible professionals* are employees or contractors who have assigned their payments to their employers or facilities, section 1848(m)(1)(A) of the Act specifies that any *Physician Quality Reporting System* incentive payment earned be paid to the employers or facilities.

40 – Reporting Period

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

For the 2007 *Physician Quality Reporting System*, which was the first program year, the reporting period was July 1, 2007 through December 31, 2007, as required by section 1848(m)(6)(C)(i)(I) of the Act.

For 2008 *and beyond*, section 1848(m)(6)(C)(i)(II) of the Act defines "reporting period" to be the entire calendar year. Under section 1848(m)(6)(C)(ii) of the Act, however, for years after 2009, the Secretary is authorized to revise such reporting periods. In addition, section 1848(m)(5)(F) of the Act requires the Secretary to, beginning with the 2008 *Physician Quality Reporting System*, establish alternative reporting periods for reporting groups of measures, or measures groups, and for reporting using a medical registry.

*Therefore, b*eginning with the 2008 *Physician Quality Reporting System*, there are 2 reporting periods for each program year: (1) a 12-month reporting period consisting of the entire calendar year and (2) a 6-month reporting period beginning July 1st and ending December 31st. Depending upon the particular program year, the second reporting period beginning July 1st may not apply to all of the *Physician Quality Reporting System* reporting options that are available for that program year (see §70 below for further details).

50 – Form and Manner of Reporting

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Eligible professionals may choose to report quality measures data to CMS using one of the following established reporting mechanisms:

- Claims-based reporting;
- Registry-based reporting *(beginning in 2008)*: or
- EHR-based reporting (beginning in 2010).

Beginning with the 2007 *Physician Quality Reporting System*, CMS implemented the claims-based reporting mechanism based on submission of quality measures data on Medicare Part B claims.

The registry-based reporting mechanism became available to *eligible professionals* beginning with the 2008 *Physician Quality Reporting System*. The registry-based reporting mechanism is available for reporting either individual *Physician Quality Reporting System* quality measures or *Physician Quality Reporting System* measures groups (see §60.1 and §60.2, respectively)

The EHR-based reporting mechanism became available to *eligible professionals* beginning with the 2010 *Physician Quality Reporting System* and is available for reporting on individual *Physician Quality Reporting System* quality measures only (see §60.1 below).

50.1 – Claims-based Reporting Mechanism

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Eligible professionals who choose to participate in *Physician Quality Reporting System* via the claims-based reporting mechanism do not have to enroll or register with CMS to begin reporting *Physician Quality Reporting System* quality measures data to CMS.

Participating *eligible professionals* whose Medicare patients fit the specifications of the *Physician Quality Reporting System* quality measures and/or measures groups will simply report on their claims the corresponding appropriate quality-data codes (QDCs), which are CPT Category II codes or G-codes (where CPT Category II codes are not yet available). CPT Category II codes and G-codes are Healthcare Common Procedure Coding System (HCPCS) codes for reporting quality data. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P.

50.1.1 – Coding and Reporting Principles for Claims-based Reporting

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

The following principles apply to the reporting of QDCs for *Physician Quality Reporting System* measures:

- The CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:
    - on the same claim(s) as the denominator billing code(s) for the same date of service (DOS)
    - for the same beneficiary
    - for the same date of service (DOS)
    - by the same *eligible professional* (individual NPI) who performed the covered service as the payment codes, usually ICD-9-CM, CPT Category I or HCPCS codes, which supply the denominator.

- All diagnoses reported on the claim will be included in *Physician Quality Reporting System* analysis, as some *Physician Quality Reporting System* measures require reporting more than one diagnosis on a claim. For line items containing a QDC, only a single reference number in the diagnosis pointer field will pass into the NCH file. To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses (base claim diagnoses) are considered in *Physician Quality Reporting System* analysis.

- Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically. The *Physician Quality Reporting System* analyzes claims data using ALL diagnoses from the base claim (Item 21 of the CMS-1500 or electronic equivalent) and service codes for each individual professional identified by his or her rendering individual NPI. In other words, base claim diagnoses apply to all rendering TIN/NPIs on the claim. *Eligible professionals* should review ALL diagnosis and encounter codes listed on the claim to make sure they are capturing ALL reported measures applicable to that patient's care.

- If the *eligible professionals'* billing software limits the number of line items available on a claim, an *eligible professional* may add a nominal amount such as a penny, to one of the line items on that second claim for a total charge of one penny. CMS will look across all claims data for common occurrences of carrier claim control numbers, equated beneficiary claim numbers (HIC), and carrier numbers.

  Only final action claims will be analyzed for *Physician Quality Reporting System*. For *Physician Quality Reporting System* measure calculation purposes, claims will be combined based on the same beneficiary for the same date-of-service, for the same TIN/NPI and analyze as one claim. Providers should work with their billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses or QDCs are not dropped.

- QDCs must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered professional service is performed.

    - The submitted charge field cannot be blank.
    - The line item charge should be $0.00.
    - If an eligible professional's billing software does not allow a $0.00 line-item charge, a nominal amount can be substituted such as 1 penny ($0.01) – the beneficiary is not liable for this nominal amount.
    - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)
    - Whether a $0.00 charge or a nominal amount is submitted to the carrier/contractor, the *Physician Quality Reporting System* QDC code line is denied and tracked.

- QDC line items will be denied for payment, but are then passed through the claims processing system for *Physician Quality Reporting System* analysis. *Eligible professionals* will receive a Remittance Advice (RA) associated with the claim which will contain the *Physician Quality Reporting System* quality-data code line-item and will include a standard remark code (N365) and a message that confirms that the QDCs passed into the NCH file. N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the *eligible professional* is attempting to report.
    - Keep track of all *Physician Quality Reporting System* cases reported so that the *eligible professionals* can verify QDCs reported against the remittance advice notice sent by the carrier/MAC. Each QDC line-item will be listed with the N365 denial remark code.

- Multiple *eligible professionals*' QDCs can be reported on the same claim using their individual NPI. Therefore, when a group is billing, the group should follow its normal billing practice of placing the NPI of the individual *eligible professional* who rendered the service on each line item on the claim including the QDC line(s).

- Some measures require the submission of more than one QDC in order to properly report the measure. *Eligible professionals* may report each QDC as a separate line item, referencing one diagnosis and including the rendering provider NPI.

- Use of CPT II modifiers (1P, 2P, 3P, 8P) is unique to CPT II codes and may not be used with other types of CPT codes. Only CPT II modifiers may be appended to CPT II codes. Do not append CPT I modifiers to CPT II codes or vice versa.

- Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent).

- *Eligible professionals* may submit multiple codes for more than one measure on a single claim.

- Multiple CPT Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim.

- If a denied claim is subsequently corrected through the appeals process to the Carrier/AB MAC, with accurate codes that also correspond to the measure's denominator, then QDCs that correspond to the numerator should also be included on the resubmitted claim as instructed in the measure specifications.

- Claims may NOT be resubmitted for the sole purpose of adding or correcting QDCs.

- *Eligible Professionals* should use the 8P reporting modifier judiciously for applicable measures they have selected to report. The 8P modifier may not be used indiscriminately in

an attempt to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

Submission through Carriers/MACs
QDCs shall be submitted to carriers/MACs either through:
Electronic submission, which is accomplished using the ***ASC X 12N Health Care Claim Transaction (Version 5010)*****.**

CPT Category II and/or temporary G-codes should be submitted in the **SV101-2** "Product/Service ID" Data Element on the **SV1** "Professional Service" Segment of the ***2400 "Service Line" Loop***.

- It is also necessary to identify in this segment that a HCPCS code (HC) is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.

- Diagnosis codes are submitted at the claim level, ***Loop 2300, in data element HI01***, and if there are multiple diagnosis codes, in ***HI02 through HI12*** as needed with a single reference number in the diagnosis pointer.

- In general for group billing, report the NPI for the rendering provider in ***Loop 2310B*** (Rendering Provider Name, claim level) or ***2420A*** (Rendering Provider Name, line level), using data elements ***NM109 (NM108=XX)***.

OR

Paper-based submission, which is accomplished by using the ***CMS-1500 claim form (version 08-05)***. Relevant ICD-9-CM diagnosis codes are entered in ***Field 21. Service codes*** (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in ***Field 24D*** with a single reference number in the diagnosis pointer ***Field 24E*** that corresponds with the diagnosis number in Field 21.

- For group billing, the ***National Provider Identifier (NPI)*** of the rendering provider is entered in ***Field 24J***.

- The ***Tax Identification Number (TIN)*** of the employer is entered in ***Field 25***.

Group NPI Submission
When a group bills, the group's NPI is submitted at the claim level, therefore, the individual rendering physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.

Individual NPI Submission
The individual NPI of the solo practitioner must be included on the claim line as is the normal billing process for submitting Medicare claims. For the *Physician Quality Reporting System*, the

QDC must be included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in *Physician Quality Reporting System* analysis.

CMS-1500 Claim Example

An example of a claim in CMS-1500 format that illustrates how to report several *Physician Quality Reporting System* measures is available in the *Physician Quality Reporting System* Implementation Guide, a downloadable document that is updated for each program year and posted on the CMS *Physician Quality Reporting System* website *http://www.cms.hhs.gov/PQRS*.

Satisfactorily Reporting Measures

Physician Quality Reporting System participants should also refer to *the "How to Get Started" section of the Physician Quality Reporting System website, available at http://www.cms.gov/PQRS. This section provides helpful information on how to get started with reporting quality measures for the Physician Quality Reporting System.*

Timeliness of Quality Data Submission

Claims processed by the Carrier/MAC must reach the National Claims History (NCH) file by no later than 2 months after the end of the reporting period to be included in the analysis. For the 2010 *Physician Quality Reporting System*, for example, claims processed by the Carrier/MAC must reach the NCH file by no later than February 28, 2011 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis for *Physician Quality Reporting System*.

50.2 – Registry-based Reporting Mechanism

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Beginning in 2008, Individual *eligible professionals* may choose to participate in the *Physician Quality Reporting System* via the registry-based reporting mechanism. *Eligible professionals* who choose to participate in the *Physician Quality Reporting System* via the registry-based reporting mechanism do not have to enroll or register to begin registry-based reporting of *Physician Quality Reporting System* quality measures data to CMS. However, to report *Physician Quality Reporting System* quality measures data via the registry-based reporting mechanism, an *eligible professional* must select a registry *qualified under the Physician Quality Reporting System for the program year* and enter into and maintain an appropriate legal arrangement with the selected registry. Such arrangements should provide for the registry's receipt of patient-specific data from the *eligible professional* and the registry's disclosure of quality measures results and numerator and denominator data on *Physician Quality Reporting System* quality measures or measures groups on behalf of the *eligible professional* to CMS. An *eligible professional* choosing the registry-based reporting mechanism must submit information on *Physician Quality Reporting System* individual quality measures or measures groups to his or her selected registry in the form and manner and by the deadline specified by the registry. Thus the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L.104-191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as "data submission vendors." The "data submission vendors" would have the requisite legal authority to provide clinical quality measures results and numerator and denominator data on individual

quality measures or measures groups on behalf of the eligible professional for the *Physician Quality Reporting System*.

CMS qualifies registries to participate in each program year through a self-nomination process. Registries that were qualified to submit data on behalf of *eligible professionals* in a prior program year are not required to go through the qualification process again unless they were unsuccessful at submitting *Physician Quality Reporting System* data for the prior program year by the registry's data submission deadline *or CMS makes changes to the registry qualification requirements*. The final list of qualified registries for a particular program year is made available on the CMS *Physician Quality Reporting System* website at *http://www.cms.hhs.gov/PQRS*. The list is usually made available in the summer of the program year in question. For example, the list of qualified registries for the 2008 *Physician Quality Reporting System* was made available in the summer of 2008.

50.3 – Electronic Health Record-based (EHR-based) Reporting Mechanism

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

To report *Physician Quality Reporting System* quality measures data via *a direct* EHR-based reporting mechanism, an *eligible professional* must select a qualified *direct* EHR product. *For each program year, an eligible professional* choosing the EHR-based reporting mechanism must:

- Have *access to a CMS-specified identity management system, such as IACS*;
- Submit a test file containing dummy clinical quality data extracted from the EHR to a CMS clinical data warehouse; and
- Submit a file containing the *eligible professional's Physician Quality Reporting System* clinical quality data extracted from the EHR for the entire reporting via *the CMS-designated clinical data warehouse* by no later than 2 months after the end of the reporting period

CMS qualifies EHR vendors and their specific product(s) for use by *eligible professionals* to submit *Physician Quality Reporting System* quality measures data to CMS. The list of qualified EHR vendors and products for a specific program year are made available on the CMS *Physician Quality Reporting System* website at *http://www.cms.hhs.gov/PQRS*. The list of *qualified EHR vendors and products is generally posted before the start of program year or shortly thereafter. For example, the list of 2011 qualified EHR vendors and products was posted prior to January 2011.*

To report Physician Quality Reporting System quality measures data via an EHR data submission vendor, an eligible professional must select a qualified EHR data submission vendor product.

60 – *Physician Quality Reporting System* Measures

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

To qualify to earn the *Physician Quality Reporting System* incentive payment, an *eligible professional* must report data on quality measures. Beginning with the 2008 *Physician Quality Reporting System*, *eligible professionals* have the option of reporting data on individual quality measures or on measures groups. *Physician Quality Reporting System* measures groups are created by CMS by grouping 4 or more *Physician Quality Reporting System* measures that have a clinical condition or focus in common. The *Physician Quality Reporting System* measures that comprise a measures group share a common denominator specification and therefore differ in their specifications from that of individual measures.

60.1 – *Reporting of* Individual *Physician Quality Reporting System* Quality Measures

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

When the *Physician Quality Reporting System* was first implemented in 2007, the program consisted of 74 individual quality measures*, all of which were reportable via the claims-based reporting mechanism only.*

In 2008, CMS retired some of the 2007 measures but added new measures so that the total number of *Physician Quality Reporting System* individual quality measures expanded to 119. The 2009 *Physician Quality Reporting System* included a total of 153 individual quality measures. Data on 53 of the 2009 *Physician Quality Reporting System* measures may only be reported through a qualified registry and may not be reported through claims-based reporting (see §50 above).

The 2010 *Physician Quality Reporting System* includes a total of 175 individual quality measures. Data on 10 of the 2010 *Physician Quality Reporting System* measures may be reported via a qualified EHR product, however, two of these may not be reported through claims-based reporting. In addition, data on 50 of the 2010 *Physician Quality Reporting System* measures may not be reported through claims-based reporting. Such data must be reported through a qualified registry, or if the measure is 1 of the 10 measures designated for EHR reporting, via a qualified EHR product.

The 2011 Physician Quality Reporting System included a total of 190 individual quality measures that may be reported via claims, registry, and/or EHR.

The 2012 Physician Quality Reporting System includes a total of 224 individual quality measures that may be reported via claims, registry, and/or EHR. Note that these are some limitations as to which measures may be reported via claims, registry and/or EHR.
A complete list of the individual Physician Quality Reporting System quality measures for a specific program year, as well as their detailed measure specifications and respective reporting requirements can be found on the CMS Physician Quality Reporting System website at http://www.cms.gov/PQRS. Measure specifications for the current or upcoming program year can be found on the Measures Codes page of the CMS Physician Quality Reporting System website. Measure specifications for prior program years are archived to the appropriate

Physician Quality Reporting System Program page of the CMS Physician Quality Reporting System website.

When measures for a particular program year are selected from a prior year's measure set, the detailed measure specifications for such measures may have been updated or modified during the National Quality Forum endorsement process or for other reasons. The *Physician Quality Reporting System* quality measure specifications for any given measure selected for use in a specific program year may, therefore, be different from specifications for the same quality measure used for a prior program year. For example, the 2009 *Physician Quality Reporting System* specifications for a measure that was used in the 2008 *Physician Quality Reporting System* may be different from the 2008 *Physician Quality Reporting System* specifications for the same measure. *Eligible professionals* must ensure that they are using the published specifications for the correct program year.

60.2 – Reporting of *Physician Quality Reporting System* Measures Groups

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

For the 2008 *Physician Quality Reporting System*, CMS established 4 measures groups to address the following clinical topics:
(1) Diabetes Mellitus,
(2) Chronic Kidney Disease (CKD),
(3) Preventive Care, and
(4) End Stage Renal Disease (ESRD).

For the 2009 *Physician Quality Reporting System*, CMS removed the ESRD measures group, but added 4 additional measures for a total of 7 measures groups. The 2009 *Physician Quality Reporting System* measures groups address the following clinical topics:
(1) Diabetes Mellitus,
(2) CKD,
(3) Preventive Care,
(4) Coronary Artery Bypass Graft (CABG) Surgery,
(5) Rheumatoid Arthritis,
(6) Perioperative Care, and
(7) Back Pain.

For the 2010 *Physician Quality Reporting System*, CMS retained all of the 2009 *Physician Quality Reporting System* measures groups and added 6 new measures groups for a total of 13 measures groups. The 2010 *Physician Quality Reporting System* measures groups address the following clinical topics:
(1) Diabetes Mellitus,
(2) CKD,
(3) Preventive Care,
(4) CABG Surgery,
(5) Rheumatoid Arthritis,
(6) Perioperative Care,
(7) Back Pain,
(8) Coronary Artery Disease (CAD),

(9) Heart Failure,
(10) Hepatitis C,
(11) Ischemic Vascular Disease (IVD),
(12) Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), and
(13) Community-Acquired Pneumonia (CAP).

For the 2011 Physician Quality Reporting System, CMS retained all of the 2010 Physician Quality Reporting System measures groups and added 1 new measures group, for a total of 14 measures groups. The 2011 Physician Quality Reporting System measures groups address the following clinical topics:
(1) Diabetes Mellitus,
(2) CKD,
(3) Preventive Care,
(4) CABG Surgery,
(5) Rheumatoid Arthritis,
(6) Perioperative Care,
(7) Back Pain,
(8) Coronary Artery Disease (CAD),
(9) Heart Failure,
(10) Hepatitis C,
(11) Ischemic Vascular Disease (IVD),
(12) Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), and
(13) Community-Acquired Pneumonia (CAP).
(14) Asthma

For the 2012 Physician Quality Reporting System, CMS retained all of the 2011 Physician Quality Reporting System measures groups and added 8 new measures groups, for a total of 22 measures groups. The 2012 Physician Quality Reporting System measures groups address the following clinical topics:
(1) Diabetes Mellitus,
(2) CKD,
(3) Preventive Care,
(4) CABG Surgery,
(5) Rheumatoid Arthritis,
(6) Perioperative Care,
(7) Back Pain,
(8) Coronary Artery Disease (CAD),
(9) Heart Failure,
(10) Hepatitis C,
(11) Ischemic Vascular Disease (IVD),
(12) Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS),
(13) Community-Acquired Pneumonia (CAP),
(14) Asthma,
(15) COPD,
(16) IBD,
(17) Sleep Apnea,

(18) Dementia,
(19) Parkinson's,
(20) Elevated Blood Pressure,
(21) Cardiovascular Prevention, and
(22) Cataracts.

In addition, all measures contained in the following 2012 Physician Quality Reporting System measures groups are also reportable as individual measures:
(1) Diabetes Mellitus,
(2) CKD,
(3) Preventive Care,
(4) CABG Surgery,
(5) Rheumatoid Arthritis,
(6) Perioperative Care,
(7) Coronary Artery Disease (CAD),
(8) Heart Failure,
(9) Hepatitis C,
(10) Ischemic Vascular Disease (IVD),
(11) Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS),
(12) Community-Acquired Pneumonia (CAP),
(13) Asthma,
(14) COPD, and
(15) Cardiovascular Prevention.

In addition, data on the CABG, CAD, Heart Failure, HIV/AIDS, IBD, Sleep Apnea, Dementia, Parkinson's, Elevated Blood Pressure, and Cataracts measures groups may only be reported through a qualified registry and may not be reported through claims-based reporting (see §50 above).

Measures groups specifications are different from the specifications for individually reported measures *(if any measures in a measures group may be reported individually)* that form the group. Therefore, the specifications, including the list of measures selected for inclusion in each of the *Physician Quality Reporting System* measures groups, and reporting instructions for the *Physician Quality Reporting System* measures groups are provided separately from the specifications for the individual *Physician Quality Reporting System* measures. The specifications manual for measures groups can be found on the CMS *Physician Quality Reporting System* website at *http://www.cms.hhs.gov/PQRS*. Measures group specifications for the current or upcoming program year can be found on the Measures Codes page of the CMS PQRS website. Measures group specifications for prior program years are archived to the appropriate *Physician Quality Reporting System* Program page of the CMS *Physician Quality Reporting System* website.

To initiate claims-based reporting of measures groups, it is necessary that the *eligible professionals* indicate the intention to begin reporting a measures group by submitting a measures group-specific G-code on the patient claim. There is one defined measures group-specific G-code for each *Physician Quality Reporting System* measures group. It is not necessary to submit the measures group-specific G-code on more than one claim. If the

measures group-specific G-code for a given group is submitted multiple times during the reporting period, only the submission with the earliest date of service will be included in the *Physician Quality Reporting System* analyses; subsequent submissions of that code will be ignored. It is not necessary to submit the measures-group specific G-code for registry-based submissions. In addition, beginning for the 2009 *Physician Quality Reporting System*, if **all** quality actions for the applicable measures in a measures group have been performed for the patient, **one *Physician Quality Reporting System* composite G-code** may be reported in lieu of the individual quality-data codes for each of the measures within the group. There is one defined composite G-code for each *Physician Quality Reporting System* measures group.

Similar to the specifications for individual *Physician Quality Reporting System* measures, when measures groups for a particular program year are selected from a prior year's measures group set, the detailed measures group specifications for such a measures group may have been updated or modified during the National Quality Forum endorsement process or for other reasons. In addition, the individual measures that comprise a specific measures group may change from year to year. Therefore, the *Physician Quality Reporting System* measures group specifications for any given measures group selected for use in a specific program year may be different from specifications for the same measures group used for a prior program year. For example, the measures that form the Diabetes Mellitus and CKD measures groups for the 2009 *Physician Quality Reporting System* are different from the measures that were included in these measures groups for 2008.

Not only do *eligible professionals* need to ensure that they are using the measures groups specifications rather than the specifications for the individual *Physician Quality Reporting System* measures, but *eligible professionals* also must ensure that they are using the measures groups specifications for the correct program year.

70 – Criteria for Determination of Satisfactory Reporting

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

In order to qualify to earn a *Physician Quality Reporting System* incentive payment, *eligible professionals* and group practices must meet the criteria for satisfactorily reporting data on *Physician Quality Reporting System* quality measures. The criteria that are applicable depend on whether participation is at the individual *eligible professional* level or at the group practice level and may differ from one program year to another.

70.1 – Criteria for Determination of Satisfactory Reporting *of Individual Measures and Measures Groups* for Individual *Eligible Professionals*

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

For *eligible professionals* participating in the *Physician Quality Reporting System* at the individual *eligible professional* level, the criteria for satisfactory reporting differ depending on the reporting period an *eligible professional* chooses to report, the manner in which an *eligible professional* reports (whether the *eligible professional* chooses the claims-based, registry-based, or EHR-based reporting mechanism), and whether an *eligible professional* chooses to report on individual quality measures or on measures groups.

For the 2007 *Physician Quality Reporting System*, there was only 1 reporting option and a single reporting period that an *eligible professional* could use to attempt to satisfactorily report quality measures. There was no option of reporting on measures groups, or reporting through a qualified registry or qualified EHR.

In 2008, with the introduction of registry-based reporting, reporting on measures groups, and alternative reporting periods for the *Physician Quality Reporting System*, multiple reporting options became available.

For the 2008 *Physician Quality Reporting System*, there were a total of 9 reporting options. For the 2009 *Physician Quality Reporting System*, 9 reporting options were also available but there were some differences between the 2008 *Physician Quality Reporting System* reporting options and the 2009 *Physician Quality Reporting System* reporting options.

For the 2010 *Physician Quality Reporting System*, 11 reporting options are available.

For the 2011 Physician Quality Reporting System, there were still 11 reporting options available. However, there are some differences between the 2010 Physician Quality Reporting System reporting options and the 2011 Physician Quality Reporting System reporting options. To qualify for a Physician Quality Reporting System incentive payment for a particular program year, each eligible professional must ensure that he or she meets the criteria for satisfactory reporting for the relevant reporting period, relevant reporting mechanism, and for reporting either individual measures or measures groups, as appropriate.

For the 2012 Physician Quality Reporting System, there are a total of 9 reporting options that an individual eligible professional could use to attempt to satisfactorily report quality measures. The change in the number of reporting options from 11 in 2011 to 9 in 2012 is due to the following factors: (1) the elimination of the 6-month reporting period, except for reporting on measures groups via registry and (2) adoption of an additional reporting option for EHR-based reporting that aligns with the criteria for meeting the clinical quality measure objective for achieving meaningful use under the Medicare EHR Incentive Program in 2012.

Although there are multiple reporting options for satisfactory reporting, an *eligible professional* only needs to satisfactorily report under one option for a specific program year to qualify for the incentive payment applicable to a reporting period for the program year. An *eligible professional* who qualifies for more than one reporting period for a particular program year will receive the incentive payment for the longest reporting period for which the professional qualifies for that program year. Only one incentive payment per program year may be obtained regardless of how many reporting options the *eligible professional* chooses.

For purposes of determining satisfactory reporting, if an *eligible professional* attempts to submit data for a quality measure or measures group at least once, then the measure or measures group is presumed to be applicable to the *eligible professional*. *Eligible professionals* are responsible for selecting the quality measures and/or measures groups that are applicable to their practices.

70.1.1 – Criteria for Determination of Satisfactory Reporting *of Individual Measures* for Claims-based Reporting

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

As discussed in §60 above, *eligible professionals* have the option of reporting on individual quality measures or on measures groups. The criteria for determining whether an *eligible professional* satisfactorily reports data on *Physician Quality Reporting System* quality measures for reporting individual quality measures are different from the criteria for satisfactory reporting of measures groups.

To qualify for a *Physician Quality Reporting System* incentive payment through claims-based reporting of individual measures *prior to the 2011 program year*, each *eligible professional* must meet the following criteria for satisfactory reporting during the applicable reporting period:

- Report at least 3 *Physician Quality Reporting System* measures for the relevant program year, or 1-2 measures, if less than 3 measures apply to an *eligible professional*; and
- Report each measure on at least 80 % of the Medicare Part B FFS patients to whom the measure applies.

For years prior to the 2011 Physician Quality Reporting System, if an eligible professional reports less than 3 measures, the eligible professional must:

- *Report on all measures that apply to the services furnished by the professional, and*
- *Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure(s) applies.*

The eligible professional may also be subject to a Measure Applicability Validation (MAV) process, which would allow CMS to determine whether an eligible professional should have reported QDCs for additional measures.

For the 2007 *Physician Quality Reporting System*, these criteria applied to the 6-month reporting period beginning July 1st only.

For the 2008 and 2009 *Physician Quality Reporting System*, these criteria applied to the 12-month reporting period beginning January 1st only.

For the 2010 *Physician Quality Reporting System*, these criteria apply to both the 12-month reporting period beginning January 1st and the 6-month reporting period beginning July 1st for claims-based reporting of individual measures. This results in a total of 2 reporting options for claims-based reporting of individual measures for the 2010 *Physician Quality Reporting System*.

The 2011 Physician Quality Reporting System retained the 2 reporting options established in the 2010 Physician Quality Reporting System. However, the 2011 Physician Quality Reporting System reduced the percentage of instances eligible professionals must report per measure. Eligible professionals need only report on 50% instead of 80% of the Medicare Part B FFS patients to whom each measure applies.

The 2012 Physician Quality Reporting System retains 1 of the 2 reporting options established in the 2011 Physician Quality Reporting System. The reporting option established for a 6-month reporting period was eliminated. In addition, under all 2012 claims-based reporting options for the 2012 Physician Quality Reporting System, measures reported with a zero percent performance rate will not be counted.

The 2012 Physician Quality Reporting System criteria for satisfactorily reporting individual quality measures through claims-based reporting that each eligible professional must meet under these 2 reporting options are summarized in ***Table 1*** *below along with the relevant reporting period for each reporting option.*

Table 1: 2012 Criteria for Satisfactory Reporting of Individual Quality Measures through Claims

Reporting Criteria	***Reporting Period***
• *Report at least 3 Physician Quality Reporting System measures, or* • *1-2 measures if less than 3 measures apply to an EP; and* • *Report each measure for at least 50% of Medicare Part B FFS patients to whom the measure applies.* *If reporting less than 3 measures, the eligible professional must:* • *Report on all measures that apply to the services furnished by the professional, and* • *Report each measure for at least 50% of the eligible professional's Medicare Part B PFS patients for whom services were furnished during the reporting period to which the measure(s) applies.* • *May also be subject to a MAV process*	*January 1, 2012– December 31, 2012*

Eligible professionals who report on fewer than three individual *Physician Quality Reporting System* individual quality measures may be subject to a two-step measure-applicability validation (MAV) process. The purpose of the MAV is to determine whether the *eligible professional* should have submitted quality-data codes for additional measures. If CMS finds that *eligible professionals* who have reported fewer than three quality measures have not reported additional measures that are also applicable to the services they furnished during the reporting period, then those *eligible professionals* cannot earn the incentive payment. More information on the MAV process for a specific program year is available in the Analysis and Payment section of the CMS PQRS website at *http://www.cms.hhs.gov/PQRS*.

When claims-based reporting of measures groups was introduced in the 2008 *Physician Quality Reporting System* program, the only reporting period available for claims-based reporting of measures groups was the 6-month reporting period beginning July 1, 2008. However, there were 2 reporting options for claims-based reporting of measures groups for 2008. The first reporting option for claims-based reporting of measures groups for the 2008 *Physician Quality Reporting System* consisted of the following criteria for satisfactory reporting:

- Report at least 1 measures group; and
- Report each measure in the measures group on at least 15 consecutively seen Medicare Part B FFS patients to whom the measures in the measures group apply for each participating *eligible professional*.

The term "consecutive" refers to the manner in which the patients are seen by the *eligible professional* and are selected for inclusion in the *eligible professional's* patient sample. The patient sample must consist of at least 15 unique Medicare Part B FFS patients seen consecutively, or in order, by date of service, by the *eligible professional*.

The second reporting option for claims-based reporting of measures groups for the 2008 *Physician Quality Reporting System* consisted of the following criteria for satisfactory reporting:

- Report at least 1 measures group; and
- Report each measure in the measures group on at least 80% of Medicare Part B FFS patients for whom the measures in the measures group apply for each participating *eligible professional*.

Beginning with the 2009 *Physician Quality Reporting System*, CMS implemented two reporting periods for claims-based reporting of measures groups: a 12-month reporting period beginning January 1st and a 6-month reporting period beginning July 1st.

For the 2009 *Physician Quality Reporting System*, there were 3 reporting options for claims-based submission of measures groups. Whereas for the 2008 *Physician Quality Reporting System* only the 6-month reporting period was available for claims-based submission of measures groups, both the 12-month and the 6-month reporting periods are available for claims-based submission of measures groups for the 2009 *Physician Quality Reporting System*. In addition, CMS eliminated the option of reporting on at least one measures group on 15 consecutive patients for the 6-month reporting period but added the option of reporting on at least 30 consecutive Medicare Part B FFS patients during the 12-month reporting period instead. We also added a minimum sample size requirement for *eligible professionals* reporting on at least 80% of applicable Medicare Part B FFS patients. *Eligible professionals* reporting on 80% of applicable Medicare Part B FFS patients for the 12-month reporting period must have at least 30 applicable patients. *Eligible professionals* reporting on 80% of applicable Medicare Part B FFS patients for the 6-month reporting period must have at least 15 applicable patients.

CMS implemented the following changes to the 2009 Physician Quality Reporting System for the 2010 Physician Quality Reporting System: (1) eliminated the requirement that the 30 patients be seen consecutively to allow an *eligible professional* to report on any 30 patients seen at any time during the reporting period; and (2) reduced the minimum patient sample size threshold for *eligible professionals* reporting on at least 80% of applicable Medicare Part B FFS patients to 15 and 8 for the 12-month and 6-month reporting periods, respectively.

With respect to the reporting options for claims-based submission of measures groups, the 2011 Physician Quality Reporting System is largely identical to the 2010 Physician Quality Reporting System. However, CMS implemented the following change in 2011: eligible professionals need only report at least 50% (instead of the 80% that was required in the 2010 Physician Quality

Reporting System) of their Medicare Part B FFS patients seen during the reporting period to which the measures group applies.

For the 2012 Physician Quality Reporting System, CMS retained the two 2011 reporting options for the 12-month reporting period. However, CMS implemented the following change for 2012: measures within a measures group with a zero percent performance rate will not be counted. Therefore, the 2012 Physician Quality Reporting System criteria for satisfactorily reporting measures groups through claims-based reporting that each eligible professional must meet under these 2 reporting options are summarized in ***Table 2*** *below along with the relevant reporting period for each reporting option.*

Table 2: 2012 Criteria for Satisfactory Reporting of Measures Groups through Claims

Reporting Criteria	***Reporting Period***
• *Report at least one measures group; and* • *Report each measure within the measures group for at least 30 Medicare Part B FFS patients to whom the measures group apply* • *Measures within a measures group with a zero percent performance rate will not be counted.*	*January 1, 2012 – December 31, 2012*
• *Report at least one measures group; and* • *Report each measure within the measures group for at least 50% of Medicare Part B FFS patients to whom the measures in the measures group apply; but* • *Report each measures group on at least 15 patients during the reporting period for which the measures group applies.* • *Measures within a measures group with a zero percent performance rate will not be counted.*	*January 1, 2012– December 31, 2012*

Eligible professionals choosing to participate in the *Physician Quality Reporting System* through the claims-based reporting mechanism, regardless of whether they choose to report on individual measures or measures groups, must have their own individual-level NPI and must consistently use their individual NPI to correctly identify their services, procedures, and QDCs for an accurate determination of satisfactory reporting. As stated in §30 above, the analysis of whether an *eligible professional* has satisfactorily reported is performed at the individual *eligible professional* level using the individual-level NPI. The *eligible professional's* individual NPI must be listed correctly along with the HCPCS codes for services, procedures, and QDCs on the claim. More information on reporting options for a specific program year is available on the CMS *Physician Quality Reporting System* website at *http://www.cms.hhs.gov/PQRS*.

70.1.2 – Criteria for Determination of Satisfactory Reporting *of Individual Measures* for Registry-based Reporting

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

In addition to the option of reporting on individual quality measures or on measures groups, *eligible professionals*, beginning with the 2008 *Physician Quality Reporting System*, also have the option of reporting *Physician Quality Reporting System* quality measures information to CMS via a qualified registry instead of submitting the quality measures data on claims (see §50).

The criteria for determining whether an *eligible professional* satisfactorily reports data on *Physician Quality Reporting System* quality measures for reporting via a registry are different from the criteria for satisfactory reporting via claims.

When registry-based reporting of *Physician Quality Reporting System* quality measures data was introduced in the 2008 *Physician Quality Reporting System*, there were two reporting periods available for registry-based reporting of individual measures: the 12-month reporting period beginning January 1, 2008 and the 6-month reporting period beginning July 1, 2008. To qualify to earn a 2008 *Physician Quality Reporting System* incentive payment through registry-based reporting of individual measures, each *eligible professional* had to meet the following criteria for satisfactory reporting:

- Report at least 3 individual *Physician Quality Reporting System* measures; and
- Report each measure on at least 80 % of the Medicare Part B FFS patients to whom the measure applies.

These criteria were applicable to both 2008 reporting periods for registry-based reporting. Consequently, there were 2 reporting options for registry-based reporting of individual measures.

No changes have been made to the criteria for registry-based reporting of individual measures until the 2011 program year. *For the 2011 Physician Quality Reporting System, measures with a zero percent performance rate will not be counted. That is, if the recommended clinical quality action is not performed on at least 1 patient for a particular measure or measures group reported by the eligible professional via a registry or EHR, we will not count the measure (or measures groups) as a measure (or measures group) reported by an eligible professional.*

The 2012 Physician Quality Reporting System retained the 2011 reporting criteria for the 12-month reporting period. The reporting options continue for registry-based reporting for the 2012 Physician Quality Reporting System of individual measures are summarized in ***Table 3*** *below.*

Table 3: 2012 Criteria for Satisfactory Reporting of Individual Quality Measures through Registries

Reporting Criteria	***Reporting Period***
• *Report at least 3 Physician Quality Reporting System measures; and* • *Report each measure for at least 80% of Medicare Part B FFS patients to whom the measure applies.* • *Measures with a zero percent performance rate will not be counted.*	*January 1, 2012 – December 31, 2012*

For registry-based reporting of measures groups, there were 2 reporting periods available when registry-based reporting of measures groups was first introduced in the *Physician Quality Reporting System* for 2008: the 12-month reporting period beginning January 1, 2008 and the 6-month reporting period beginning July 1, 2008.

For the 2008 *Physician Quality Reporting System*, there were 2 reporting options available for registry-based reporting of measures groups for the 12-month reporting period. An *eligible professional* could either:

- Report on at least one measures group for at least 30 consecutive patients to whom the measures of the measures group apply; OR
- Report on at least one measures group for at least 80% of Medicare Part B FFS patients to whom the measures of the measures group apply.

For the 2008 *Physician Quality Reporting System*, there were 2 reporting options available for registry-based reporting of measures groups for the 6-month reporting period. An *eligible professional* could either:

- Report on at least one measures group for at least 15 consecutive patients to whom the measures of the measures group apply; OR
- Report on at least one measures group for at least 80% of Medicare Part B FFS patients to whom the measures of the measures group apply.

There are 2 differences between the 2008 criteria for registry-based reporting of measures groups and the 2009 criteria. The first difference is the elimination of the reporting option based on reporting for at least 15 consecutive patients for the 6-month reporting period. The second difference is the addition of a minimum sample size requirement for *eligible professionals* reporting on at least 80% of applicable Medicare Part B FFS patients. Identical to the 2009 criteria for claims-based submission of measures groups discussed in §70.1.1 above, *eligible professionals* reporting in 2009 on 80% of applicable Medicare Part B FFS patients for the 12-month reporting period were required to have at least 30 applicable patients. *Eligible professionals* reporting in 2009 on 80% of applicable Medicare Part B FFS patients for the 6-month reporting period were required to have at least 15 applicable patients.

The 2010 criteria for registry-based reporting of measures groups are similar to the 2009 criteria except for 2 differences. First, CMS eliminated the requirement that the 30 patients be seen consecutively to allow an *eligible professional* to report on any 30 patients seen during the reporting period. The second difference is that CMS reduced the minimum sample size requirement for *eligible professionals* reporting on at least 80% of applicable Medicare Part B FFS patients to 15 and 8 for the 12-month and 6-month reporting periods, respectively.

For the 2011 Physician Quality Reporting System, measures within a measures group with a zero percent performance rate will not be counted. Furthermore, in registry-based reporting, in contrast to prior program years, the minimum patient numbers or percentages must be met by Medicare Part B FFS patients exclusively and not non-Medicare Part B FFS patients.

For reporting measures groups via registry under the 2012 Physician Quality Reporting System, CMS retained all 3 of the 2011 reporting options for the 6 and 12-month reporting periods described above. Therefore, the 2012 Physician Quality Reporting System criteria for satisfactory reporting that each eligible professional must meet to qualify to earn an incentive payment through registry-based reporting of measures groups in 2012 are summarized in ***Table 4*** *below.*

Table 4: 2012 Criteria for Satisfactory Reporting of Measures Groups through Registries

Reporting Criteria	***Reporting Period***
• *Report at least one measures group (measures groups with a zero percent performance rate will not be counted); and* • *Report each measures group for at least 30 patients Medicare Part B FFS patients to whom the measures in the measures group apply. Measures within a measures group with a zero percent performance rate will not be counted.*	*January 1, 2012 – December 31, 2012*
• *Report at least one measures group (measures with a zero percent performance rate will not be counted); and* • *Report each measures groups for at least 80 % of Medicare Part B FFS patients to whom the measures in the measures group applies; but* • *Report each measures group on at least 15 Medicare Part B FFS patients during the reporting period to which the measures group applies.* • *Measures within a measures group with a zero percent performance rate will not be counted.*	*January 1, 2012 – December 31, 2012*
• *Report at least one measures group; and* • *Report each measures group for at least 80 % of Medicare Part B FFS patients to whom the measures in the measures group applies; but* • *Report each measures group on no less than 8 Medicare Part B FFS patients seen during the reporting period to which the measure group applies.* • *Measures within a measures group with a zero percent performance rate will not be counted.*	*July 1, 2012 – December 31, 2012*

70.1.3 – Criteria for Determination of Satisfactory Reporting *of Individual Measures* for EHR-based Reporting

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Beginning with the 2010 *Physician Quality Reporting System*, an individual *eligible professional* who chooses to report on individual *Physician Quality Reporting System* quality measures rather than measures groups has the additional option of reporting on the individual *Physician Quality*

Reporting System quality measures via a qualified EHR product in lieu of submitting the quality measures data on claims or via a qualified registry (see §50).

For 2010 and 2011, the criteria for determining whether an eligible professional satisfactorily reports data on individual Physician Quality Reporting System quality measures for reporting via an EHR was identical to the criteria for satisfactory reporting of individual Physician Quality Reporting System quality measures via a qualified registry. However, there was only one reporting period available for EHR-based reporting of individual measures: the 12-month reporting period beginning January 1st. Consequently, there is only one reporting option for EHR-based reporting of individual measures for the 2010 and 2011 Physician Quality Reporting System. To qualify to earn a 2010 and 2011 Physician Quality Reporting System incentive payment through EHR-based reporting of individual measures, each eligible professional must meet the following criteria for satisfactory reporting:

- *Report at least 3 individual Physician Quality Reporting System measures; and*
- *Report each measure on at least 80 % of the Medicare Part B FFS patients to whom the measure applies.*

The following changes to the EHR-based reporting option were introduced for the 2012 Physician Quality Reporting System: (1) allowing EHR-based reporting via a qualified direct EHR product or a qualified EHR data submission vendor, and (2) adding criteria under EHR-based reporting that are identical to the criteria for meeting the clinical quality measure objective of achieving meaningful use under the Medicare EHR Incentive Program. The reporting options for satisfactory reporting via the EHR-based reporting mechanism in 2012 are summarized in ***Table 5*** *below.*

Table 5: Criteria for Satisfactory Reporting of Individual Measures through EHR

Reporting Mechanism	***Reporting Criteria***	***Reporting Period***
Qualified Direct EHR Product	• *Report at least 3 individual Physician Quality Reporting System EHR measures; and* • *Report each measure on at least 80 % of the Medicare Part B FFS patients to whom the measure applies.* • *Measures within a measures group with a zero percent performance rate will not be counted.*	*January 1, 2012 – December 31, 2012*
Qualified EHR Data Submission Vendor	• *Report at least 3 individual Physician Quality Reporting System EHR measures; and* • *Report each measure on at least 80 % of the Medicare Part B FFS patients to whom the measure applies.* • *Measures within a measures group with a zero percent performance rate will not be counted.*	*January 1, 2012 – December 31, 2012*

Direct EHR Technology that is both "qualified" for the Physician Quality Reporting System and Certified EHR Technology	• *Report on ALL three Medicare EHR Incentive Program core measures.* • *If the denominator for one or more of the Medicare EHR Incentive Program core measures is zero, report on up to three Medicare EHR Incentive Program alternate core measures; and* • *Report on three (of the 38) additional measures available for the Medicare EHR Incentive Program.*	*January 1, 2012 – December 31, 2012*
EHR Data Submission Vendor Technology that is both "qualified" for the Physician Quality Reporting System and Certified EHR Technology	• *Report on ALL three Medicare EHR Incentive Program core measures.* • *If the denominator for one or more of the Medicare EHR Incentive Program core measures is zero, report on up to three Medicare EHR Incentive Program alternate core measures; and* • *Report on three (of the 38) additional measures available for the Medicare EHR Incentive Program.*	*January 1, 2012 – December 31, 2012*

70.2 – Criteria for Determination of Satisfactory Reporting for Group Practices and Process for Reporting by Group Practices

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

In accordance with section 1848(m)(3)(C)(i) of the Act, we established, beginning with the 2010 *Physician Quality Reporting System*, a new process whereby group practices can qualify to earn a *Physician Quality Reporting System* incentive based on a determination that the practice satisfactorily reports data on *Physician Quality Reporting System* quality measures.

For 2010, group practice is defined under the Physician Quality Reporting System as 200 or more individual eligible professionals.

For 2011, group practice is defined under the Physician Quality Reporting System as 2 or more individual eligible professionals and there are two group practice reporting options (GPRO). Group practices with 200 or more eligible professionals participate in the GPRO option named GPRO I, whereas group practices comprised of 2-199 eligible professionals participate in the GPRO option named GPRO II.

Effective January 1, 2012, group practice is defined under the Physician Quality Reporting System as 25 or more individual eligible professionals. CMS eliminated the GPRO II classification. As in prior years, realizing the size of a group practice may vary throughout the reporting period, for purposes of determining a group practice's reporting requirements under the Physician Quality Reporting System, the size of the group is determined at the time the group's participation in one of the 2012 GPRO options is approved by CMS. However, please

note that the group practice must, at all time, have at least the minimum number of eligible professionals required under the definition of group practice (i.e., 25 eligible professionals for 2012) in order to participate in the GPRO.

Each group practice selected to participate in the *Physician Quality Reporting System* GPRO (see §20.3 for discussion of how a group practice can qualify to participate in the *Physician Quality Reporting System* GPRO) *must complete a data collection web-interface that* pre-populated with an assigned sample of patients and those patients' demographic and utilization information. The group practice is required to populate the remaining data fields necessary for capturing quality measure information on each of the consecutively assigned Medicare beneficiaries with respect to services furnished during the relevant *Physician Quality Reporting System* reporting period. The selected group practices are provided access to the pre-populated *web-interface* no later than the first quarter of the year following the program year in which the practice is participating in the *Physician Quality Reporting System* GPRO. For example, if the group practice is participating in the *2011 Physician Quality Reporting System* GPRO, the practice would be provided access to the pre-populated *web-interface* no later than the first quarter of *2012*. Upon *receiving access to* this pre-populated data collection *web-interface*, the practice must complete the remaining data elements for a specified number of patients and return the completed *web-interface* to CMS.

For purposes of determining whether a group practice satisfactorily submits *Physician Quality Reporting System* quality measures data for a particular program year, each selected group practice is required to complete this data collection *web-interface* for a specified number of quality measures. The quality measures are grouped into disease modules plus a series of *patient* care measures. Data from the January 1st through October 29th NCH file for the program year (10 months) is used by CMS to randomly assign Medicare beneficiaries to each physician group practice TIN. Medicare beneficiaries are retrospectively assigned to the TIN based on a determination by CMS that the group practice provided the plurality of office or other outpatient services to the beneficiary (with a minimum of at least two visits) in the 10-month period. Furthermore, part-year and managed care patients are not considered since CMS would have incomplete claims data for these beneficiaries and group practices may not have had sufficient time to impact the quality of their care.

For each disease module or *patient* care measure, *depending on the group's size,* the selected *Physician Quality Reporting System* GPRO practice must complete the data collection *web-interface* for the first *218 (for groups comprised of 25-99 eligible professionals) or* 411 *(for groups comprised of 100+eligible professionals)* consecutively assigned and ranked Medicare beneficiaries. Assigned beneficiaries will be limited to those Medicare FFS beneficiaries with Medicare Part B for whom Medicare is the primary payer. If the pool of eligible assigned beneficiaries is less than *218 or* 411 for any module/measure, then the group practice must report on 100% (all) of the assigned beneficiaries for that module/measure to satisfactorily participate in the *Physician Quality Reporting System* GPRO.

70.2.1 – Criteria for Determination of Satisfactory Reporting for Group Practices and Process for Reporting under the GPRO

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

For purposes of determining whether a group practice satisfactorily submits Physician Quality Reporting System quality measures data for a particular program year, each selected group practice is required to complete this data collection web-interface for a specified number of quality measures. The quality measures are grouped into disease modules plus a series of patient care measures. Data from the January 1st through October 29th NCH file for the program year (10 months) is used by CMS to randomly assign Medicare beneficiaries to each physician group practice TIN. Medicare beneficiaries are retrospectively assigned to the TIN based on a determination by CMS that the group practice provided the plurality of office or other outpatient services to the beneficiary (with a minimum of at least two visits) in the 10-month period. Furthermore, part-year and managed care patients are not considered since CMS would have incomplete claims data for these beneficiaries and group practices may not have had sufficient time to impact the quality of their care.

In 2011, for each disease module or patient care measure, the selected Physician Quality Reporting System GPRO I practice was required to complete the data collection web-interface for the first 411 consecutively assigned and ranked Medicare beneficiaries. Assigned beneficiaries will be limited to those Medicare FFS beneficiaries with Medicare Part B for whom Medicare is the primary payer. If the pool of eligible assigned beneficiaries was less than 411 for any module/measure, then the group practice was required to report on 100% (all) of the assigned beneficiaries for that module/measure to satisfactorily participate in the Physician Quality Reporting System GPRO I. The reporting mechanism, reporting period, and criteria for satisfactory reporting under the GPRO I for 2011 are summarized in the ***Table 6*** *below.*

Table 6: 2011 Physician Quality Reporting System Process for Physician Group Practices to Participate as Group Practices and Criteria for Satisfactory Reporting of Data on Quality Measures by Group Practices for GPRO I

Reporting Mechanism	***Reporting Criteria***	***Reporting Period***
A pre-populated data collection web-interface provided by CMS	• *Report on all measures included in the data collection web-interface (26 measures); and* • *Complete the web-interface for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each disease module or patient care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.*	*January 1, 2011– December 31, 2011*

In addition, for 2011, GPRO II groups were required to report on a specified number of individual measures and measures groups depending on the group practice's size. For individual measures reporting, GPRO II groups were required to report on a specified percentage of patients. To satisfactorily report measures groups for the 2011 Physician Quality Reporting System GPRO II, the group practice need only report on the minimum number of patients specified in Table 9 for their group size. In addition, since we did not have the ability to determine whether the registries can ensure that only unique patients are counted, GPRO II groups were required to report the 2011 Physician Quality Reporting System data via claims

unless the only measures groups that apply to the practice are one of the four registry-only measures groups. Group practices that must report on one of the four registry-only measures groups in order to meet the criteria for satisfactory reporting were able to use the registry-reporting mechanism to submit all of their 2011 Physician Quality Reporting System data via the registry reporting mechanism. The reporting mechanism, reporting period, and criteria for satisfactory reporting under the GPRO II for 2011 are summarized in the ***Table 7*** *below.*

Table 7: 2011 Physician Quality Reporting System Process for Physician Group Practices to Participate as Group Practices and Criteria for Satisfactory Reporting of Data on Quality Measures by Group Practices for GPRO II

Group size (number of eligible professionals)	***Number of measures groups required to be reported***	***Minimum number of Medicare Part B patients in denominator for satisfactory reporting of measures groups***	***Number of individual measures required to be reported***	***Percent of Medicare Part B patients in denominator for satisfactory reporting of individual measures via claims (%)***	***Percent of Medicare Part B patients in denominator for satisfactory reporting of individual measures via registries (%)***
2-10	*1*	*35*	*3*	*50*	*80*
11-25	*1*	*50*	*3*	*50*	*80*
26-50	*2*	*50*	*4*	*50*	*80*
51-100	*3*	*60*	*5*	*50*	*80*
101-199	*4*	*100*	*6*	*50*	*80*

In 2012, the GPRO II reporting option was eliminated, leaving a single GPRO reporting option. However, CMS finalized two different satisfactory reporting criteria under the GPRO for groups comprised of 25-99 eligible professionals and groups comprised of 100+ eligible professionals. With respect to the criteria for satisfactory reporting for groups comprised of 25-99 eligible professionals, for each disease module or patient care measure, the selected Physician Quality Reporting System GPRO practice must complete the data collection web-interface for the first 218 consecutively assigned and ranked Medicare beneficiaries. Assigned beneficiaries will be limited to those Medicare FFS beneficiaries with Medicare Part B for whom Medicare is the primary payer. If the pool of eligible assigned beneficiaries was less than 218 for any module/measure, then the group practice is required to report on 100% (all) of the assigned beneficiaries for that module/measure to satisfactorily participate in the Physician Quality Reporting System GPRO.

With respect to the criteria for satisfactory reporting for groups comprised of 100+ eligible professionals, for each disease module or patient care measure, the selected Physician Quality Reporting System GPRO practice must complete the data collection web-interface for the first 411 consecutively assigned and ranked Medicare beneficiaries. Assigned beneficiaries will be limited to those Medicare FFS beneficiaries with Medicare Part B for whom Medicare is the

primary payer. If the pool of eligible assigned beneficiaries was less than 411 for any module/measure, then the group practice was required to report on 100% (all) of the assigned beneficiaries for that module/measure to satisfactorily participate in the Physician Quality Reporting System GPRO.

The reporting mechanism, reporting period, and criteria for satisfactory reporting under the GPRO for 2012 are summarized in the ***Table 8*** *below.*

Table 8: 2012 Criteria for Satisfactory Reporting of Data on Quality Measures by Group Practices for theGPRO

Group 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 (29 measures); and* • *Populate the 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 over-sampler of 327) for each disease module or patient 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 (29 measures); and* • *Populate the date fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 616) for each disease module or patient 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*

80 – Limitations on Review

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Section 1848(m)(5)(E) of the Act, except for the informal review process noted below, there is no administrative or judicial review or otherwise of the determination of: (1) the determination of quality measures applicable to services furnished by eligible professionals, (2) the determination of satisfactory reporting, or (3) the determination of any incentive payment.

However, section 1848(m)(5)(I) of the Act, as added by the Affordable Care Act, requires the establishment of an informal review process by January 1, 2011. As such, beginning with the

2011 Physician Quality Reporting System, eligible professionals may seek an informal review of the determination that an eligible professional or group practice did not satisfactorily submit data on quality measures under the Physician Quality Reporting System. To request an informal review, an eligible professional or group practice must submit a written request to CMS within 90 days of the release of the applicable year's feedback reports. The request must state the eligible professional's or group practice's reasons for requesting an informal review which may include information to assist in the review. CMS will provide a final, written response to the request within 60 days of the receipt of the original request. With respect to an informal review request received in 2012 based on 2011 data, CMS will provide a final, written response to the request within 60 days of the receipt of the original request. With respect to an informal review request received in 2013 based on 2012 data and subsequent years, CMS will provide a final, written response to the request within 90 days of the receipt of the original request. All decisions are final and are not subject to further review.

90 – Confidential Feedback Reports

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

In accordance with section 1848(m)(5)(H) of the Act, CMS provides confidential annual feedback reports on Physician Quality Reporting System reporting to participating eligible professionals at or near the time that the lump sum incentive payments for a particular payment year are made. Feedback reports for the 2009 Physician Quality Reporting System, for example, would be provided in 2010.

In addition to confidential annual feedback reports, beginning 2012, CMS will provide confidential interim feedback reports on Physician Quality Reporting System reporting.

Access to confidential feedback reports may require eligible professionals to complete an identity-verification process. However, receipt of a report is not required to participate in the Physician Quality Reporting System or to receive an incentive payment.

Feedback reports are available for every TIN under which at least one eligible professional (identified by his or her National Provider Identifier, or NPI) submitting Medicare Part B FFS claims reported at least one valid Physician Quality Reporting System measure a minimum of once during the reporting period. Thus, to receive a feedback report the eligible professional must have had at least one valid Physician Quality Reporting System submission. A valid submission is defined as receipt by CMS of the correct numerator, denominator codes, age and gender (where applicable) as listed in the applicable Physician Quality Reporting System quality measure specifications manual. The Physician Quality Reporting System quality measure specifications are subject to change for each program year. The Physician Quality Reporting System quality measure specifications manual for the current or an upcoming program year is posted on the Measures Codes page at http://www.cms.gov/PQRS. Physician Quality Reporting System measure specifications for prior program years are archived on the appropriate Physician Quality Reporting System Program page of the CMS Physician Quality Reporting System website at http://www.cms.gov/PQRS.

In addition, section 1848(m)(5)(G) of the Act requires CMS to post on the CMS website, in an easily understandable format, a list of the names of the *eligible professionals* who satisfactorily

submitted data on quality measures under *Physician Quality Reporting System*. Therefore, beginning with the 2009 *Physician Quality Reporting System*, the names of *eligible professionals* and group practices who satisfactorily submit data on quality measures for the *Physician Quality Reporting System* will be posted on http://www.medicare.gov. The names of *eligible professionals* (and group practices) who satisfactorily submit data on quality measures for a particular year are publicly posted after the lump sum incentive payments for that program year are made in the following year.

100 – Direct Mailings

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

At the request of CMS, contractors shall print and distribute hardcopy mailings to all or a subset of their active providers related to the Physician Quality Reporting System. Mailings shall be sent to the best address to reach the provider, not the billing agency used by the provider. As such, contractors should consider using the correspondence address in PECOS if it is available.

Medicare Quality Reporting Incentive Programs Manual

Chapter 2 – The Electronic Prescribing (eRx) Incentive Program

Table of Contents
(Rev.10, Issued: 07-27-12)

Transmittals for Chapter 2

10 - Background

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Chapter 2 of this manual focuses on the requirements for the Electronic Prescribing (eRx) Incentive Program, a quality reporting program which promotes the adoption and use of eRx systems *through a combination of incentives and payment adjustments*. *ERx* is the transmission of prescription or prescription-related information through electronic media. ERx takes place between a prescriber, dispenser, pharmacy benefit manager, or health plan. It can take place directly or through an intermediary (such as a network).

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required the Secretary to establish a new *reporting* program for individual eligible professional*s* who are successful electronic prescribers as defined by MIPPA, beginning on January 1, 2009. While the eRx Incentive Program has similarities in structure and processes to the Physician Quality Reporting *System (formerly the Physician Quality Reporting Initiative or PQRI)* described in Chapter 1 of this Publication, this program is a stand alone program with distinct reporting requirements and associated incentive payment *and payment adjustment*.

The eRx Incentive Program encourages significant expansion of the use of eRx by authorizing a combination of financial incentives and payment differentials. Any incentive payment earned through the eRx Incentive Program is separate from and in addition to any incentive payment that *eligible professionals* may earn through the *Physician Quality Reporting System* program. Except for *eligible professionals* who wish to participate in the eRx Incentive Program under the group practice reporting option (GPRO) *beginning* 2010 (see §20.*2)*, *eligible professionals* do not have to participate in *Physician Quality Reporting System* to participate in the eRx Incentive Program or vice-versa.

See Chapter 1, "Physician Quality Reporting *System*," for information on the *Physician Quality Reporting System*.

20 – *Eligibility*

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

20.1 – Individual Eligible Professionals

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

For purposes of the eRx Incentive Program, the definition of "eligible professional" is identical to that for the *Physician Quality Reporting System*. An *eligible professional* is any one of the following:

- Physician
  - Doctor of Medicine
  - Doctor of Osteopathy
  - Doctor of Podiatric Medicine
  - Doctor of Optometry
  - Doctor of Dental Surgery
  - Doctor of Dental Medicine
  - Doctor of Chiropractic

- Practitioner
  - Physician assistant
  - Nurse Practitioner
  - Clinical nurse specialist
  - Certified registered nurse anesthetist (and Anesthesiologist Assistant)
  - Certified nurse midwife
  - Clinical social worker
  - Clinical psychologist
  - Registered dietitian
  - Nutrition professional
  - Audiologists (as of January 1, 2009)

- Therapist
  - Physical therapist
  - Occupational therapist
  - Qualified speech-language therapist (began billing Medicare directly as of July 1, 2009)

All Medicare-enrolled professionals in these categories are eligible to participate in the eRx Incentive Program regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims. However, eligibility is further restricted by scope

of practice to those professionals who have prescribing authority under their respective state practice laws.

20.1.*1* – Professionals Eligible to Participate But Not Able to Participate

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Some professionals who are included in the definition of "*eligible professional*" above are eligible to participate but are not able to participate for one or more reasons. These include: *eligible professionals* in certain settings in which Medicare Physician Fee Schedule billing is processed by Medicare fiscal intermediaries (FIs)/AB Medicare Administrative Contractors (MACs). The FI/MAC claims processing systems for the following settings currently cannot accommodate billing at the individual *eligible professional* level:

- Critical access hospitals (CAHs), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the regular FI or Part A MAC for the covered professional services furnished by the *eligible professional*.

- All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.

20.1.2 – Professionals Not Eligible to Participate

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Providers and professionals not defined as *eligible professionals* are not eligible to participate in the eRx Incentive Program do not qualify for an incentive*, and are not subject to a payment adjustment*. Services payable under or based on fee schedules or methodologies other than the PFS are not included in the eRx Incentive Program (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, portable x-ray suppliers, independent laboratories, hospitals [including critical access], rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for the eRx Incentive Program since DME is not based on or paid under the PFS.

20.1.3 – Professionals Eligible to Participate But For Whom the Payment Adjustment Does Not Apply

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

The payment adjustment does not apply to an eligible professional if any of the following apply:

- *Based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES),the eligible professional is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of –*
  - *June 30, 2011 for the 2012 payment adjustment,*
  - *June 30, 2012 for the 2013 payment adjustment, or*
  - *June 30, 2013 for the 2014 payment adjustment.*
- *The eligible professional does not have prescribing privileges and reports G-code G8644 (defined as not having prescribing privileges) at least one time on a Medicare Part B claim prior to –*
  - *June 30, 2011 for the 2012 payment adjustment,*
  - *June 30, 2012 for the 2013 payment adjustment, and/or*
  - *June 30, 2013 for the 2014 payment adjustment.*
- *The eligible professional does not have at least 100 cases containing an encounter code in the eRx measure's denominator for dates of service between –*
  - *January 1, 2011 and June 30, 2011 for the 2012 payment adjustment,*
  - *January 1, 2012 and June 30, 2012 for the 2013 payment adjustment, and/or*
  - *January 1, 2013 and June 30, 2013 for the 2014 payment adjustment.*

20.2 – Participation by Group Practices *Using the eRx Group Practice Reporting Option (GPRO)*

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Prior to 2010, the eRx Incentive Program was limited to *participating as an* individual *eligible professional* and the determination of whether an *eligible professional* is a successful electronic prescriber was made at the individual professional level, based on the National Provider Identifier (NPI). No incentive payments were available to a group practice based on a determination that the group practice, as a whole, was a successful electronic prescriber. To the extent that individual *eligible professionals* (based on individuals' NPIs) are associated with more than one practice, or Taxpayer Identification Number (TIN), the determination of whether an *eligible professional* is a successful electronic prescriber was made for each unique TIN/NPI combination. Therefore, the incentive payment amount was calculated for each unique TIN/NPI combination and payment was made to the holder of the applicable TIN (see *§40* below).

As required by the MIPPA, beginning in 2010, group practices, *by participating in the eRx group practice reporting option (GPRO),* are eligible to qualify for an eRx incentive payment based on the determination that the group practice, as a whole, is a successful electronic prescriber. The criteria for determining whether a group practice is a successful electronic prescriber and the process for reporting by group practices under the *eRx* GPRO are discussed in §60.2 below.

In 2010, for purposes of being able to participate in the eRx Incentive Program under the eRx GPRO, a "group practice" was defined as a TIN with at least 200 or more individual eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN.

However, in 2011, with the addition of "GPRO II" described in Chapter 1, § 20.3, the definition of group practice was expanded to include a TIN with at least 2 or more individual eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN.

In 2012, the definition of group practice for the eRx Incentive Program was further modified to mirror the 2012 definition of group practice for the 2012 Physician Quality Reporting System as described in Chapter 1, § 20.3 of this manual. Therefore, a group practice was defined as a TIN with at least 25 or more individual eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN. In 2012, the definition of group practice also includes those groups participating in certain Medicare-approved demonstrations projects or various other CMS programs, under which Physician Quality Reporting System requirements and incentives have been incorporated, such as groups participating in the Medicare Shared Savings Program.

In order to participate in the eRx Incentive Program through the GPRO, *including those groups that are deemed participating in the Physician Quality Reporting System,* group practices must have *self-nominated and* been selected to participate in the *Physician Quality Reporting System* GPRO (see Chapter 1, §20 for information on the requirements for participation in the *Physician Quality Reporting System* GPRO). CMS assesses whether the participation requirements are met by each self-nominated group practice and notifies group practices of a decision.

As required by section 1848(m)(3)(C)(iii) of the Social Security Act (the Act), an individual *eligible professional* who is a member of a group practice selected to participate in the eRx GPRO for a particular program year is not eligible to separately earn an eRx incentive payment as an individual *eligible professional* under that same TIN (that is, for the same TIN/NPI combination) for that year. Once a group practice (TIN) is selected to participate in the GPRO for a particular program year, this is the only method of eRx Incentive Program participation available to the group and all individual NPIs who bill Medicare under the group's TIN for that program year.

In addition, the group practice will be assessed for applicability of the payment adjustment, beginning in 2012, discussed in § 60.2.2 below under the GPRO criteria as well. Although the determination of whether a GPRO is a successful electronic prescriber will be analyzed at the TIN level, if group practices elect to participate in the eRx GPRO for a particular program year and the group practice fails to meeting the reporting thresholds for reporting its eRx activities (i.e., fails to become a successful electronic prescriber), each eligible professional who belongs to the group practice will be subject to the payment adjustment, regardless of whether or not the eligible professional, as an individual, successfully reports . For example, for purposes of the 2012 payment adjustment, if a group practice consisting of 2 individual eligible professionals elects to participate in the eRx GPRO under the 2011 eRx GPRO II option, based on the size of this group practice (which is 2), this group practice must report the eRx measure via claims on 75 unique events for patients in the denominator of the measure for services occurring between January 1, 2011 and June 30, 2011. If an eligible professional within the group practice reports the eRx measure on 25 unique events during the January 1, 2011 and June 30, 2011 reporting period and the other eligible professional does so for only 5 unique events , provided a limitation or significant hardship exemption does not apply to the group practice, the group practice as a whole (i.e., both individual eligible's) will be subject to a 1.0% payment adjustment on all their

Medicare Part B PFS allowed charges for covered professional services furnished in 2012. Although the first eligible professional would have successfully reported as an individual, the entire group practice (i.e., both eligible professionals) will be subject to the 2012 payment adjustment for failing to reach the reporting threshold of 75 unique events that was required for groups with 2 eligible professionals.

30 – *Reporting Period*

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

30.1 – Reporting Period for the Incentive Payments

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

The reporting period for the eRx Incentive Program incentive payments is the entire calendar year. Specifically, the reporting periods for the following incentive payments are as follows:

Incentive Payment	*12-month Reporting Period*
2009	*January 1, 2009 – December 31, 2009*
2010	*January 1, 2010 – December 31, 2010*
2011	*January 1, 2011 – December 31, 2011*
2012	*January 1, 2012 – December 31, 2012*
2013	*January 1, 2013 – December 31, 2013*

30.2 – Reporting Period for the Payment Adjustments

Except for the 2012 payment adjustment, there are two reporting periods for purposes of the eRx Incentive Program payment adjustments: (1) the 12-month calendar year 2 years prior to the applicable payment adjustment and (2) a 6-month reporting period occurring during the first 6 months of the calendar year prior to the applicable payment adjustment. For the 2012 payment adjustment, there was only one reporting period: the 6-month reporting occurring during the first 6 months of 2011. Specifically, the reporting periods for the following payment adjustments are as follows:

Payment Adjustment	*12-month Reporting Period*	*6-month Reporting Period*
2012	*N/A*	*January 1, 2011 – June 30, 2011*
2013	*January 1, 2011-December 31, 2011*	*January 1, 2012 – June 30, 2012*
2014	*January 1, 2012 – December 31, 2012*	*January 1, 2013 – June 30, 2013*

40 – *Payment for Reporting*

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

A participating individual eligible professional or group practice (see §20) who is determined to be a "successful electronic prescriber" (see §60) may earn an incentive payment or receive a payment adjustment with respect to covered professional services furnished by the eligible professional (or group practice) during a specified reporting period (see §30). Section 1848(k)(3)(A) of the Act defines "covered professional services" as services for which payment is made under, or is based on, the Medicare Part B PFS and which are furnished by an eligible professional (or group practice).

An eligible professional who is determined to be a successful electronic prescriber may qualify to earn an incentive payment or receive a payment adjustment equal to a percentage of the total estimated Medicare Part B allowed charges for covered professional services furnished by the eligible professional during the respective reporting period. The incentive payments for successful electronic prescribers for each authorized year are as follows:

- *2.0 percent for 2009;*
- *2.0 percent for 2010;*
- *1.0 percent for 2011;*
- *1.0 percent for 2012; and*
- *0.5 percent for 2013.*

In addition to the eRx incentive payment, under § 1848(a)(5)(A) of the Act, a PFS payment adjustment applies beginning in 2012 to those who are not successful electronic prescribers for 2012. The payment adjustments for eligible professionals who are not successful electronic prescribers for each authorized year are as follows:

- *1.0 percent for 2012;*
- *1.5 percent for 2013; and*
- *2.0 percent for 2014.*

The eRx incentive payment amount is calculated based on an eligible professional's (or group practice's) total estimated allowed charges for all covered professional services: (1) furnished during the applicable reporting period, (2) received into the National Claims History (NCH) file by no later than 2 months after the end of the reporting period, and (3) paid under or based upon the Medicare PFS. Because claims processing times may vary by time of the year and Medicare Carrier/AB MAC, eligible professionals should submit claims from the end of the reporting period promptly, so that if, for example, the reporting period ends on December 31st of a particular year, claims from the end of the reporting period will reach the NCH file by February 28th of the following year. The eRx incentive payments are paid as a lump sum. Eligible professionals and group practices who receive an eRx incentive will see the following statement on their paper remittance advice: "This is an E-Rx incentive payment." On electronic remittance statements, the code "LE" and a year indicator (e.g., "RX10 for a 2010 incentive payment) appears on the remittance advice to indicate the amount provided is for an eRx incentive earned. A glossary of these codes is provided for eligible professionals or group practices.

The eRx payment adjustment amount is calculated based on the Secretary's total estimated allowed part B charges for all covered professional services: (1) furnished by the eligible professional (or group practice) during the applicable payment adjustment year and (2) paid

under or based upon the Medicare PFS. Eligible professionals and group practices that are subject to a payment adjustment will see the following codes on their remittance advice: CARC #237 ("Legislated/Regulatory Penalty") and RARC #N545 ("Payment reduced based on status as an unsuccessful eprescriber per the ERx Incentive Program"). If a payment adjustment was applied in error and an eligible professional or group practice is reimbursed due to this error, CARC #237 and RARC #N546 ("Payment represents a previous reduction based on the ERx Incentive Program") will appear on the remittance advice. A glossary of these codes is provided for the eligible professionals or group practices.

Payment for this program is calculated at the individual eligible professional level using individual NPI data and beginning in 2010, for group practices participating in the eRx GPRO, at the group practice level using TIN data. CMS uses the TIN as the billing unit so that any eRx incentive payment earned (regardless of whether the incentive payment was earned by an individual eligible professional or a group practice) is paid to the TIN holder of record. Individual incentive payments for groups that bill under one TIN are aggregated and paid to the holder of the TIN. Some individuals (NPIs) may be associated with more than one practice or TIN, and thus CMS groups claims by TIN for purposes of the incentive. In other words, the incentive payment is made for each unique TIN/NPI combination so that an eligible professional who qualifies for the eRx incentive payment under more than one TIN would receive a separate eRx incentive payment associated with each TIN.

Under the statute, however, there is a limitation with regard to the application of the incentive and payment adjustment. The incentive and payment adjustment does not apply to eligible professionals (and group practices participating in the eRx GPRO), for the reporting period, if the Medicare allowed charges for all covered professional services for the codes to which the eRx quality measure applies are less than 10% of the total allowed charges under Medicare Part B for all such covered professional services furnished by the eligible professional (or group practice).

The eRx incentive payment and payment adjustment amount is calculated using allowed charges for all covered professional services, not just those charges associated with eRx events. The term "allowed charges" refers to total charges, including the beneficiary deductible and co-payment, not just the 80% paid by Medicare or the portion covered by Medicare where Medicare is a secondary payer. Note that the amounts billed above the Medicare PFS amounts for assigned and non-assigned claims do not apply to the incentive and/or payment adjustment. The statute defines eRx covered professional services as those paid under or based upon the Medicare PFS only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology.

Other Part B services and items that may be billed by eligible professionals but are not paid under or based upon the Medicare PFS are not included in the calculation of the eRx incentive and/or payment adjustment amount.

Please note that, according to section 1848(m)(2)(D) of the Act, an eligible professional cannot receive an incentive payments under both the Medicare eRx Incentive Program and Medicare EHR Incentive Program.

For information on operational payment instructions related to the eRx Incentive Program, please see Chapter 3(§30) of this manual titled "Contractor Incentive Program Payment Operational Instructions."

50 – Form and Manner of Reporting *for the Purpose of Receiving Incentive Payments and Payment Adjustments*

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Prior to the 2010 eRx Incentive Program, participation in the eRx Incentive Program was limited to the submission of quality data codes (QDCs) for the eRx measure through Medicare's claim processing system. Beginning with the 2010 eRx Incentive Program, *eligible professionals* may choose to report the eRx measure to CMS using one of the following reporting mechanisms:

- Claims-based reporting;
- Registry-based reporting; or
- EHR-based reporting.

50.1 – Claims-based Reporting Mechanism

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Individual *eligible professionals and group practices* who choose to participate in the eRx Incentive Program via the claims-based reporting mechanism do not have to enroll or register to begin claims-based reporting of the eRx measure to CMS.

Participating *eligible professionals* or group practices who bill for the services or procedures included in the denominator of the eRx measure report the corresponding appropriate numerator G-code on their claim. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P. The specifications for the eRx measure are available on the E-Prescribing Measure section page of the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive *and may be updated on an annual basis*.

The applicable G-code quality data must be reported on the same claim as the billable service or procedure to which the QDC applies. The eRx measure does not require a specific diagnosis to help determine the denominator; therefore, any diagnosis reported on the claim is sufficient. The analysis algorithms that are used to determine whether an *eligible professional* is a "successful electronic prescriber" match the QDCs to the service and/or procedure codes on the claim. Thus, QDCs that are not submitted on the same claim as the applicable service and/or procedure codes do not count toward an *eligible professional* meeting the requirements of being a "successful electronic prescriber."

Claims-based reporting is the only reporting mechanism available for purposes of reporting on the eRx measure for the 2012 payment adjustment and for the 6-month reporting periods for the 2013 and 2014 payment adjustments.

50.1.1 - Coding and Reporting Principles for Claims-based Reporting

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

The following principles apply for claims-based reporting of the eRx measure:

For the *eRx measure used for the reporting period that occurred during calendar year 2009,* report one of the three eRx codes listed below as the claim numerator, when applicable:

- G8443 - "All prescriptions created during the encounter were generated using a qualified eRx system."
- G8445 - "No prescriptions were generated during the encounter."
- G8446 - "Provider does have access to a qualified eRx system and some or all of the prescriptions generated during the encounter were printed or phoned in as required by the State or Federal Law or regulations, patient request or pharmacy system being unable to receive electronic transmission; or because they were for narcotics or other controlled substances."

One of these codes must be reported on at least 50% of patients who meet the denominator criteria of the measure.

For *the eRx measure used for the reporting period that occurred during calendar year* 2010 the eRx measure's numerator includes only 1 G-code (CMS eliminated the 3 numerator G-codes used for *the* 2009 *reporting period*). To report the eRx measure for *the* 2010 *reporting period*, report the following eRx numerator G-code, when applicable:

- G8553 – At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.

For the eRx measure for reporting periods that occurred during calendar year 2011, the eRx measure's numerator is the same G-code used in the 2010 reporting period. To report the eRx measure for 2011 reporting periods, report the following eRx numerator G-code, when applicable:

- *G8553 – "At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system."*

For the eRx measure used for reporting periods that occur during the 2012 or 2013 calendar year, the eRx measure's numerator code is the same G-code used in 2010 and 2011 reporting periods. To report the eRx measure for the 2012 or 2013 reporting periods, report the following eRx numerator G-code, when applicable:

- *G8553 – "At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system (faxes do not count)."*

The eRx G-code, which supplies the numerator, must be reported for the applicable amount of unique visits (for services in the denominator) to successfully report for incentive payment purposes:

- *on the claim(s) with the denominator billing code(s) that represent the eligible encounter for the 2012 eRx incentive payment;* ***OR*** *on the claim(s) with any billing code(s) that represent the encounter to avoid the 2013 eRx payment adjustment,*
- *for the same beneficiary,*
- *for the same date of service (DOS), and*
- *by the same eligible professional (individual NPI) who performed the covered service as the payment codes, CPT Category I or*

The eRx G-code must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed:

- *The submitted charge field cannot be blank.*
- *The line item charge should be $0.00.*
- *If an eligible professional's billing software does not allow a $0.00 line-item charge, a nominal amount, such as $0.01, can be substituted - the beneficiary is not liable for this nominal amount.*
- *Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)*
- *Whether a $0.00 charge or a nominal amount is submitted to the Carrier/Medicare Administrative Contractor (MAC), the eRx G-code line is denied and tracked.*

ERx line items will be denied for payment, but are passed through the claims processing system to the NCH database and used for eRx claims analysis. Eligible professionals will receive a Remittance Advice (RA) which includes a standard remark code (N365). N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does NOT indicate whether the eRx G-code is accurate for that claim or for the measure the eligible professional is attempting to report. N365 only indicates that the eRx G-code passed into NCH.

When a group bills, the group NPI is submitted at the claim level, the individual rendering/performing physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.

Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent).

Claims may **NOT** be resubmitted for the sole purpose of adding or correcting an eRx code.

Submission Through Carriers/MACs

ERx G-codes shall be submitted to carriers/MACs either through: *Electronic submission using the ASC X 12N Health Care Claim Transaction (Version 5010), or via paper-based submission, using the CMS-1500 claim form.*

Electronic-based Submission:

Physician Quality Reporting QDCs are submitted on the claim just like any other code; however, QDCs will have a $0.00 (or nominal) charge. Electronic submission, which is accomplished

using the ASC X 12N Health Care Claim Transaction (Version 5010), should follow the current HIPAA standard version of the ASC x12 technical report 3.

Paper-based Submission:
Paper-based submissions are accomplished using the CMS-1500 claim form (version 08-05). Relevant ICD-9-CM diagnosis codes are entered in Field 21. Service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in Field 24D with a single reference number in the diagnosis pointer Field 24E that corresponds with the diagnosis number in Field 21.

For group billing, the NPI of the rendering/performing provider is entered in Field 24J and the TIN of the employer is entered in Field 25.

Timeliness of Quality Data Submission
Claims processed by the Carrier/MAC must reach the National Claims History (NCH) file by no later than 2 months after the end of the reporting period to be included in the analysis. For the *2011* eRx Incentive Program, for example, claims processed by the Carrier/MAC must reach the NCH file by no later than February 28, 2011 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

50.2 – Registry-based Reporting Mechanism
(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Beginning with the 2010 eRx Incentive Program, individual eligible professionals and group practices Individual *eligible professionals and group practices* may choose to participate in the eRx Incentive Program via the registry-based reporting mechanism *for all reporting periods except those 6-month reporting periods associated with a payment adjustment. Eligible professionals* and group practices that choose to participate in the eRx Incentive Program via the registry-based reporting mechanism do not have to enroll or register to begin registry-based reporting of the eRx measure to CMS. However, to report eRx measure data via the registry-based reporting mechanism, an *eligible professional* or group practice must select a qualified clinical data registry and must enter into and maintain an appropriate legal arrangement with a qualified clinical data registry. Such arrangements should provide for the registry's receipt of patient-specific data from the *eligible professional* and the registry's disclosure of eRx measure results and numerator and denominator data on behalf of the *eligible professional* or group practice to CMS. An *eligible professional* or group practice choosing the registry-based reporting mechanism must submit information on the eRx measure to their selected registry in the form and manner and by the deadline specified by the registry. Thus the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L.104-191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as "data submission vendors." The "data submission vendors" would have the requisite legal authority to provide information on eRx measure results and numerator and denominator data on the eRx measure on behalf of the eligible professional for the eRx.

Only a registry that is qualified to submit *Physician Quality Reporting System* quality measures information to CMS on behalf of *eligible professionals for the applicable program year* is

eligible to become a qualified registry for the purpose of submitting eRx measure information to CMS on behalf of *eligible professionals* or group practices. CMS qualifies registries for *the Physician Quality Reporting System* for each program year through a self-nomination process (see Chapter 1, §50.2). The list of qualified registries for a specific program year are made available on the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive. For a specific program year, this list usually is made available in the summer of that same year. For example, we anticipate the list of qualified registries for the 2010 eRx Incentive Program *was anticipated to* be made available in the summer of 2010.

Please note that, for all 6-month reporting periods associated with a payment adjustment, only the claims-based reporting mechanism may be used for purposes of the eRx payment adjustment. For example, for purposes of the 6-month reporting period for the 2013 payment adjustment (i.e., January 1, 2012-June 30, 2012, only the claims-based reporting mechanism may be used for purposes of the 2013 eRx payment adjustment even though the registry-based reporting mechanism was finalized for use by eligible professionals for the 12-month reporting period for the 2013 payment adjustment (i.e., January 1, 2011 – December 31, 2011) and for purposes of the reporting period for the 2012 incentive (i.e., January 1, 2012-December 31, 2012). As such, to the extent an eligible professional intends to use a registry to submit eRx measure data for purposes of qualifying for the 2012 eRx payment incentive, the eligible professional would still need to submit eRx measure data on claims for services furnished between January 1, 2012 and June 30, 2012, in order to avoid the 2013 eRx payment adjustment.

50.3 – Electronic Health Record-based (EHR-based) Reporting Mechanism

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

Beginning with the 2010 eRx Incentive Program, Individual *eligible professionals* and group practices may choose to participate in the eRx Incentive Program via the EHR-based reporting mechanism *for all reporting periods except those 6-month reporting periods associated with a payment adjustment. Beginning in 2012, as described in further detail in Chapter 1, section 50.3, eligible professionals and group practices may participate in the eRx Incentive Program via two EHR-based reporting mechanisms: (1) a qualified direct EHR or (2) a qualified EHR data submission vendor.*

Eligible professionals and group practices that choose to participate in the eRx Incentive Program via the EHR-based reporting mechanism do not have to enroll or register to begin EHR-based reporting of the eRx measure to CMS.

Likewise, eligible professionals and group practices that choose to participate in the eRx Incentive Program via EHR data submission vendors do not have to enroll or register to begin EHR-based reporting of the eRx measure to CMS.

However, to report eRx measure data via the EHR-based reporting mechanism, an *eligible professional* or group practice must select a qualified EHR product. An *eligible professional* or group practice choosing the EHR-based reporting mechanism must:

- *Have an active Individuals Authorized Access to CMS Systems (IACS) user account that will be used to submit the eRx measure data extracted from the EHR to CMS;*
- *Submit a test file containing real or dummy clinical quality data extracted from the EHR to a CMS clinical data warehouse; and*
- *Submit a file containing the eligible professional's or group practice's eRx measure data extracted from the EHR for the entire reporting period via IACS by no later than 2 months after the end of the reporting period. (For the 2010 incentive, the submission period will be 02/01/11 – 03/31/11).*

Only an EHR product that is qualified for use by *eligible professionals* to submit *Physician Quality Reporting System* quality measures information to CMS is eligible to become a qualified EHR product for the purpose of an *eligible professional* or group practice using the product to submit eRx measure information to CMS. CMS qualifies EHR vendors and their specific product(s) for use by *eligible professionals* to submit *Physician Quality Reporting System* quality measures data to CMS (see Chapter 1, §50.3). The list of qualified EHR *direct and data submission* vendors and *their qualified* products for a specific program year are made available on the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive.

Please note that, for all 6-month reporting periods associated with a payment adjustment, only the claims-based reporting mechanism may be used for purposes of the eRx payment adjustment. For example, for purposes of the 6-month reporting period for the 2013 payment adjustment (i.e., January 1, 2012-June 30, 2012, only the claims-based reporting mechanism may be used for purposes of the 2013 eRx payment adjustment even though the EHR-based reporting mechanism was finalized for use by eligible professionals for the 12-month reporting period for the 2013 payment adjustment (i.e., January 1, 2011 – December 31, 2011) and for purposes of the reporting period for the 2012 incentive (i.e., January 1, 2012-December 31, 2012). As such, to the extent an eligible professional intended to use an EHR or EHR data submission vendor to submit eRx measure data for purposes of qualifying for the 2012 eRx payment incentive, the eligible professional would still need to submit eRx measure data on claims for services furnished between January 1, 2012 and June 30, 2012, in order to avoid the 2013 eRx payment adjustment unless the eligible professional was a successful prescriber for the 12-month 2011 reporting period or a hardship exemption or other exclusion applies.

60 – Criteria for Determination of Successful Electronic Prescriber

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

In order to qualify to earn an eRx incentive payment *and/or avoid a payment adjustment* for a particular program year, *unless an exception applies, eligible professionals* and group practices must be considered a "successful electronic prescriber." The criteria that will be used to determine whether an *eligible professional* or group practice is a successful electronic prescriber differ depending on whether participation is at the individual *eligible professional* level or at the group practice level and may differ from one program year to another.

60.1 – *Eligible Professionals*

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

The criteria for the determination of a successful electronic prescriber for individual eligible professionals with respect to receiving incentive payments and/or avoiding payment adjustments are described in §§ 60.1.1 and 60.1.2 of this manual. See below.

60.1.1 – Criteria for Determination of Successful Electronic Prescriber for the Incentive Payments – Individual Eligible Professionals

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

For the 2009 incentive, an individual *eligible professional* was considered a "successful electronic prescriber" if he/she reported the eRx measure (as specified for 2009) on at least 50% of the cases in which the measure is reportable by the eligible professional during the 2009 reporting period.

For *the 2010 through 2013 incentives,* an individual *eligible professional was/*is considered a "successful electronic prescriber" if he/she reports the eRx measure (as specified for *the year*) for at least 25 unique denominator-eligible events during *respective incentive reporting periods*.

60.1.2 – Criteria for Determination of Successful Electronic Prescriber for the Payment Adjustments – Individual Eligible Professionals

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

For the 2012 payment adjustment, an individual eligible professional is considered a "successful electronic prescriber" if the eligible professional reports the eRx measure's numerator via claims for at least 10 unique eRx events for patients in the denominator of the measure between January 1, 2011 and June 30, 2011.

For the 2013 payment adjustment, an individual eligible professional is considered a "successful electronic prescriber" if the eligible professional meets the criteria for being a successful electronic prescriber for the 2011 incentive. Additionally, an individual eligible professional may also be considered a "successful electronic prescriber" if the eligible professional reports the eRx measure's numerator via claims for at least 10 unique eRx events (regardless of whether the event is one associated with the eRx measure's denominator) between January 1, 2012 and June 30, 2012.

For the 2014 payment adjustment, an individual eligible professional is considered a "successful electronic prescriber" if the eligible professional meets the criteria for being a successful electronic prescriber for the 2012 incentive. Additionally, an individual eligible professional may also be considered a "successful electronic prescriber" if the eligible professional reports the eRx measure's numerator via claims for at least 10 unique eRx events (regardless of whether the event is one associated with the eRx measure's denominator) between January 1, 2013 and June 30, 2013.

60.2 –Group Practices

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

The criteria for the determination of a successful electronic prescriber for group practices with respect to receiving incentive payments and/or avoiding payment adjustments are described in §§ 60.2.1 and 60.2.2 of this manual. See below.

60.2.1 – Criteria for Determination of Successful Electronic Prescriber for the Purpose of Receiving Incentive Payments – Group Practices

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

For the 2010 incentive, a group practice selected to participate in the eRx GPRO is considered a "successful electronic prescriber" if the practice reports the eRx measure (as specified for 2010) for at least 2,500 unique denominator-eligible events during the 2010 reporting period.

For the 2011 incentive, a group practice selected to participate in the eRx GPRO is considered a "successful electronic prescriber" if the practice reports the eRx measure (as specified for 2011) for at least 75-2,500 unique denominator-eligible events, depending on the group practice's size, during the 2011 incentive reporting period. The following is a table showing the required number of instances a group practice must report the eRx measure in order to be deemed a successful electronic prescriber according to group size:

Group size (Number of Eligible Professionals)	*Required Number of Unique Visits Where an Electronic Prescription was Generated to be a Successful Electronic Prescriber*
2-10	*75*
11-25	*225*
26-50	*475*
51-100	*925*
101-199	*1875*
200+	*2500*

For the 2012 and 2013 incentives, a group practice selected to participate in the eRx GPRO is considered a "successful electronic prescriber" if the practice reports the eRx measure (as specified for the year) for the following number of instances, depending on the group practice's size, during the respective 2012 and 2013 incentive reporting periods:

- *625 unique denominator-eligible events for group practices comprised of 25-99 eligible professionals or*
- *2,500 unique denominator-eligible events for group practices comprised of 100+ eligible professionals.*

60.2.2 – Criteria for Determination of Successful Electronic Prescriber for the Payment Adjustments – Group Practices

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

For the 2012 payment adjustment, a group practice is considered a "successful electronic prescriber" if, depending on the group's size, the group practice reports the eRx measure via claims on 75-2,500 unique eRx events for patients in the denominator of the measure for services occurring between January 1, 2011 and June 30, 2011. The following table shows the required number of instances a group practice must report the eRx measure according to group size:

Group size (Number of Eligible Professionals)	*Required Number of Unique Visits Where an Electronic Prescription was Generated to be a Successful Electronic Prescriber*
2-10	*75*
11-25	*225*
26-50	*475*
51-100	*925*
101-199	*1875*
200+	*2500*

For the 2013 payment adjustment, a group practice is considered a "successful electronic prescriber" if the group meets the criteria for the 2011 incentive. A group practice may also be considered a "successful electronic prescriber" if, depending on the group's size, the group practice reports the eRx measure's numerator via claims on 625 (for group practices comprised of 25-99 eligible professionals) or 2,500 (for group practices comprised of 100+ eligible professionals) unique eRx events, regardless of whether the event is associated with the eRx measure's denominator, between January 1, 2012 and June 30, 2012.

For the 2014 payment adjustment, a group practice is considered a "successful electronic prescriber" if the group meets the criteria for the 2012 incentive. A group practice may also be considered a "successful electronic prescriber" if, depending on the group's size, the group practice reports the eRx measure's numerator via claims on 625 (for group practices comprised of 25-99 eligible professionals) or 2,500 (for group practices comprised of 100+ eligible professionals) unique eRx events, regardless of whether the event is indicated in the eRx measure's denominator, between January 1, 2013 and June 30, 2013.

70 – Significant Hardship Exemptions for the Purposes of the Payment Adjustments

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

70.1 – Significant Hardship Exemptions for the Purposes of the Payment Adjustments – Individual Eligible Professionals and Group Practices

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

For the 2012 payment adjustment, an eligible professional or group practice may request a significant hardship exemption via the Quality Reporting Communication Support Page if any of the following situations apply:

- *The eligible professional practices in a rural area without sufficient high speed internet access (also reportable via reporting G-code G8642 on claims)*
- *The eligible professional practices in an area without sufficient available pharmacies for eRx (also reportable via reporting G-code G8643on claims)*
- *Eligible professionals who register to participate in the Medicare or Medicaid EHR Incentive Programs and adopt Certified EHR Technology*
- *Inability to electronically prescribe due to local, state, or federal law or regulation*
- *Limited prescribing activity*
- *Insufficient opportunities to report the eRx measure due to limitations of the measure's denominator*

For the 2012 payment adjustment, the initial deadline for submitting a request for the first two significant hardship exemption categories via submission of the appropriate G-code on at least one claim was the end of the 2012-6-month payment adjustment reporting period (that is, June 30, 2011). For group practices that self-nominated to participate in the 2011 GPRO, group practices were required to request a significant hardship exemption for these first two significant hardship exemption categories at the time that they self-nominated to participate in either GPRO I or II for 2011. However, with the addition of the last four significant hardship exemption categories to the 2012 payment adjustment in September 2011, the deadline for individual eligible professionals to submit a request for a significant hardship exemption under all significant hardship exemption categories via the Quality Reporting Communication Support Page was extended to November 1, 2011. Similarly, group practices that participated in the eRx GPRO for 2011 were given until November 1, 2011 to submit a letter requesting a significant hardship exemption under all significant hardship exemption categories.

For the 2013 and 2014 payment adjustments, an eligible professional or group practice may request a significant hardship exemption via the Quality Reporting Communication Support Page if any of the following situations apply:

- *The eligible professional or group practice practices in a rural area without sufficient high speed internet access (also reportable via reporting G-code G8642 on claims)*
- *The eligible professional or group practice practices in an area without sufficient available pharmacies for eRx (also reportable via reporting G-code G8643on claims)*
- *The eligible professional or group practice is unable to electronically prescribe due to local, state, or Federal law or regulation*
- *The eligible professional who prescribes fewer than 100 prescriptions during a 6-month, payment adjustment reporting period*

The deadline for eligible professionals and group practices to report the first two hardships via the respective G-code on a claim is June 30, 2012 for the 2013 payment adjustment and June 30, 2013 for the 2014 payment adjustment. For eligible professionals, the deadline for submitting a request for a significant hardship exemption to the 2013 and 2014 payment adjustment via the Quality Reporting Communication Support Page is June 30, 2012 and June 30, 2013 respectively.

Group practices wishing to request a significant hardship exemption to the 2013 and 2014 payment adjustment must indicate its request for a significant hardship exemption due to one of the above significant hardship exemption categories in its self-nomination letter to participate in the eRx GPRO for the 2012 and/or 2013 respective program year. Therefore, the deadline for group practices to submit a significant hardship exemption letter via its self-nomination letter is the date in which the self-nomination letter is due for the respective program year.

80 – Confidential Feedback Reports

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

CMS provides confidential feedback reports to participating *eligible professionals* for a particular program year *on or about* the time that the lump sum incentive payments are made for the program year. For example, *eligible professionals* who participate in the 2009 eRx Incentive Program can expect to receive confidential feedback reports with respect to the 2009 program year after the 2009 incentive payments are made in 2010. Access to confidential feedback reports may require *eligible professionals* to complete an identity-verification process. Receipt of a report is not a requirement for participation in the eRx Incentive Program or to receive an incentive payment.

To receive a feedback report the *eligible professional* must have had at least one valid eRx measure submission. A valid submission is defined as receipt by CMS of the correct numerator, denominator, age and gender (where applicable) as listed in the eRx measure specifications. The eRx measure specifications are subject to change for each program year. The eRx measure specifications for the current or an upcoming program year, as well as those for prior program years are posted or archived on the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive.

90 – Direct Mailings

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

At the request of CMS, contractors shall print and distribute hardcopy mailings to all or a subset of their active providers related to the eRx Incentive Program. Mailings shall be sent to the best address to reach the provider, not the billing agency used by the provider. As such, contractors should consider using the correspondence address in PECOS if it is available.

100 – Public Posting of Program Performance

(Rev.10, Issued: 07-27-12, Effective: 10-29-12, Implementation: 10-29-12)

In addition, section 1848(m)(5)(G) of the Act requires CMS to post on the CMS website, in an easily understandable format, a list of the names of the *eligible professionals* (or group practices) who are successful electronic prescribers. Therefore, beginning with the 2009 eRx Incentive Program the names of *eligible professionals* group practices who are determined to be successful electronic prescribers for the eRx Incentive Program are required to be posted on http://www.medicare.gov. The names of *eligible professionals* and group practices who are successful electronic prescribers for a particular year will be publicly posted after the lump sum

incentive payments for that program year are made in the following year. *CMS will also indicate whether an eligible professional is a successful electronic prescriber on the Physician Compare website, available at http://www.medicare.gov/Default.aspx.*

Note: The eRx measure specifications are subject to change for each program year. The eRx measure specifications for the current or an upcoming program year, as well as those for prior program years are posted or archived on the appropriate eRx Incentive Program page of the CMS eRx Incentive Program website at http://www.cms.gov/eRxincentive.