2015 Physician Quality Reporting System (PQRS)

Group Practice Reporting Option (GPRO) Guide for EHR Direct and EHR Data Submission Vendors

March 2015

Background

The Physician Quality Reporting System (PQRS) is a voluntary quality reporting program that applies a negative payment adjustment to promote the reporting of quality information by eligible professionals (EPs). The program applies a negative 2% payment adjustment to practices with EPs, identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN), or group practices participating via the group practice reporting option (GPRO), referred to as PQRS group practices, who **do not** satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (MPFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Beginning in 2015, the program will apply a negative payment adjustment to EPs and PQRS group practices who did not satisfactorily report data on quality measures for covered professional services in 2013. Those who report satisfactorily for the 2015 program year will avoid the 2017 PQRS negative payment adjustment.

Purpose

The purpose of this document is to assist EHR Direct Vendors and EHR Data Submission Vendors (both referred to as "EHR vendors" in this document) in understanding the requirements for submitting quality measures data for group practices that registered to participate via 2015 PQRS GPRO using an EHR that meets the definition of certified EHR technology (CEHRT). For more information on CEHRT, please visit the EHR Incentive Program Certified EHR Technology website.

Disclaimer: *If a group is reporting for PQRS through another Centers for Medicare & Medicaid Services (CMS) program (such as the Comprehensive Primary Care Initiative, Medicare Shared Savings Program, or Pioneer Accountable Care Organizations), please check the program's requirements for information on how to report quality data to avoid the PQRS payment adjustment. Please note: although CMS has attempted to align or adopt similar reporting requirements across programs, EPs should look to the respective quality program to ensure they satisfy the requirements for each program (such as PQRS, EHR Incentive Program, Value-based Payment Modifier (VM), etc.) in which they participate.*

Reporting as a Group Practice

A "group practice" under 2015 PQRS is defined as a single TIN with two or more EPs, as identified by individual NPI, who have reassigned their billing rights to the TIN. Refer to the complete *List of Eligible Medicare Professionals* on the PQRS How to Get Started webpage for information regarding who is considered an EP for purposes of PQRS. Group practices may register to participate in PQRS via the group

practice reporting option (GPRO) and will be analyzed as a group, or at the TIN level, for purposes of avoiding the 2017 PQRS payment adjustment. Complete information about **how to report once** for multiple Medicare quality reporting programs is available on the CMS PQRS Educational Resources webpage.

For complete information regarding 2015 PQRS GPRO reporting using an EHR, refer to the *Reporting Using a Direct EHR Product or Data Submission Vendor Guide for Group Practices Using PQRS Group Practice Reporting Option (GPRO)*.

EHR Measure Specifications

Vendors should note that group practices participating via GPRO using an EHR will reference the Medicare EHR Incentive Program's eCQM Library webpage to obtain the *2015 eCQM Specifications for Eligible Professionals* (released June 2014) and supporting documentation. **EPs will be required to select and report the July 2014 version of the eCQMs for 2015 reporting.** EPs wishing to report another version of the measures must do so by Attestation, which will only satisfy requirements for the EHR Incentive Program and not for PQRS.

Vendor Requirements

Certification Requirements for EHR Vendors

The criteria for satisfactory reporting electronically using an EHR for PQRS is aligned with the CQM component of the Medicare EHR Incentive Program, which requires EPs and group practices to submit CQMs using CEHRT. The Office of the National Coordinator for Health Information Technology (ONC) certification process has established standards and other criteria for structured data that EHRs must use. CMS has provided additional guidelines for submitting data collected using CEHRT to CMS. ***EHR vendors must work with their authorization and testing body to make sure they are able to submit the July 2014 update of the eCQMs data for 2015 PQRS and must be sure to meet the CMS requirements for form and manner in order to submit that data.***

The following are items to consider for populating the Quality Reporting Document Architecture (QRDA) files:

QRDA Considerations for EHR Vendors

• GPRO measure reporting is at the TIN level, and **not** the TIN/NPI level. The EHR vendor should report the applicable patient data meeting the measure criteria for the TIN. See Appendix A for an example of how to aggregate data at the TIN level for a measure that requires more than one encounter.
  o QRDA I submissions should contain all information for the patient, containing no duplications, and should represent the patient as seen by the TIN, not the individual NPIs within the TIN.
  o QRDA III submissions should consist of one aggregate file for the entire TIN, containing no duplications, and should represent the data at the TIN level.
• **PQRS_MU_GROUP** is a code within the CMS Program Name to select for PQRS GPROs reporting as a GPRO for PQRS and the Medicare EHR Incentive Program. ***Note:*** *Using the correct program identifier is critical for successful submissions. CMS will only use data that is according to the program identifier with which it is submitted.*
• EHR vendors do ***not*** need to submit all NPIs within GPRO. For purposes of the Medicare EHR Incentive Program, CMS will determine which NPIs satisfactorily report within a GPRO.
• The NPI is an optional field within the QRDA III and should not be included for PQRS GPRO reporting.

The *2015 CMS QRDA Implementation Guides for EP Clinical Quality Measures* is available in the Downloads section of the Clinical Quality Measures webpage.

Other Requirements for EHR Vendors

The following are the file format, consent requirement, and submission requirements for EHR vendors submitting 2015 PQRS GPRO data:

QRDA Submission Requirements for EHR Vendors
• EHR vendors submitting PQRS GPRO data will only need to submit ***one file format***, either QRDA category I ***or*** category III. • Data Submission Vendors must enter into and maintain with participating professionals an appropriate Business Associate Agreement that provides for the EHR vendor's receipt of patient-specific data from the group practice, as well as the EHR vendor's disclosure of patient-specific data on behalf of the group practice that wishes to participate in PQRS.   o Vendor to obtain and keep on file signed documentation that each holder of an NPI has authorized the EHR vendor to submit PQRS data on all patients to CMS for the purpose of PQRS and EHR Incentive Program participation. This documentation must be obtained at the time the group practice signs up with the EHR vendor for purposes of PQRS participation and must meet any applicable laws, regulations, and contractual business associate agreements. • EHR vendors planning to support data submission via GPRO must make sure that the data submitted are accurate. The submission of inaccurate data could adversely affect the group practice in PQRS, VM, the EHR Incentive Program, Physician Compare, and other CMS initiatives. • EHR data for 2015 PQRS will be submitted ***one time*** during the submission period, ending on **February 29, 2016**. • If an organization or EP changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis. • All reporting periods under the 2015 PQRS GPRO are 12 months, January 1 – December 31, 2015. • When reporting using an EHR, data is collected for all payer types; however, to be eligible for PQRS, data must also contain at least one Medicare Part B Patient.

Additional Information

The following links provide additional information about 2015 PQRS:

- View *2015 PQRS GPRO Criteria* for submission of PQRS measure data on the PQRS GPRO webpage.
- View steps on how to report electronically using an EHR in the *2015 PQRS: EHR Reporting Made Simple* document.

The following links provide additional information about the 2015 EHR Incentive Programs and 2015 reporting options for CQMs:

- Refer to the EHR Incentive Programs website for general information on the EHR Incentive Programs.
- The *2015 eCQM Specifications for Eligible Professionals* and supporting documentation is available at the eCQM Library.
- The *2015 CMS QRDA Implementation Guides for EP Clinical Quality Measures* is available in the Downloads section of the Clinical Quality Measures Basics webpage.

Questions?

Contact the **QualityNet Help Desk** at **1-866-288-8912** (TTY 1-877-715-6222), available 7 a.m. to 7 p.m. Central Time Monday through Friday, or via e-mail at qnetsupport@hcqis.org. To avoid security violations, **do not** include personal identifying information, such as Social Security Number or TIN, in email inquiries to the QualityNet Help Desk. For information about the EHR Incentive Program and EHR measure specifications, contact the EHR Information Center at **1-888-734-6433.**

Appendix

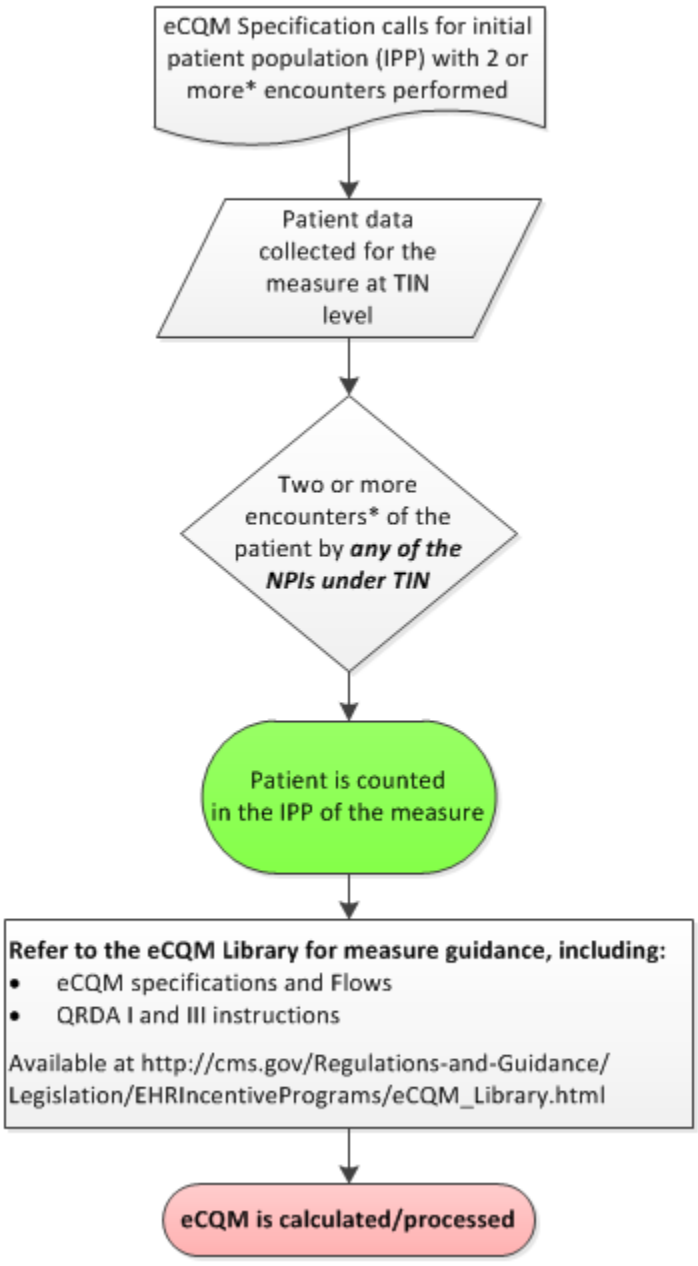
An Illustrative Example of Aggregating Measures with More than One Encounter at TIN Level

Group practices that registered to participate in the PQRS GPRO reporting through EHR Direct or a Data Submission Vendor will need to be analyzed at the TIN level. The EHR vendor must aggregate the data at the TIN level to ensure that the data is calculated correctly for group practice reporting. Therefore, for those measures that require two or more encounters, the EHR vendor must take into account encounters from ***all of the NPIs*** under the TIN. If the EHR vendor does not analyze this measure at the TIN level, then some encounters may not be included when computing the measure, resulting in an incorrect reporting rate.

For example, CMS measure #147 requires two or more encounters. For group practice reporting, the EHR vendor must take into account all patient visits from all NPIs under the TIN. Therefore, if a patient has multiple encounters with different NPIs under the TIN (if NPI is provided), then the patient will be counted in the initial patient population (IPP) for this measure only once. The group ***should*** submit data for the measure regardless of whether the group met the performance for a specific patient or not.

Figure 1 is a visual workflow that outlines the process of collecting data for measures that require more than one encounter at the TIN level for group practices participating in the 2015 GPRO. Keep in mind that collecting data is determined by the eCQM specification and that Figure 1 only illustrates how to collect data at the TIN level if the measure requires two or more encounters, such as with CMS measure #147.

Figure 1: Example of Aggregating Measures with More than One Encounter at TIN Level



** This is an illustrative example only, as different measures may have different encounter criteria.*