2015 Physician Quality Reporting (PQRS):
FREQUENTLY ASKED QUESTIONS

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

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

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

Q: Can I report as a group practice?
A: Yes, Medicare allows practices of 2 or more eligible providers to report PQRS as a group (known as the Group Practice Reporting Option, or GPRO). To participate, registration with CMS must be completed through the online PV-PQRS Registration System during the registration period, which is from April 1, 2015 -June 30, 2015. The group can be modified, or registration canceled any time before the June 30 deadline. More information about participating as a group is available for download at http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_GPRO_Criteria.pdf.

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

Q: Does the AAD have a registry for members to use? Does it support group reporting?
A: Yes, the AAD’s registry is called the Quality Reporting System (QRS). The AAD’s registry is a web-based system – all you need is an internet connection to use it. No software will be downloaded on to your computer. Additionally, the QRS will support group reporting. For more details on how to report as a group, contact the Member Resource Center at 866-503-7546, or email MRC@aad.org.

Q: More than one provider practices in the office I work for. Can I purchase one product for the whole practice to use?
A: No, each participant must purchase the module individually through his/her respective AAD ID and password. This also means that several modules cannot be purchased at once under a single online login. However, if the practice wishes to purchase several modules at once, then it can call the Member Resource Center.
2015 Physician Quality Reporting (PQRS):
FREQUENTLY ASKED QUESTIONS

Q: Are my office’s Nurse Practitioners (NPs) and/or Physician Assistants (PAs) able to report through the AAD’s registry?
A: Yes, any eligible physician assistant (PA), nurse practitioner (NP), clinical nurse specialists (CNS), and advanced practice registered nurse (APRN) that practices in the office of an AAD member can purchase the module. These non-physician clinicians would just need their physician to complete the attestation form located at https://www.aad.org/education/pqrs/aad-qrs/qrs-for-non-physician-clinicians and create an AAD account, if they do not already have one.

Q: Sometimes, multiple different providers in a practice will treat a single patient. Who should report that patient?
A: A provider will report a patient only if that patient is billed under his or her individual NPI. If the provider’s individual NPI is not on the Medicare claim, then the patient should not be entered into the registry for that provider.

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

Q: If the provider works, or has worked, at multiple locations during 2015, does he or she have to report for each one?
A: Yes, CMS expects eligible providers to report under each TIN that they work under.

Q: What is the potential payment reduction for not participating in PQRS?
A: The potential payment reduction for not reporting PQRS in 2015 is 4-6% of Medicare charges, depending on the size of the practice (to be applied in 2017). This amount is comprised of the 2% PQRS payment reduction, and the 2-4% Value Based Payment Modifier (VBPM) reduction. For solo practitioners and groups of 2-9 physicians, the potential payment reduction is 2% of Medicare charges for PQRS and a 2% VBPM payment reduction. Groups of 10 or more physicians will automatically receive a 4% VBPM payment reduction, in addition to a 2% reduction. There is no longer an incentive available to eligible providers who satisfactorily report PQRS measures.

Q: What is the Value Based Payment Modifier?
A: The Value Based Payment Modifier (VBPM) provides incentives and levies payment reductions based on the quality of care and cost of care that eligible professionals provide under the Medicare Physician Fee Schedule. In 2017, all eligible professionals, including solo practitioners, who have not successfully reported PQRS measures during the 2015 reporting period, will be assessed a 2% to 4% VBPM reduction, depending on the size of the practice. The additional VBPM payment reduction can be avoided by successfully participating in PQRS.

Q: How many measures do I have to report to avoid the payment reductions?
A: The payment reductions will occur in 2017, and will be based on your participation in 2015. To avoid these payment reductions, you have to report at least 9 measures, on at least 50% of patients that apply to each measure, across at least three National Quality Strategy (NQS) domains. Additionally, providers must report at least one cross-cutting measure. This can be done either through a registry, or via claims. However, keep in mind that the dermatology-appropriate measures can only be reported via registry.
Q: What are “National Quality Strategy (NQS) domains?”
A: The domains are in which certain quality measures fall. If electing to report nine measures you must choose nine measures that span at least three of these domains. The domains are: 1) Patient Safety, 2) Person and Caregiver-Centered Experience and Outcomes, 3) Communication and Care Coordination, 4) Effective Clinical Care, 5) Community/Population Health, 6) Efficiency and Cost Reduction.

Q: What are “cross-cutting” measures?
A: Cross-cutting measures are primary care measures that Medicare is requiring of all providers who see a Medicare patient with a face-to-face encounter. Providers participating in PQRS must report at least one cross-cutting measure in 2015. The complete list of cross-cutting measures can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_CrosscuttingMeasures_12172014.pdf.

Q: How many quality measures are there for dermatologists?
A: There are five dermatology-specific measures for the 2015 Physician Quality Reporting System. The 2015 QRS module offers thirteen additional measures from which a provider can choose to report. All eighteen measures are listed below:

Measure #137 - Melanoma: Continuity of Care – Recall System
Measure #138 - Melanoma: Coordination of Care
Measure #224 - Melanoma: Overutilization of Imaging Studies in Melanoma
Measure #265 – Biopsy Follow-Up
Measure #337 – Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biological Immune Response Modifier
Measure #130 — Documentation of Current Medications in the Medical Record*
Measure #131 — Pain Assessment and Follow-Up*
Measure #173 — Preventive Care and Screening: Unhealthy Alcohol Use — Screening
Measure #194 — Oncology: Cancer Stage Documented
Measure #205 — HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea
Measure #226 — Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*
Measure #397 – Melanoma Reporting (Pathology)
Measure #46 – Medication Reconciliation *
Measure #47 – Care Plan*
Measure #110 – Preventive Care and Screening: Influenza Immunization*
Measure #111 – Pneumonia Vaccination Status for Older Adults*
Measure #128 – Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up*
Measure #358 — Patient-Centered Surgical Risk Assessment and Communication

* Denotes cross-cutting measure
2015 Physician Quality Reporting (PQRS): FREQUENTLY ASKED QUESTIONS

Q: Which measures should I select in order to span at least three NQS domains?
A: The only combinations of measures which one cannot select are measures (137,138, 265, 397, 46, 47, 194, 205, 337), (110, 111, 128, 131, 173, 226, 194, 205, 337), or any combination of (137, 138, 194, 205, 337, 358, 224, 265, 397, 173).

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

Example Scenario: “This year, I saw eleven Medicare patients with a personal history of melanoma (V10.82), and I diagnosed four Medicare patients with a new melanoma (172.X). How many of these patients do I report? How many times should I report each one?”

Answer: You would have to report at least six of your eleven patients (55%) with a history of melanoma, as well as at least two of your patients (50%) with a new diagnosis of melanoma. If all of your patients with a history of melanoma returned for follow-up appointments, you only have to enter one visit for that patient into the registry.

Q: What if I cannot report 9 measures; is there an exclusion?
A: There is no exclusion for providers who cannot participate in PQRS. However, if a provider or group practice truly does not have 9 measures to report, fewer than 9 measures can be reported and the provider or group practice can still avoid the payment reductions. Medicare determines this by applying the Measure Applicability Validation (MAV) process, which is used to evaluate whether or not eligible providers could have reported on additional measures, and determine whether or not they satisfied reporting requirements. It is highly recommended that anyone considering this option first view the CMS MAV Training Course, located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MAV-CBT-Course/.

Q: Can I have all exclusions (e.g. “system,” “patient,” or “other”) for a measure and still qualify for the incentive?
A: Yes, you can still qualify for the incentive even if you report every patient as an “exclusion” for a measure.

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

Q: Should I include patients covered under Medicare Advantage plans?
A: No, do not include Medicare Advantage patients in your PQRS submission.
2015 Physician Quality Reporting (PQRS): FREQUENTLY ASKED QUESTIONS

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

Q: When can I begin to submit my chart information?
A: The “Initiate Submit” link, located on the module main page after you log in, will become active in mid-December 2015. This will enable you to begin submitting your final chart information to CMS.

Q: When is the deadline to submit all of my chart information?
A: The Academy’s QRS registry requires that all information be submitted by January 15, 2016.

Q: Where can I view feedback reports from my past participation in PQRI/PQRS?
A: You may request any feedback report using the CMS Communication Support Page. Reports from 2014 will be available through the portal beginning in fall 2015. For more information, visit the “Physician and Other Health Care Professionals Quality Reporting Portal” at www.qualitynet.org/pqrs.

For further information or questions, please visit www.aad.org/qrs or email QRSSupport@healthmonix.com