2013 CMS Incentives FAQ
Physician Quality Reporting System

Q. What is the Physician Quality Reporting System?

Formerly known as PQRI (Physician Quality Reporting Initiative), the Physician Quality Reporting System (PQRS) is a CMS Pay-For-Performance program that started in 2007. Currently, it is a voluntary, incentivized program where eligible physicians report quality clinical data collected during patient visits to CMS. Eventually, participation in Physician Quality Reporting will be mandated. There are multiple ways to report data for Physician Quality Reporting including:

- Claims-based - where quality data codes associated with individual measures (pieces of clinical data) are reported and turned in on claims directly to CMS
- EHR-based – where eligible professionals report quality measures using a qualified EHR
- Registry-based – where eligible professionals report data for measures/measures groups to a CMS-certified registry like Covisint PQRS

For additional information, visit the CMS website at: www.cms.gov/pqri.

Q. How do I know if I am eligible to participate in the Physician Quality Reporting System?


Q. When using an alternative reporting method for 2013, can providers choose any measures to report?

Covisint PQRS offers providers two services and both are recognized by CMS as “registry” or qualified alternative reporting methods. A provider can choose to self-report Physician Quality Reporting clinical data via the Covisint PQRS web application choosing either one of 22 measures groups or three (3) individual measures. Large provider groups can submit a claim combined data file (including billing or PMS data, lab results and/or medications data) at the end of the 2013 reporting year for the Covisint PQRS Enterprise service.

If using the Covisint PQRS web application, a provider must report clinical data for 20 Unique patients for only one measure group. At least 11 of the 20 patients must be Medicare Part B FFS. Alternatively, new in 2013, providers can select three (3) individual measures applicable to their patient population and report at 80%. More information on this reporting option is available on our website at www.pqrs.covisint.com.

If using Covisint PQRS Enterprise to submit data files, a provider must provide data on all Medicare Part B patients. Covisint will analyze your data to identify at least three individual measures at 80% for the entire 2013 reporting year. There is no change to your workflow and Covisint does all the work.

Q. We’re a GPRO, can you help us?

Yes, Covisint, as a certified registry, can report on behalf of a GPRO (non-ACO) using the three individual measures at 80% reporting option. Contact sales directly at 866-823-3958 for more information or to sign up.

Q. Do all the patients have to be traditional Medicare Part B Fee-For-Service?

It depends on the reporting option. The 2013 requirement for the measure group reporting option is that greater than half or 11 out of 20 patients must be Medicare Part B FFS. The individual measure reporting option requires reporting on only Medicare Part B FFS patients.

Q. What are the available measures groups for 2013?

A measures group is composed of four to ten individual measures and they are created and approved by CMS. Measures groups are not editable to include or omit specific individual measures.
Covisint will offer all 22 approved measures groups for 2013 reporting. The following measures groups are available:

- Asthma (5-50)
- Heart Failure (18+)
- CAD (Coronary Artery Disease) (18+)
- HIV/Aids (13+)
- CKD (Chronic Kidney Disease) (18+)
- IVD (Ischemic Vascular Disease) (18+)
- Diabetes (18-75)
- Preventive Care (50+)
- Hepatitis C (18+)
- Perioperative (18+)
- CABG (18+)
- Back Pain (18-79)
- RA (Rheumatoid Arthritis) (18+)
- Cataracts (18+)
- Oncology (New) (18+)
- Hypertension (15-90)
- Cardiovascular Prevention (18+)
- Irritable Bowel Disease (IBD) (18+)
- Chronic Obstructive Pulmonary Disorder (COPD) (18+)
- Parkinson’s (18+)
- Dementia (All ages)
- Sleep Apnea (18+)

Q. Are there any changes for 2013?
Changes are as follows:

- There is one (1) new measure group, Oncology, added for 2013 reporting.
- Providers only need to report 20 patients in 2013 using the measure group reporting option. Of the 20 only 11 must be Medicare Part B FFS.
- The incentive payment for successfully reporting in 2013 is .5%
- Failure to report will result in a payment adjustment of 1.5% in 2015
- Refer to the 2013 Measure Group Guides for each measure group to see any specific reporting and patient requirements changes.

Q. What if none of the measures groups or measures within the measures group applies to us? (Zero Percent Participation Rate)
The new rule implemented in 2011 continues for 2013 Physician Quality Reporting. An eligible professional reporting via registry for a measures group needs to report all of the measures in the group (where the patient is eligible for the measure) for 20 patients AND have a performance rate >0% for each applicable measure during a specified reporting period to be considered incentive eligible. In cases where a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure, so those patients should not be affected (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria).

An answer of “Not Done/Unknown” or “Performance Not Met” equivalent for all eligible patients for a given measure within the measures group will result in a performance rate of 0% for that measure and the provider will not qualify for the Physician Quality Reporting incentive.

Providers with specialties that do not fit within the guidelines for measures groups approved by CMS are encouraged to report using an alternative reporting method. New this year, Covisint is offering an easy way to submit three (3) individual measures. Refer to the previous question on alternative reporting methods or contact us for additional information.

Q. If I participate in the Meaningful Use/EHR incentive do I still have to participate in the Physician Quality Reporting System?
These are separate incentive programs with different requirements and incentive payments. The Physician Quality Reporting System is not included in the Meaningful Use incentive unless you have self-nominated to participate in the EHR/PQRS pilot program. For 2013, you can participate in both programs and receive both incentive payments. Furthermore, only participation in 2013 PQRS will let you avoid the 1.5% penalty in 2015. Please note that successfully participating in one program does not give you credit for the other.

Q. How much is the incentive for 2013?
One-half percent (.5%) of the eligible provider's total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services provided during the 2013 reporting year.

Payment adjustments are here....

Eligible Professionals (EPs) can successfully report PQRS in 2013 to earn both an incentive as well as avoid a 1.5% payment adjustment in your 2015 fee schedule. EP's can choose to report a single measure to avoid the penalty only and not earn an incentive.
Note: In 2016 the payment adjustment increases to 2.0% based on 2014 reporting. As mentioned previously, successfully qualifying for Meaningful Use does not exempt you from the PQRS payment adjustment.

Q. If I have already started reporting data with my claims can I still submit data for payment using Covisint PQRS?

Yes. You can submit both methods with no penalty, but you will only be paid the .5% incentive once. CMS will review all submissions and accept the submission that is most beneficial to the provider.

Q. Will I earn additional incentive submitting data on more than one measure group?

No. Submitting data for multiple measure groups will not earn additional incentive.

Q. How and when will I be paid?

CMS will release incentive payments using the same method in which you receive your standard Medicare reimbursements. For example, if you typically receive reimbursements via direct deposit your incentive payment will be received via direct deposit. If you submit for multiple providers under the same practice, all incentive payments will come together as a lump sum. Historically, payments are distributed in the fall of the year following the reporting year. Payment information is confidential to your practice and Covisint does not have access to this information.

Q. What is a Feedback Report and how do I get one?

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 PFS claims reported at least one valid measure a minimum of once during the reporting period. Feedback Reports provide a breakdown of submission data, eligibility, and payment information. These reports are not automatically provided and must be requested from CMS and your Medicare carrier.

New in 2012 was the ability to request a feedback report through the Quality Reporting Communication Support page at: http://www.qualitynet.org/pqrs (see the Related Links in the upper left corner of the web page). Click on the Communication Support Page link then choose Create NPI Level Report Request and follow the instructions to request your feedback report.

Q. What does this program have to do with improving patient and care quality?

The Physician Quality Reporting System is designed to encourage providers to discuss quality care oriented questions during an office visit, as well as to encourage appropriate documentation of data in a patient’s medical chart for follow up or reference at a later date/time. Reporting the requested data for the Physician Quality Reporting System promotes awareness by providers and practices about what data may or may not be fully or appropriately documented during their current processes.

In 2013 CMS has introduced the Value Based Modifier. Medical practice groups of 100 or more eligible professionals (all of whom file Medicare Fee-For-Service claims under the physician fee schedule using a single tax identification number) must register and participate in PQRS as a group in order to avoid a negative one percent payment adjustment (in 2015) under the value modifier.

Click here for more on the value-based payment modifier.

Q. Does a copy of the patient appointment list have to be submitted with the data?

No. However, in the event validation of a patient visit is required, be sure to document the completed measures in the patient chart and retain a copy of the source you used to determine reported patients for auditing purposes.

Q. How can I contact CMS with additional questions?

You can contact the Quality Net Help Desk at 866-288-8912 or visit their http://www.qualitynet.org/.

Additional information can also be found on the CMS website. You can also participate in CMS-sponsored Provider Calls.

Covisint Programs, Pricing, and Contact Information

Q. What are the requirements to submit a measures group using the Covisint PQRS web application?

1. Register each provider using their Individual NPI and Federal TIN. (Note: Changes in TIN during the reporting calendar year may require multiple reporting, once under each TIN. Contact a Sales representative at 866-823-3958 for guidance)

2. Each provider selects one measure group to report (if there are multiple providers in a practice they do not have to report the same measure group)

3. Each provider selects 20 unique patients, of which greater than half or a minimum of 11 need to be Medicare Part B Fee-For-Service patients that meet ALL the requirements for the selected measure group (Refer to the Measure Group Guides on our Home Page once registered and logged into the web application for patient and reporting requirements)

4. Answer all the individual measures within the selected measure group for each of the patients, making sure to leave nothing blank. For most measures, there is the option to answer “Not Done/Unknown” or something similar. However, you cannot report “Not Done/Unknown” or “Performance Not Met” for all 20 patients for any given individual measure within the measure group.

   • Please refer to the question that explains the zero percent performance rates.
5. Once you’ve collected the data on all 20 patients, log into the web application using your username and password and enter the patient data under the appropriate provider.

6. Submit

7. If you have Internet connection in the exam room, you can skip using the data collection forms to collect the data and enter it directly into the web application at the time of the visit.

Q. If I registered for Covisint PQRS last year do I need to register again this year?

No. You do not need to re-register for the web application. Your login credentials will carry over each year. Use your same username and password to login to the 2013 web application. If you cannot remember your username and/or password please contact the Covisint PQRS Support Team at 866-823-3958 to have it reset.

Q. What is the cost to submit Physician Quality Reporting data through Covisint?

It is $299 per provider to submit using the Covisint PQRS web application. There is no registration fee and no upfront costs. The one-time payment of $299 per provider is paid at the time of submission using any major credit card.

The fee for Covisint PQRS Enterprise varies slightly depending on the number of submitted providers. This service is more costly than the web application. As such, we recommend it for larger practices (≥50 providers) to ensure cost effectiveness. There is an upfront data file processing fee and a per provider submission fee. Please contact a Covisint PQRS Sales representative at 866-823-3958 for additional information about pricing.

Q. Can we be invoiced for our providers’ submissions?

Yes. You will need to contact a Covisint PQRS Sales representative at 866-823-3958 to receive a coupon code to use at each submission. No provider data will be transmitted to CMS until payment is received in full.

Q. When is the last day to report for 2013?

CMS has moved the last day for registry vendors to submit back to February 28, 2014. In order to meet the CMS deadline, Covisint will close the web application on February 7, 2014.

Q. How do I contact Covisint for additional questions or support?

You can reach Covisint PQRS Sales at 866.823.3958 or info.covisint@covisint.com. For assistance with a password reset only call Covisint PQRS support at 866-823-3959.

E-Prescribing

Q. Can I get an incentive for both Meaningful Use and e-prescribing?

No. If you participate in both programs you will only receive incentive payment from Meaningful Use (MU). The 2013 reporting year is the final incentive year for e-prescribing. Successful reporting, if you are not earning a MU incentive, results in an incentive of 0.5% of your total Medicare part B allowed charges. For additional information about the e-Prescribing program, please visit the CMS website.

Q. How can I be a successful eRx submitter?

Eligible professionals (EPs) must use a qualified e-Prescribing system and submit a total of 25 unique e-Prescribing encounters for the year. All 25 patients reported must be Medicare Part B Fee-For-Service.

Covisint provides the leading cloud engagement platform for creating and enabling new mission critical external business processes. Our solutions enable organizations to connect, engage, and collaborate with the critical external audiences that define their success — including customers, business partners, and suppliers. Learn more at covisint.com.