PQRS and CAHs - Virtual Office Hour

February 8th, 2016

Questions & Answers

1. For Claims submitting, are all of these "Quality Codes" placed as Diagnoses codes or CPT codes or HCPC's? My billing department needs to know if they have to create new line items each time.

   Answer: Please see 2016 PQRS Claims Reporting Made Simple and 2016 PQRS Claims-Based Coding and Reporting Principles, available on the PQRS Educational Resources webpage, for an overview of steps individual Eligible Professionals (EPs) should take when beginning claims-based reporting. An example CMS 1450 form will be available in the 2016 PQRS Implementation Guide, to be posted soon on the PQRS How to Get Started webpage. In claim examples, the denominator-eligible visit is entered as the first line-items; QDCs for measures relevant to the visit are entered as separate line-items. The appropriate QDCs are entered in the HCPCS field. (Applies to CMS 1450 and 1500 forms)

   For additional billing questions, please contact your Medicare Administrative Contractor (MAC).

2. Surgery Measures, I am trying to qualify my surgeon PQRS activities for Measure 100 and 249. Wondering if the CPT codes 88305 etc.. regarding pathology for the denominators means the actual pathologist reading or the report from the pathologist. Coders are thinking the procedure code has to be from our clinician, however, never in a critical access hospital is our surgeon going to be performing the pathology read. I am hoping the coder can put in the CPT code for the pathologist based on the pathology report. 360-875-4553 if you want to clarify! Ha :) If selecting 9 measures and 1 of those is a cross cutting measure that is 9 in total? or 9 plus an additional cross cutting measure?

   Answer: Measure #100 (NQF 0392): Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade and #249: Measure #249 (NQF 1854): Barrett's Esophagus are intended to be reported by a pathologist. Please refer to the 2016 General Surgery Preferred Specialty Measure Set or contact the QualityNet Help Desk to determine which measures may be available to report. When reporting cross-cutting measure(s), the measures reported/submitted are included toward the count of 9 measures covering 3 domains.

3. Our CAH contracts some local family practice physicians as ER providers - the CAH bills their professional fees and the physicians receive an hourly rate. Does the CAH or

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physician have to submit data to PQRS for such physicians in their role as CAH ER physicians?

Answer: PQRS EP who have reassigned their billing rights over to the CAH (Method II) and who render professional Part B MPFS services via 837I may be included in PQRS analysis. Services billed via CAH II institutional claims are subject to PQRS because they are submitted via 837I to 85X Types of Bill (TOB), where x is any digit between 1 and 9, with physician supplier revenue codes (RCs) 96x, 97x and 98x, which will be paid based on the lesser of the submitted charges or the MPFS. See Frequently Asked Question (FAQ) 12588 for complete information about which services will be eligible for PQRS.

In addition, CMS has suggested sets of measures based on specialty, including a set for 2016 Emergency Medicine. Please see the "Specialty Measures" sets located at the bottom of the Measures Code page of the PQRS website. Otherwise, please contact the QualityNet Help Desk for individualized assistance identifying applicable measures for your organization, available at 866-288-8912 (TTY 877-715-6222) or qnetsupport@hcqis.org.

4. We are a critical access hospital and are struggling to define if this PQRS program applies to us and if so how to manage without having the penalty applied to us.

    a. Does PQRS apply in the critical access setting? If not, please provide the regulation, citation or other documentation showing it does not apply.

    Answer: Yes, beginning in 2014 providers at CAHs who bill Part B MPFS under Method II can participate in PQRS. See the PQRS List of Eligible Professionals for a complete list of providers who are considered "eligible professionals", or EPs, under PQRS. Services billed via CAH II institutional claims are subject to PQRS because they are submitted via 837I to 85X Types of Bill (TOB), where x is any digit between 1 and 9 with physician supplier revenue codes (RCs) 096x, 097x, and 098x. See Frequently Asked Question (FAQ) 12588 for complete information about which services are eligible for PQRS.

    If an organization bills Part B MPFS for professional or institutional services, and their providers are PQRS EPs, then they should review PQRS information to determine which measures those EPs can report. See the PQRS How to Get Started webpage for a list of comprehensive steps to get started.

    NOTE: PQRS EPs billing under CAH II may also be eligible to participate as a professional in the Medicare EHR Incentive Program. All EPs are encouraged to review the information on the applicable websites to determine whether they are eligible to participate in other Medicare programs.

    b. If it does apply:

i. what is the best method of selecting measures when you have providers in varying specialties (i.e. eligible professionals in anesthesia, outpatient cancer care, hospitalist, orthopedic surgeons, physical therapists, general surgeon)? We are struggling to find measure that would either apply across the continuum of care providers or to understand if the obligation is to have measures selected specifically for each of the provider's specialties.

Answer: The recommendation would be for the CAH to select a mechanism to report. If the CAH determines to individually report measures for 2016 PQRS then each individual EP should report measures that are most applicable or best represent their scope of practice. If the CAH determines that group practice reporting via group practice reporting option (GPRO) best represents the EPs within the CAH's TIN, then measures could be selected that best represent the depth of clinical scope within the CAH. Please contact the QualityNet Help Desk with further questions.

ii. What is the best method for capturing and reporting these measures on eligible professionals in a critical access setting? We have multiple EMR systems running throughout our facility for outpatient settings as well as in the inpatient medical record. This presents an obstacle for us to have a data provider pull reports as a group to submit. What are some solutions to doing this effectively and not be penalized for failure to report?

Answer: We need clarification from this inquirer in order to provide a full and accurate answer to this specific question. Do the EMR systems used by those providers who are PQRS EPs support PQRS? Is this organization planning to participate in PQRS via the group practice reporting option (GPRO), or are the providers participating as individual EPs? What type of Electronic Health Record (EHR) systems are in place, EHR Direct or Data Submission Vendor?

Information about electronically reporting quality data for PQRS is available on the PQRS website, see the 2016 PQRS EHR Reporting Made Simple document available on the PQRS Electronic Reporting Using EHR page of the PQRS web site, or contact the QualityNet Help Desk for assistance, available at 866-288-8912 (TTY 877-715-6222) or gnetsupport@hcqis.org.

5. As a CAH, we will submit PQRS as a group. Do we have to submit the same measures for every NPI, or can we choose Ortho measures for our Ortho clinic, ER measures for our ER providers, etc?

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Answer: We assume that "submit PQRS as a group" means the organization will register for 2016 PQRS GPRO. PQRS group practices that register to participate via GPRO will report as a group and be analyzed at the TIN level. This means that the organization should select the required number of applicable measures, and report quality actions for only those chosen measures for eligible encounters across the whole TIN. Please note, the reporting requirements are dependent upon the selected reporting mechanism. For example, if your organization registers to participate in 2016 PQRS via GPRO through a qualified registry, then you must select at least 9 measures across 3 domains, including one cross-cutting measure if an EP has one face-to-face encounter. The PQRS group practice will then report those 9 measures for eligible encounters rendered under that TIN.

An advantage of reporting PQRS via GPRO is that billing and reporting staff may report one set of quality measures data on behalf of all EPs within a group practice, reducing the need to keep track of EPs' reporting efforts separately. Another benefit of reporting via GPRO, is that those EPs who have difficulty meeting the reporting requirements for individual EPs may benefit from group reporting. Please contact the QualityNet Help Desk for individualized assistance identifying applicable measures for your organization, available at 866-288-8912 (TTY 877-715-6222) or qnetsupport@hcqis.org.

6. Are any eCQMs that apply to EPs the same as eCQMs that apply to hospitals (EH)s? Which registry-based measures include the hospital as a place of service? Which include skilled nursing facilities? Where can I find this out? Are the place of service codes part of the specifications for various measures?

   Answer: The Medicare EHR Incentive Program for eligible hospitals and CAHs has different requirements and measures than the Medicare EHR Incentive Program for ***professionals***. CAH facilities should report to the Medicare EHR Incentive Program for eligible hospitals and CAHs. However, EPs who bill under CAH II should report to the EHR Incentive Program for professionals.

7. Could you confirm?
   a. We are in an ACO for the first time in CY2016. As I understand, the quality measures are aligned for Web Interface reporting with a plus or minus 2% Value Based Modifier. If we were not in an ACO, the Value Based modifier would be plus or minus 4%. The VBM is based on the Tax ID, not the ACO.

      Answer: If your ACO fails to successfully report on quality measures as required by the Shared Savings Program in 2016, then your participant TINs will be subject to an automatic downward adjustment under the 2018 Value Modifier. In 2018, the automatic downward adjustment will be:
      - -4.0% for physicians, NPs, PAs, CNSs, and CRNAs in TINs containing physicians with 10 or more EPs;

- -2.0% for physicians, NPs, PAs, CNSs, and CRNAs in TINs containing physicians with between 2 and 9 EPs and physician solo practitioners; and
- -2.0% for NPs, PAs, CNSs, and CRNAs in TINs consisting only of non-physician EPs and NPs, PAs, CNSs, and CRNAs who are solo practitioners

If your ACO successfully reports on quality measures in 2016, then the 2018 Value Modifier for the participant TINs under your ACO will be calculated using the quality-tiering methodology. For TINs participating in a Shared Savings Program ACO in 2016, the Cost Composite will be classified as "Average", and the Quality Composite will be based on the quality data submitted by the ACO for the GPRO Web Interface measures, the ACO's performance on the all-cause hospital readmission measure, and the CAHPS for ACOs survey for the 2016 performance period. The maximum upward adjustment under quality-tiering in 2018 will be:

- +2.0x for physicians, NPs, PAs, CNSs, and CRNAs in TINs containing physicians with 10 or more EPs ('x' is an adjustment factor that will be determined after the conclusion of the performance period)
- +1.0x for physicians, NPs, PAs, CNSs, and CRNAs in TINs containing physicians with between 2 and 9 EPs; physician solo practitioners; NPs, PAs, CNSs, and CRNAs in TINs consisting only of non-physician EPs; and NPs, PAs, CNSs, and CRNAs who are solo practitioners.
- All TINs receiving an upward adjustment are eligible for an additional +1.0x if your ACO has an attributed patient population with an average beneficiary risk score in the top 25 percent of all beneficiary risk scores nationwide under the Value Modifier methodology.

The maximum downward adjustment under quality-tiering in 2018 will be:

- -2.0% for physicians, NPs, PAs, CNSs, and CRNAs in TINs containing physicians with 10 or more EPs
- -1.0% for physicians, NPs, PAs, CNSs, and CRNAs in TINs containing physicians with between 2 and 9 EPs and physician solo practitioners.

NPs, PAs, CNSs, and CRNAs in TINs consisting only of non-physician EPs and NPs, PAs, CNSs, and CRNAs who are solo practitioners are held harmless from downward adjustments for poor performance.

b. Is there any intent to move towards eCQMs only for ACO(s)? The measures are not always the same and seems to be a step backwards for EHR implementation.

Answer: We will need some clarification from the inquirer in order to provide an accurate answer; therefore, we ask that they contact the appropriate help desk listed below. A help desk representative will be able to provide the individualized support needed to answer this question.

- Medicare Shared Savings Program via email at sharedsavingsprogram@cms.hhs.gov
- Pioneer ACO via email at PIONEERQUESTIONS@cms.hhs.gov

- NGACO Model via email at NextGenerationACOModel@cms.hhs.gov

8. Please talk about how to submit PQRS data for providers who work in a rural health clinic and also cover the ER for the critical access hospital who bills Method II.

   Answer: If a PQRS EP renders services under Part B MPFS in addition to services under other billing schedules or methodologies, then (s)he must meet the PQRS reporting requirements for those services that fall under Part B MPFS for that TIN in order to avoid future PQRS payment adjustments regardless of the organization's participation in other fee schedules or methodologies.

   First, identify which Part B MPFS (CPT I codes) services are rendered. Then compare their billable codes to the PQRS measures specification and supporting documents located on the Measures Codes page of the PQRS website to identify applicable measures. Please note, the 2016 PQRS Single Source Code Master is in a spreadsheet format so it will allow you to filter or search by codes (ICD, CPT, and HCPCS) across all measures for all reporting mechanisms, which may help speed up the process. Next, review the information provided on the PQRS website to determine which reporting mechanism would be best for your organization. These step-by-step instructions and complete information is available on the PQRS How to Get Started webpage.

9. Explain if CRNAs are eligible and able to participate in PQRS if they are a contracted provider with the critical access hospital and have "pass through" billing/reimbursement. Hospital bills for the CRNA on UB form, but in the scenario of a surgery there is apparently no place on the form for the CRNA's NPI.

   Answer: CRNA is an eligible taxonomy included on the 2016 PQRS List of Eligible Professionals, available on the How to Get Started page of the PQRS website. To determine if a provider is eligible to participate in PQRS, CMS will analyze claims (for that unique TIN) to identify those EPs (by individual/rendering NPI) who render Part B MPFS services. During this process, CMS will first analyze the claims for rendering/individual NPIs, either at the service line level or at the claim level. If a rendering/individual NPI is not provided, then the claim is analyzed for an attending provider at the service line level or the claim level. For the 5010 version of the 837I, the Fiscal Intermediary Shared System (FISS) shall accept individual/rendering NPI information at the line level (loop 2420A) or attending provider NPI information at the claim level (loop 2310D). See FAQ 12588 for more information.

10. On a UB for an outpatient surgery performed at a critical access hospital the surgeon and his/her NPI must be specified. The hospital doesn't bill for the surgeon, nor is the surgeon employed by or contracted with the hospital. What do they do about PQRS in this situation?

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Answer: You are only responsible for reporting quality measures for those services billed under your organization's TIN. PQRS analysis is based on the individual/rendering National Provider Identifier (NPI)-level within a Taxpayer Identification Number (TIN), or unique TIN/NPI combination, or at the TIN-level for group practices participating via GPRO. Therefore, EPs will need to meet the satisfactory reporting requirements for each unique TIN/NPI combination, or TIN if participating via GPRO, under which they bill Part B MPFS. For more information see FAQ 12588 and the PQRS Implementation Guide available on the Educational Resources page of the PQRS website.

11. We have a group of CRNA's that we bill for but are having a difficult time determining 9 measures that can meet the requirements. The same scenario applies for our ED providers, they don't have enough measures that apply. What do we do?

    Answer: EPs should report all applicable measures. In the instance that there are less than 9 measures or less than 3 domains and all attempted measures are satisfactorily reported then Measure Applicability Validation (MAV) would be applied. This is a process to evaluate if there are other measures that were clinically relevant for the EP to report. In order to understand how MAV may impact you specifically, please contact the QualityNet Help Desk.

12. We were told at QIO training sessions provided by the CMS team (Molly MacHarris and Dr. Green) that in 2015 ALL patients, regardless of payer, were to be included when submitting PQRS using EHR-Direct or EHR-DSV methods. Given this, I was surprised to see the following in the 2015 CMS Implementation Guide for QRDA Cat I and III; Eligible Professional Programs and Hospital Quality Reporting (HQR) (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/QRDA_EP_HQR_Guide_2015.pdf) , Page 36/104 for QRDA III submission: "For the PQRS individual EP reporting, CQM populations include all Medicare patients seen by the EP during the reporting period, which is one full year (January 1, 2015 - December 31, 2015). For PQRS GPRO reporting, CQM populations include all unique Medicare patients from all practice sites in the group practice seen by the group during the reporting period (January 1, 2015 - December 31, 2015). Data for both individual EPs and GPROs is then submitted January 1, 2016 through February 2, 2016." There is no mention of including only Medicare patients under the QRDA I discussion; however, it states the Medicare HIC number "should" be included. Obviously, non-Medicare patients will not have this number It is my understanding that providers may submit either QRDA I or QRDA III files to CMS to satisfy PQRS reporting. Given the above conflicting instructions as to whether to include all patients or only Medicare patients—what should we be telling providers? Providers run monthly reports to use for improvement, but the rates will differ depending on which patients they include—Medicare/all payers. Also, when providers submit the QRDA files, their performance rates may differ depending on whether they submit QRDA I or QRDA III files (if one includes ALL patients while the other includes only Medicare). This doesn't seem logical. Could someone please explain this to me? have

vendors been instructed to include all patients in QRDA I files but only Medicare patients in QRDA III files?
In addition: I've been asked by providers why they should submit ALL patients to Medicare as part of the QRDA I files—they feel that would be a HIPAA violation because CMS has no right to collect patient-level information about non-Medicare patients.
We are also concerned that non-Medicare patients may reject from the QRDA I files, as they have in the past.

Answer: Whether you are submitting QRDA files using a direct EHR vendor or using an EHR Data Submission Vendor (DSV), data for all payers is required regardless of whether you are electronically reporting for PQRS only or for both PQRS and the Medicare EHR Incentive Program. In previous years under PQRS, the EHR-based data were reported on Medicare patients only. As CMS evolved the programs and aligned with other programs, we have clarified this requirement that for PQRS and the Medicare EHR Incentive Program, you must report on all payers. We note that for PQRS reporting, at least one patient must be a Medicare patient. See Table 26: CMS Payer Groupings on page 59 of the 2015 QRDA Implementation Guide for the list of accepted values.

Data for all payers is also required if reporting 2015 PQRS data via a Qualified Clinical Data Registry (QCDR). However, if reporting 2015 PQRS data via claims or qualified registry, then only Medicare Part B data is required. See FAQ 12486 and the PQRS EHR Reporting Made Simple document for additional information.

For other questions related to electronic reporting, please contact the EHR Incentive Program Information Center at (888) 734-6433, or TTY (888) 734-6563.

13. Providers want to know which performance rates will be published in Physician compare (ALL patients or only Medicare patients) and they want to know how the national thresholds will be set for the VM—e.g., using only Medicare or using ALL patients. Thank you for clarifying these questions.

    Answer: For Physician Compare, we will publicly report the rates as supplied by PQRS. If PQRS is using all data, that is what will be publicly reported. We do not recalculate the data in any way for Physician Compare.

    For Value Modifier, the prior year PQRS benchmarks are based on PQRS data submitted by groups and solo practitioners who met the criteria to avoid the PQRS payment adjustment. The PQRS data that feeds into the benchmark are based on Medicare patients only for some reporting mechanisms (e.g., GPRO Web Interface, Claims), but for other reporting mechanisms, providers are allowed to submit data for both Medicare and non-Medicare patients (e.g., Registry, EHR, QCDR & Measures Group reporting).

The prior year benchmarks for the CAHPS measures and the claims-based outcome measures are calculated using Medicare patients only. For most measures and providers, performance rates must meet a minimum case size applied at the TIN or ACO level in order to be included in the benchmark.

14. The question is in reference to CAH's billing method II, with a non-RHC or non-FQHC clinic that is billing under the hospitals TIN. If a CAH's QRUR's is not reflecting the clinic activity, and several EP's that perform office visits are not listed in exhibit 1 through claims, is that due to the way the hospital is billing the clinic activity. For example, identifying the EP at the claim level, rather than the line level charge for the professional fee? Do CAH's need to identify the professional at the line item for the professional fee?

    Answer: See the answer to question #9 above for information on which claim fields are used for PQRS analysis. A CAH provider paid under Method II is required to report the rendering NPI at the line level ***if*** it is different than the rendering NPI at the claim level. For more information about this billing standard requirement, refer to MLN Matters Article® MM7578 titled "Fiscal Intermediary Shared System (FISS) and Common Working File (CWF) System Enhancement for Storing Line Level Rendering Physicians/Practitioners National Provider Identifier (NPI) Information".

    If you have additional questions about the QRUR, please contact the Physician Value Help Desk at 888-734-6433 (select option 3) or pvhelpdesk@cms.hhs.gov.

15. Does the penalty for not reporting PQRS apply to Method II bills? Does the VM penalty/bonus apply to Method II bills?

    Answer: Individual EPs and PQRS group practices receiving the 2015 PQRS negative payment adjustment will see the indicator "LE" on their Remittance Advice for ***all*** Medicare Part B services rendered from January 1 – December 31, 2015. The remittance advice will also contain a Claim Adjustment Reason Code (CARC) of 237, indicating an adjustment, and a Remittance Advice Remark Code (RARC) of N699, indicating it was adjusted due to PQRS. For additional review, please refer to the Quick-Reference Guide for Understanding the 2015 PQRS Negative Payment Adjustment on the PQRS website, stored under Analysis and Payment.

    No, the Value Modifier payment adjustment does not apply to payments for professional services furnished in CAHs when the services are billed and paid under the CAH Method II payment methodology.

    However, PFS payments for professional services furnished in Method I CAHs by physicians (and, starting in 2018, for professional services furnished by certain non-physician practitioners) are subject to the Value Modifier.

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Therefore, please note, that even if your TIN's physicians typically furnish services in a CAH that bills for physician services under the CAH Method II payment methodology, the payments for services that these physicians furnish in other settings may still be subject to the Value Modifier if the services are billed and paid under the PFS (such as in an office or in a CAH that bills for its services under the standard payment methodology or Method I).

16. Explain the MAV process. What measures actually fit or work for the CAH's

    Answer: Measure Applicability Validation (MAV) is an analytic process that CMS uses to determine if more measures may have been applicable for an EP when they have satisfactorily reported less than 9 measures or less than 3 NQS domains. As long as an EP bills for services under Medicare Part B, then any measures within 2016 PQRS would be applicable to report depending on the EPs scope of practice. For more specific measures applicable to EPs that may practice within the CAH, the recommendation would be to contact the QualityNet Help Desk.

17. Does the informal review process actually work?

    Answer: Individual EPs, designated support staff/vendors, and group practices that believe they have been incorrectly assessed the 2016 PQRS negative payment adjustment may request to have an informal review of their PQRS reporting performance. An informal review may be requested if the feedback report reveals that the individual EP or PQRS group practice participating via GPRO did not earn the applicable PQRS incentive payment when they believe they should have, when they believe the payment amount was incorrect, or if they disagree with the analysis of satisfactory reporting to avoid a future payment adjustment. For more information, see the Analysis and Payment page on the CMS PQRS web site.

18. Is there any information about how MIPPS/MACRA will apply to CAH-affiliated physician practices?

    Answer: CMS added language on how MIPS would apply to CAH-IIs in the NPRM, proposing that they would be treated as eligible clinicians, similar to how they function today under PQRS and the EHR Incentive Program. I would refer them to the regulation for more details, available on the MACRA page of the PQRS website.

19. Some of our CAHs are having weird results on the QRURs where they are assigned many fewer patients than expected and have much higher costs. We think it is due to Method II billing, but someone just raised the issue that it might be in how they are filling out their claims. One group that we work with closely puts the TIN/NPI combination at the claim level, not the line level. Would that make a difference in how the patients are attributed to primary care practices?

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Answer: A CAH provider paid under Method II is required to report the rendering NPI at the line level if it is different than the rendering NPI at the claim level. Otherwise, it does not make a difference for purposes of assigning beneficiaries to a TIN if the rendering NPI is reported at the claim level or line level. See the answer to question #9 above for detailed information on which claim fields are used for PQRS analysis. If you have further questions, please contact the Physician Value Help Desk at 888-734-6433 (select option 3) or pvhelpdesk@cms.hhs.gov.

20. We have an APRN working in our Emergency Department Room at CAH. What is the best way to report PQRS for this provider? We are working with a Registry. We also have a specialty provider in a clinic setting. What is the best way to report for this provider? The measure groups do not look like an option.

    Answer: PQRS mechanisms that may be applicable could be claims, registry, or group practice reporting for these EPs. It appears that these EPs may already be working with a registry to submit measures on their behalf. As long as these EPs are billing for services within Medicare Part B, there are a variety of measures within 2016 PQRS that could be applicable. Some resources that may assist with measure selection would be the 2016 Measures List or the 2016 Claims and Registry Measure Specifications. These documents are found at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html. Please contact the QualityNet Help Desk for more information.

21. Is there a way for CAHs to determine how many EPs they have to report for if they are reporting individually? CAHs don't always know how many EPs are on their list due to the high use of locums or one-off specialists. Also, they aren't always clear on when they are generating Method II bills versus Part B bills and for which providers, so it is hard for them to track down who their EPs are themselves.

    Answer: CMS will not know exactly which providers will be eligible for PQRS until an organization submits claims for the given PQRS reporting period. To get an idea of approximately how many and who is eligible at your organization, we suggest you work with your IT department, revenue cycle vendor, patient accounts, or whoever manages your billing software to pull a report that identifies which NPIs billed Part B MPFS in calendar year 2015. Assuming the scope of your organization does not change, this will give you a rough idea of how many and who bills Part B MPFS.

    When billing under CAH Method II, show the professional services separately, along with the appropriate HCPCS code (physician or other practitioner) in one of the following revenue codes - 096X, 097X, or 098X.

    Under Section 1834(g)(2) of the Act, a CAH may elect the Optional Payment Method, under which it bills the MAC for both facility services and professional services furnished to its outpatients by a physician or practitioner who has reassigned his or her billing

rights to the CAH. However, even if a CAH makes this election, each physician or practitioner who furnishes professional services to CAH outpatients can choose to either:

a. Reassign his or her billing rights to the CAH, agree to be included under the Optional Payment Method, attest in writing that he or she will not bill the MAC for professional services furnished in the CAH outpatient department, and look to the CAH for payment for the professional services; **or**
b. File claims for his or her professional services with the MAC for standard payment under the Medicare PFS.

For each physician or practitioner who agrees to be included under the Optional Payment Method and reassigns benefits accordingly, the CAH must forward a copy of a completed Form CMS-855R/Medicare Enrollment Application for Reassignment of Medicare Benefits to the MAC and keep the original on file. This attestation will remain at the CAH.

Once the Optional Payment Method is elected, it will remain in effect until the CAH submits a termination request to the MAC. A CAH is no longer required to make an annual election to be paid under the Optional Payment Method in a subsequent year. If a CAH elects to terminate its Optional Payment Method, the termination request must be submitted in writing to the MAC at least 30 days prior to the start of the next cost reporting period.

The Optional Payment Method election applies to all CAH professional services furnished in the CAH outpatient department by physicians and practitioners who:

- Agree to be included under the Optional Payment Method by reassigning their billing rights to the CAH;
- Complete Form CMS-855R; **and**
- Attest in writing that they will not bill the MAC for their outpatient professional services.

22. If a CAH has radiologist that read radiology exams remotely, is this still considered a "face to face" visit in terms of PQRS? What is the definition of a "face to face" visit?

Answer: For the purpose of 2016 PQRS, face to face encounter is defined as an instance in which the EP billed for services such as general office visits, outpatient visits, and surgical procedure codes under the Medicare Physician Fee Schedule (MPFS), see the 2016 Face to Face Encounter List.

23. Are CAH groups supposed to report to PQRS on just their Part B patients or are they also supposed to report for their Method II patients?

Answer: EPs under Method II who render denominator-eligible Part B MPFS services via CMS-1500 or CMS-1450 claim are able to participate in PQRS regardless of the organization's participation in other fee schedules or methodologies. If an eligible PQRS EP renders services under Part B MPFS in addition to services under other billing schedules or methodologies, then (s)he must meet the PQRS reporting requirements for those services that fall under the MPFS in order to avoid future PQRS payment adjustments. Services rendered under Method I and billing methodologies other than Part B MPFS will ***not*** be included in PQRS analysis.

24. If a CAH has radiologists that remotely READ radiology exams for their facility, and the CAH submits the billing for those radiologist using a 1500 form with the radiologist NPI listed on the 1500 form, does the CAH have to submit ALL of the radiologist quality data, including the data at the other facilities that the radiologist works for? Or, does the CAH only submit the data specific to their facility?

    Answer: You should only report quality data for services rendered under your TIN, see the answer to question #10 above. You should report quality data for only those services that fall within the denominator of the selected PQRS measures that you are reporting. You are strongly encouraged to call the QualityNet Help Desk and provide them with the CPT codes that you bill, available at 866-288-8912 (TTY 877-715-6222) or qnetsupport@hcqis.org. QualityNet Help Desk will be able to provide individualized assistance for this question.

25. Is a provider considered eligible for PQRS reporting if they see patients in a CAH emergency room or inpatient area, and those services are billed on a 1500 form with their NPI listed on the 1500 form, but the CAH itself does NOT bill under CAH Method II billing, but rather CAH Method I billing?

    Answer: Part B MPFS services rendered by PQRS EPs under CAH Method II are eligible for PQRS.

26. Are CAHs supposed to report to PQRS on the patients they see that generate Method II bills? Or are they only supposed to report on patients that generate Part B bills?

    Answer: Part B MPFS services rendered by PQRS EPs under CAH Method II are eligible for PQRS.

27. Does CMS have plans to include Method II bills in the QRURs/VM in the future? As background, one CAH in our QIN had 23 assigned patients (rather than the 3-4k they were expecting) and their total per capita costs were 12 standard deviations above the mean. When we delved into the data, we saw that the only patients they were assigned through Part B claims had extended SNF or Swing Bed stays. They were not assigned any patients that they saw regularly through their clinic because all of those patients were billed under Method II. This method has discouraged several CAHs from reporting PQRS,

as they believe that they will face a penalty for being high cost regardless of whether or not they report, so they see no reason to expend the time, energy, and money to report.

Answer: Professional services furnished in a CAH that are billed and paid under the Medicare CAH Method II payment methodology are not subject to the Value Modifier. CMS does not have any current plans to revise that policy for the Value Modifier program. However, any such proposals would be included in the rulemaking process and allow for public comment.

28. The penalty for not reporting PQRS: Does it apply to Method II bills? As background, several of our CAHs are considering not reporting PQRS in 2015. A 4% penalty on their Part B claims is minimal, and it would cost more for them to report than they would lose through the penalty program. We know the VM only applies to Physician Part B payments. Our understanding is that the PQRS penalty applies only to Part B payments (for all EPs). If, however, the PQRS penalty also applied as a 2% penalty on Method II bills, more of our CAHs would be likely to report to PQRS.

    Answer: If not participating in 2015 PQRS, the 2017 PQRS negative payment adjustment will be applied to all Method II Part B MPFS reimbursements issued in calendar year 2017 for that TIN/NPI, or TIN if the organization registered in 2015 PQRS GPRO. EPs who render denominator-eligible professional services under Part B MPFS via CMS-1500 or CMS-1450 claim, or the electronic equivalents, are encouraged to participate in PQRS to avoid future negative payment adjustments. The organization will need to determine if it is within their interest to support quality reporting initiatives for those EPs who have a small beneficiary load.

    Note: *Providers who are eligible for PQRS may also be eligible for separate adjustments under the Value-based Payment Modifier and the Medicare EHR Incentive Program* ***as a professional****. PQRS EPs are encouraged to review the information on the applicable websites to determine whether they are eligible to participate in other Medicare programs.*

29. How can any given clinic or CAH learn which services they are billing subject them to participate in PQRS? We've had multiple entities get penalty letters and they have no idea what they've billed that is subjected to PQRS.

    Answer: See the answer to question #21 above. Beginning in 2014, PQRS EPs who work at CAHs and have reassigned their billing rights over to the CAH (Method II) are considered eligible to participate in PQRS. Part B MPFS services rendered by PQRS EPs under CAH Method II are eligible for PQRS.

30. The QIN-QIOs were provided a report (Measure Rate Report) that shows which measures each provider triggered (ie, submitted a claim with services that were included in the denominator for a given measure). Is it possible for a clinic or CAH to

learn what measures they've triggered throughout the performance year? In small hospitals and clinics they can spend untold hours trying to figure out which measures to use based on small populations treated for a range of conditions. This seems like a waste of resource and an unnecessary cost when CMS has the ability to tell them which measures are applicable to the claims they submitted.

Answer: The following PQRS reporting mechanisms will help an organization identify which encounters are eligible for PQRS either during the reporting period or during the submission period, including qualified registry, Qualified Clinical Data Registry (QCDR), electronic reporting via EHR, and the GPRO Web Interface, which is only available to groups that register for GPRO. Otherwise, if the organization prefers to participate via claims, they can work with their IT department, revenue cycle vendor, patient accounts, or whoever manages their billing software to create a report that identifies which NPIs bill services under Part B MPFS, and possibly set-up a system to track when EPs render PQRS-eligible services - though the process will vary depending the billing system.

Otherwise, you can contact the QualityNet Help Desk and provide them with the CPT codes that you bill and they will help you identify applicable measures, available at 866-288-8912 (TTY 877-715-6222) or qnetsupport@hcqis.org.

31. Do CAHs need to report PQRS data on radiologists who only interpret images? The professional component of the procedure is billed by the radiologist under his/her TIN while the technical component is billed by the CAH. The radiologists are being included in the EP group for the CAH when only technical components are billed.

    Answer: Technical services are not eligible for PQRS. Only professional and institutional services paid under or based on Part B Medicare Physician Fee Schedule (MPFS) submitted via CMS-1500 and CMS-1450 claim form, or the electronic equivalents 837P and 837I will be eligible for PQRS.
    - Only EPs who render denominator-eligible, Part B MPFS professional and/or institutional services are considered *able* to participate in PQRS and will be analyzed for future PQRS negative payment adjustments.
    - There is no threshold to participate in PQRS so all Part B MPFS services, even if minimally billed, count.

32. Some CAHS are seeing overly large number of NPIs listed under their TIN. After investigation, many of the NPIs are for referring physicians who only order diagnostic procedures or lab tests. The CAH is not billing for professional services for the referring physicians. They are only billing for the technical component of the diagnostic procedure or the lab test.

    Answer: Technical services are not eligible for PQRS. Only professional and institutional services paid under or based on Part B Medicare Physician Fee Schedule (MPFS)

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- Only EPs who render denominator-eligible, Part B MPFS professional and/or institutional services are considered *able* to participate in PQRS and will be analyzed for future PQRS negative payment adjustments.
- There is no threshold to participate in PQRS so all Part B MPFS services, even if minimally billed, count.

33. Please explain the difference, at the claim/billing level, between CAH Method 1 and CAH Method 2. Our experience seems to be that it does not matter what method is used but rather what claim (1450 or 1500) and whether the individual EP NPI is used or not. We have multiple CAH Method 1 facilities who are very surprised and shocked that they are subjected to PQRS. The FAQs only speak to Method 2 and are silent on Method 1.

    Answer 33: PQRS only applies to Method II billing. The difference between Method 1 and 2 follows:

    Under Method I:

    - The CAH bills for facility services.
    - The physicians/practitioners bill separately for their professional services.

    Under Method II:

    - The CAH bills for facility services.
    - If a physician/practitioner has reassigned his/her benefits to the CAH, the CAH bills for that particular physician's/practitioner's professional service.
    - If a CAH has elected Method II, the physician/practitioner is not required to reassign his or her benefits to the CAH.

    For those physicians/practitioners who do not reassign their benefits to the CAH, the CAH only bills for facility services and the physicians/practitioners separately bill for their professional services (similar to Method I).

34. An RHC has an electronic medical record which gathers and tracks PQRS measures with relative ease. The CAH, which is under the same TIN, has an electronic medical record which does not track PQRS measures (because it tracks hospital side CQMs). Can they use the PQRS data from the RHC EHR on the RHC patient population to report PQRS or must they use data from the CAH side on the patient population billed to MPFS?

    Answer: Since the RHC data file does not capture services rendered at different locations under the TIN then it might not include all eligible cases for that TIN. Individual EPs or group practice participating via GPRO (PQRS group practice) must follow the 2016 PQRS electronic reporting requirements, which state that they must report at least 9 measures covering a minimum of 3 National Quality Strategy (NQS) domains. If the EP's

CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report all the measures for which there is Medicare patient data for the 12-month period. An EP must report on at least 1 measure containing Medicare patient data and report on all payers. Be sure that you identify and capture **all eligible cases per the measure denominator** for each measure you choose to report, **for all payers**.

EPs and group practices that submit less than one full year of data for all eligible patients bear the risk that doing so may prevent EPs and group practices from meeting the measure criteria for PQRS. Please note, during submission the submitter will be asked to attest that the data file is complete and accurate. If only the RHC data file is being submitted, and the submitter attests that it is a complete and accurate file, then the organization may encounter issues if selected for a Medicare audit.

For complete information about 2016 PQRS electronic reporting, see the 2016 PQRS: Reporting using and EHR Made Simple document on the EHR Based Reporting Using an EHR page of the PQRS web site.

35. What mechanism can a CAH use to learn all of the NPIs associated with or who submitted claims to MPFS under their TIN?

    Answer: See the answer to question #30 above.

36. What is the escalation process for a TIN who cannot get access into EIDM and QualityNet was unable to assist them?

    Answer: We are unable to answer this question without clarification. Why weren't they able to get access? What was the QualityNet incident number? Why couldn't QualityNet assist them?

    The QualityNet Help Desk is the primary contact for EIDM questions and issues. Please submit a new inquiry. Additional EIDM resources can be found on the PQRS Analysis and Payment webpage.