NATIONAL ASSOCIATION OF EPILEPSY CENTERS
NAEC

2015 Medicare Physician Fee Schedule
Final Rule Summary

On October 31, 2014, the Centers for Medicare and Medicaid Services (CMS) released the final Medicare Physician Fee Schedule (MPFS) for 2015. The rule updates payment policies and payment rates for services furnished under the MPFS and includes changes to the quality reporting initiatives associated with the MPFS – the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) meaningful use program, and the physician value-based payment modifier.

The rule in its entirety and the addenda can be found here. The majority of the provisions in the rule will be effective January 1, 2015 unless stated otherwise.

The following summarizes the major provisions of the proposed rule.

SGR and Conversion Factor (CF) Impact
In April, Congress passed the *Protecting Access to Medicare Act of 2014* (PAMA), which extended the current conversion factor through March 31, 2015. Based on the changes included in the rule, the conversion factor will be reduced slightly from $35.82 to $35.80 from January 1, 2015 to March 31, 2015. Congress will need to pass legislation prior to March 31 in order to prevent an approximate 20% reduction in the CF driven by the Sustainable Growth Rate (SGR) formula from occurring on April 1, 2015.

Specialty Impact
Table 93(see Attachment 1), extracted from the rule, provides a summary of the impact of the changes in the rule by specialty. This chart does not include the impact of any reductions caused by the SGR that may occur after March 31, 2015. The changes in the rule are budget-neutral in the aggregate which explains why the impact for all physicians (i.e., total row) is shown as zero. Most specialties will see changes in the range of plus or minus 1%.

Mis-valued Codes
High Expenditure Services across Specialties -
With the passage of the *Protecting Access to Medicare Act of 2014* (PAMA), Congress broadened CMS' authority to identify services as misvalued and to require a re-evaluation of those services. In the proposed rule, CMS identified over 60 codes for review that represent high expenditure services with Medicare allowed charges of more than $10 million that haven't been reviewed by the AMA RUC since 2009. Initially it was proposed that these codes would be reviewed in 2015. However, because of the proposed change in the global package for 10-day and 90-day global surgical services discussed in the next section and the impact this would have on the RUC's workload, CMS decided that specialties can voluntarily delay surveys of these potentially misvalued codes until some date in the future.

Evaluation of Global Surgical Packages –
CMS is planning to transform all 10- and 90-day global surgical codes to 0-day codes beginning in 2017. CMS proposed this change in response to reports from the Office of the Inspector General, which found that the RVUs for certain 10 and 90 day surgical packages included more visits in the global period than were actually furnished. CMS is also concerned that post-surgical visits are valued higher than visits furnished and billed separately by non-surgical specialties. The conversion to 0-day global services will be made for 10-day global codes in 2017 and 90-day codes in 2018. CMS will allow for separate payment for medically necessary visits occurring pre- and post-operatively, except those provided on the day of surgery. The RUC has prioritized the re-evaluation of the approximately 4,200 10-day and 90-day global services in 2015 and 2016. In addition, CMS is considering ways to streamline the re-evaluation process particularly for lower volume surgical services.

Change in CPT and RUC Processes for New, Revised and Potentially Misvalued Codes

In the CY 2012 MPFS rulemaking process, CMS consolidated its five-year review of CPT codes with its process of identifying potentially misvalued codes on an annual basis. Under this process, CMS issues interim final RVUs for all new and re-evaluated codes in the MPFS final rule and payments are based upon these values during the calendar year covered by the final rule. The interim values were subject to comments and could be further revised the following year. CMS follows this process because of the lack of synchronization between CMS' MPFS rulemaking cycle and the release of codes by the AMA CPT Editorial Panel and the RUC review process.

Over the past several years, stakeholders have expressed concern when the MPFS final rule included reductions in payment due to the assigning of interim relative value units to codes arguing that they did not receive notice of the reduction (RUC recommendations are not public) nor did they have an opportunity to comment before they went into effect. CMS has agreed to change the process for valuing new, revised and potentially misvalued codes beginning with a transition in 2016 and full implementation in 2017. This will result in the values for the vast majority of codes going through a notice and comment process prior to being adopted. CMS has also agreed to make several changes in the process to minimize the use of temporary "G" codes which was strongly objected to by many who commented on the rule.

Geographic Practice Expense Index (GPCI)

The GPCI is an adjustment CMS calculates and applies to both the work and practice expense relative value units for each code to reflect differences in labor, rent and other cost elements based on geographic areas. Currently, there is a floor of 1.0 for the GPCI for practice expenses for 5 "frontier" states, which the *Protecting Access to Medicare Act of 2014* (PAMA) extended until March 31, 2015. However, this floor expires unless extended by Congress. The final rule also includes the GPCI's that will take effect on April 1, 2015 – December 31, 2015.

Malpractice Relative Value Units

For 2015, CMS is proposing new malpractice RVUs for all services. In updating the malpractice RVUs CMS followed the methodology used in its 2010 update and based the new values on updated professional liability insurance premiums.

Off-Campus Provider-Based Departments

As hospital purchasing of physician group practices continues to increase, CMS is interested in better understanding hospital costs associated with physician services and how hospitals are billing for physician services provided off site. For 2016, CMS is requiring hospitals to use a modifier to indicate a service that is provided in a hospital-owned clinic or practice and is billed through the hospital outpatient prospective payment system. In 2015, this modifier would be voluntary for hospitals for data collection purposes. Physicians will also be required in the future to use new place of services codes for professional claims, but not before January 1, 2016. .

Telehealth Services

CMS is finalizing its proposal to add the following services to the telehealth benefit psychotherapy services, the annual wellness visit and the prolonged evaluation and management services (99354 and 99355).

Complex Chronic Care Management (CCM) Services

In the final MPFS rule, CMS added a new code for chronic care management (CCM) services. The CCM code is for the non-face-to-face time spent managing patients with two or more complex chronic conditions that are expected to last at least 12 months or until death, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. The service could be provided by a physician and/or by staff under a physician's direction. While it is anticipated that this service will be

typically reported by primary care physicians, specialists can also report the new CCM code. Only one physician is eligible to bill the service per patient, and the patient must sign a consent form acknowledging that the service will be provided. Patients will also be responsible for a co-pay for this service.

CMS is adopting CPT code 99490 with a payment rate of $40.39, rather than the G-code discussed in the proposed rule. The code may be reported once per calendar month and reflects 20 minutes of service provided over the calendar month. CMS rejected comments to raise the payment rate and establish another code for more complex patients. CMS stated that it will evaluate the utilization of this code and consider payment changes if warranted in the future.

Other requirements for billing the service, which were part of the 2014 MPFS include:

- 24/7 access to address a patient's acute chronic care needs
- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to have successive routine appointments
- Care management for chronic conditions including systemic assessment and development of a patient centered plan of care
- Management of care transitions
- Coordination with home and community based clinical service providers
- Enhanced opportunities for a patient to communicate with the provider through telephone and secure messaging, internet, or other asynchronous non-face-to-face consultation methods

CMS revised its "incident to" policy related to the provision of this service. CMS will consider for purposes of billing the CCM service any time (during or outside business hours) spent by clinical staff, who need not be direct employees of the billing physician as long as the staff are under the general supervision of the billing physician and all other requirements of the "incident to" regulations are met.

Providers of CCM services must utilize EHRs or another health IT platform that include an electronic care plan, which is accessible to all providers within the practice, including those providing care outside of normal business hours and shared with care team members outside of the practice. CMS modified its proposal about the use of EHRs, in response to comments about the use of certified EHRs. The final rule requires that the CCM service be provided using EHRs that are certified for the EHR Incentive Program as of December 31 of the calendar year preceding the provision of the service. CMS believes this change allows providers more flexibility as they transition to the use of certified EHRs.

CMS finalized its proposal that only practitioners who are not participating in Innovation Center programs that include the Multi-payer Advance Primary Care Practice Demonstration and the Comprehensive Primary Care Initiative are eligible to bill for the CCM service.

Clinical Laboratory Fee Schedule (CLFS)

In the 2014 MPFS final rule, CMS finalized a process for re-examining the lab fee schedule with a focus on technological changes that have occurred in laboratory testing. With the passage of the *Protecting Access to Medicare Act of 2014* (PAMA) in April, CMS is required by law to revise the CLFS based on private payer rates. In this rule, CMS eliminated the changes it made during last year's rulemaking in light of PAMA and explains that it will propose parameters for the collection of private payer rate information and other requirements of PAMA through a separate rulemaking process at a later date.

Local Coverage Determination Process for Clinical Diagnostic Laboratory Testing

In the notice of proposed rulemaking, CMS is proposed an expedited Local Coverage Decision (LCD) process for all new clinical diagnostic laboratory tests based on its experience with the National Coverage Determination (NCD) process and the Palmetto MolDx pilot project. Based on the comments received,

CMS did not finalize the changes included in the proposed rule and stated that it would address this issue in future rulemaking.

Physician Quality Reporting System (PQRS)

Since its initial implementation in 2007, PQRS has continued to evolve largely as a result of statutory updates enacted by Congress. It moved into a penalty phase with the CY 2013 program, which is continuing. As mandated by Congress, those providers who do not report quality measures in CY 2015 will have their payments adjusted by -2% in CY 2017. Starting in 2015, physicians and other eligible providers will no longer receive a bonus payment for satisfactorily reporting quality measures.

In this final rule, CMS continues to take steps to align reporting requirements across its quality programs, including the PQRS, the Medicare Shared Savings Program (ACOs), the EHR Incentive Program and the value-based payment modifier (VM).

Criteria to Satisfactorily Report. To avoid the penalty, eligible providers are required to report at least 9 measures covering 3 of the National Quality Strategy domains for 50 percent of the Medicare Part B patients they see during the reporting period. Depending on their reporting method, an eligible professional or group practice that sees at least 1 Medicare patient in a face-to-face encounter would be required to report on 1 cross-cutting PQRS measure, which are specified by CMS. (Telehealth visits are not considered face-to-face encounters for this requirement.) The cross-cutting PQRS measure counts as 1 of the 9 required measures; it is not reported in addition to the 9 measures. Complete details on the reporting requirements by reporting method can be found in the table attached to this summary. CMS will continue to allow eligible professionals using the claims-based reporting mechanism to report 3 measures on 50 percent of their applicable patients to avoid the payment adjustment.

Note that all groups of 100 or more eligible professionals are required to report the CAHPS survey. It remains optional for groups under 99 eligible professionals.

Quality Measures. It is statutorily mandated that measures must be endorsed by the National Quality Forum or entities under contract with NQF. But, CMS will consider measures not NQF-endorsed when no endorsed measure in an area exists. In addition, CMS will not restrict the type of organizations that can develop quality measures and there are no requirements for measure development. For 2015, CMS added 20 new individual measures and 2 measures groups and removed 50 measures. For 2015, PQRS includes 255 individual measures.

All proposed measures have been classified into 1 of 6 domains based on the National Quality Strategy's six priorities:

1. Patient Safety
2. Person and Caregiver-Centered Experience and Outcomes
3. Communication and Care Coordination
4. Community/Population Health
5. Efficiency and Cost Reduction
6. Effective Clinical Care

Other major changes to the PQRS program in the rule include:

- Physicians practicing in critical access hospitals (CAHs) will be able to participate in the PQRS for the first time in CY 2015 using all of the available reporting mechanisms.

- All practices with 25 or more eligible professionals must report quality measures on 248 patients. This reduces the required number of patients from 411 for groups of 100+ eligible professionals and raises the required number of patients by 30 for practices between 25-99 eligible professionals.

- Most reporting options require eligible professionals to report on 1 measure from the new cross-cutting measures set.

- PQRS continues to provide eligible professionals with reporting mechanism options. The program retained the claims, registry, qualified clinical data registries (QCDRs), EHR, administrative claims, the GPRO web-interface, and the Clinical Group Consumer Assessment of Healthcare Providers and Systems Survey, which will now be called CAHPS for PQRS, rather than CG-CAHPS.

- Last year CMS introduced reporting through qualified clinical data registries. CMS has changed the requirements for this reporting method. They are as follows:

  - To avoid the penalty, eligible providers must report on at least 2 outcome measures. If less than 2 are available, they must report on at least 1 outcomes measures and at least 1 of the following types of measures: resource use, patient experience of care, or patient safety or efficiency/appropriate use.
  - CMS has also increased the number of non-PQRS measures that can be reported from 20 to 30.
  - To serve as a QCDR, the entity must make the quality measures data for which its eligible professionals report publicly available. The quality measures data must be available by April 31 of the year following the reporting period.

Electronic Health Record (EHR) Incentive Program (Meaningful Use)

CMS was statutorily directed to develop a plan to integrate quality measures reported under PQRS with the EHR meaningful use requirements. In 2014, CMS received feedback that it was difficult and expensive to test and recertify Certified Electronic Health Record Technology (CEHRT) products to the most recent version. In this final rule, CMS will not require EPs to ensure that their CEHRT products are recertified to the most recent version of the electronic specifications for the Clinical Quality Measures (CQM), but notes that they must still use the most recent version of the electronic specifications when reporting CQMs.

CMS finalized its proposal to retain the group reporting option that was finalized in 2014, but relaxed the requirement for Comprehensive Primary Care (CPC) practice sites to report CQMs to cover three domains. For 2015 only, CPC sites will be required to report 9 CQMs from at least 2 domains, allowing these sites to satisfy both the CPC and meaningful use reporting by reporting just once. These sites are encouraged to report measures across 3 domains if feasible.

Physician Compare Website

The 2015 PFS final rule finalizes the proposal to expand public reporting of group-level measures by making all 2015 PQRS GPRO web interface, registry, and EHR measures for group practices of two or more EPs and all measures reported by ACOs available for public reporting on Physician Compare in 2016. Measures that are new to PQRS will not be reported on the website the first year they are in effect. CMS is also including an indicator on the Physician Compare website for satisfactory reporters under PQRS in 2015 and participants in EHR.

Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program

The establishment of a value-based payment modifier (VM) was mandated by the ACA in order to provide differential payment to physicians and group practices based upon the quality and cost of care furnished to Medicare beneficiaries during a specific performing period. The statute requires the VM be implemented in a budget neutral manner, meaning that positive adjustments for high performance must be offset by the penalties imposed for poor performance. All physicians will be subject to the VM by January 1, 2017,

based on their reporting of quality and cost measures in 2015. In this rule CMS decided to apply the VM to non-physician providers beginning in CY 2018.

In the final rule, CMS decided to increase the maximum payment adjustment from -2 to -4 percent in 2017 for groups of 10 or more eligible professionals (EPs) that do not meet the quality reporting requirements of the PQRS. For groups with 2 – 9 EPs and solo practitioners that do not meet the reporting requirements of PQRS the maximum adjustment will be -2 percent in 2017.
Groups of 2 – 9 eligible professionals that meet the satisfactory reporting criteria through the PQRS GPRO, EHR or registry reporting or groups of physicians that do not participate in the GPRO, but at least 50 percent of the eligible professionals billing under the group meet the PQRS satisfactory reporting criteria or satisfactorily participate in a PQRS clinical quality data registry will avoid the payment adjustment.

Groups of 10 or more EPs that meet the PQRS reporting requirements will be subject to quality tiering. CMS increased the downward adjustment to -4 percent and the potential upward adjustment to +4 percent for groups in this category. Quality tiering is the analysis used to determine the type of adjustment (upward, downward or neutral) and the range of adjustment based on performance on quality and cost measures. Quality tiering will determine if a group practice's performance is statistically better, the same, or worse than the national mean. CMS establishes composite scores based on performance, one reflecting quality of care and the other cost. The quality of care composite is based on PQRS performance. Total per capita costs plus specific cost measures will be weighted equally to compute the cost composite.

Beginning with CY 2017, CMS will apply the VM to all eligible professionals participating in an Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program.

CMS will continue to provide annual Quality and Resource Use Reports (QRURs) to EPs as a method of providing feedback on the quality and cost of care furnished to Medicare beneficiaries. They will explain how the VM will impact Medicare payments.

Physician Compare Website

The 2015 PFS final rule finalizes the proposal to expand public reporting of group-level measures by making all 2015 PQRS GPRO web interface, registry, and EHR measures for group practices of two or more EPs and all measures reported by ACOs available for public reporting on Physician Compare in 2016. Measures that are new to PQRS will not be reported on the website the first year they are in effect. CMS is also including an indicator on the Physician Compare website for satisfactory reporters under PQRS in 2015 and participants in EHR.

This methodology will be applied to all those in Category 1 and being classified in Category 1 does not guarantee that an EP will not be subject to a penalty. However, groups between 2 and 9 EPs and solo practitioners would only receive positive or neutral adjustments as determined by quality-tiering. Groups of 10 or more EPs could be subject to the negative adjustment.

Beginning with CY 2017, CMS is proposing to apply the VM to all eligible professionals participating in an Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program, the Comprehensive Primary Care Initiative or other similar Innovation Center model.

CMS will continue to provide annual Quality and Resource Use Reports (QRURs) to EPs as a method of providing feedback on the quality and cost of care furnished to Medicare beneficiaries. They will explain how the VM will impact Medicare payments. In late summer of 2014, CMS will distribute QRURs based on CY 2013 data.

Open Payments Program (Sunshine Act)

The Open Payments program requires drug and device manufacturers to annually report information on payments or other transfers of value made to physicians and teaching hospitals. While separate implementing regulations were published in February 2014, CMS included proposed changes to its open payments program in the MPFS proposed rule. CMS finalized several proposals from the proposed rule, including:

1. The deletion of the definition of "covered device" as it is duplicative of the definition of "covered drug, device, biological or medical supply" which is already defined in regulation.
2. A requirement that the marketed name and therapeutic area or product category of the related covered drugs, devices, biologicals, or medical supplies be reported, unless the payment or other transfer of value is not related to a particular covered or non-covered drug, device, biological or medical supply.
3. Applicable manufacturers will have to report stocks, stock options or any other ownership interest as distinct categories.

In addition, CMS as included in the proposed rule, deleted the current exclusion for reporting transfers of value to speakers or attendees at Continuing Education events. However, CMS is re-interpreting other sections of the existing regulation in such a way that most manufacturer payments for speakers at CME programs will not be reported as long as the manufacturer does not select or pay the speaker directly or provide the CME provider with a distinct list of speakers for consideration (existing language in 403.904(i)(1) of the regulation).

CMS suggests that payments for physicians to attend CME events also will not be reportable if the manufacturer did not know the identity of the physician attendees beforehand. However, CMS states that it will provide "sub-regulatory guidance specifying tuition fees provided to physician attendees that have been generally subsidized at continuing education events by manufacturers are not expected to be reported."

The rule states that these requirements would take effect beginning January 1, 2016. This implies that the CME exemption would remain in place for calendar year 2015.

TABLE 93: CY 2015 PFS Final Rule with Comment Period Estimated Impact Table: Impacts of Work, Practice Expense, and Malpractice RVUs, and the MEI Adjustment*

(A)	(B)	(C)	(D)	(E)	(F)
	Allowed Charges (mil)	**Impact of Work RVU Changes**	**Impact of PE RVU Changes**	**Impact of MP RVU Changes**	**Combined Impact**
TOTAL	$88,045	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$216	0%	0%	0%	0%
ANESTHESIOLOGY	$1,993	0%	0%	0%	0%
AUDIOLOGIST	$60	0%	0%	0%	0%
CARDIAC SURGERY	$355	0%	0%	-1%	-1%
CARDIOLOGY	$6,470	0%	0%	0%	0%
CHIROPRACTOR	$812	0%	0%	-1%	-1%
CLINICAL PSYCHOLOGIST	$704	0%	-1%	0%	-1%
CLINICIAL SOCIAL WORKER	$522	0%	-1%	0%	-1%
COLON AND RECTAL SURGERY	$159	0%	0%	0%	0%
CRITICAL CARE	$287	0%	0%	0%	0%
DERMATOLOGY	$3,177	0%	-1%	0%	-2%
DIAGNOSTIC TESTING FACILITY	$715	0%	-2%	0%	-2%
EMERGENCY MEDICINE	$3,046	0%	0%	1%	1%
ENDOCRINOLOGY	$457	0%	0%	0%	0%
FAMILY PRACTICE	$6,107	1%	1%	0%	1%
GASTROENTEROLOGY	$1,884	0%	0%	0%	0%
GENERAL PRACTICE	$506	0%	0%	0%	0%
GENERAL SURGERY	$2,245	0%	0%	0%	0%
GERIATRICS	$227	1%	1%	0%	1%
HAND SURGERY	$160	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	$1,811	0%	1%	0%	1%
INDEPENDENT LABORATORY	$714	-1%	0%	0%	-1%
INFECTIOUS DISEASE	$652	0%	0%	0%	1%
INTERNAL MEDICINE	$11,123	1%	1%	0%	1%
INTERVENTIONAL PAIN MGMT	$678	0%	1%	0%	0%
INTERVENTIONAL RADIOLOGY	$273	0%	1%	0%	0%
MULTISPECIALTY CLINIC/OTHER PHY	$84	0%	0%	0%	0%
NEPHROLOGY	$2,181	0%	0%	0%	0%
NEUROLOGY	$1,513	0%	0%	0%	1%
NEUROSURGERY	$740	0%	0%	1%	0%
NUCLEAR MEDICINE	$49	0%	0%	0%	0%
NURSE ANES / ANES ASST	$1,186	0%	0%	0%	0%
NURSE PRACTITIONER	$2,224	0%	0%	0%	1%
OBSTETRICS/GYNECOLOGY	$1,186	0%	0%	0%	-1%
OPHTHALMOLOGY	$5,685	0%	0%	-2%	-2%
OPTOMETRY	$1,163	0%	0%	-1%	-1%
ORAL/MAXILLOFACIAL SURGERY	$45	0%	0%	0%	0%
ORTHOPEDIC SURGERY	$3,672	0%	0%	0%	-1%
OTHER	$28	0%	0%	-1%	-1%
OTOLARNGOLOGY	$1,174	0%	0%	0%	0%
PATHOLOGY	$1,077	-1%	1%	0%	0%

PEDIATRICS	$59	0%	0%	0%	0%
PHYSICAL MEDICINE	$1,008	0%	0%	0%	0%
PHYSICAL/OCCUPATIONAL THERAPY	$2,836	0%	0%	1%	1%
PHYSICIAN ASSISTANT	$1,565	0%	0%	0%	0%
PLASTIC SURGERY	$374	0%	0%	-1%	0%
PODIATRY	$2,001	0%	0%	0%	0%
PORTABLE X-RAY SUPPLIER	$112	0%	-2%	0%	-2%
PSYCHIATRY	$1,352	0%	0%	0%	0%
PULMONARY DISEASE	$1,795	0%	0%	0%	0%
RADIATION ONCOLOGY	$1,794	0%	0%	0%	0%
RADIATION THERAPY CENTERS	$57	0%	0%	0%	1%
RADIOLOGY	$4,523	0%	-1%	0%	-1%
RHEUMATOLOGY	$541	0%	0%	0%	-1%
THORACIC SURGERY	$343	0%	0%	-1%	0%
UROLOGY	$1,838	0%	0%	0%	0%
VASCULAR SURGERY	$978	0%	0%	0%	0%

* Table 93 shows only the payment impact on PFS services. These impacts use a constant conversion factor and thus do not include the effects of the April 2015 conversion factor change required under current law.

PQRS Reporting for Individual Eligible Professionals

<table>
<tr><td colspan="2">Claims-Based and Registry Reporting</td></tr>
<tr><td>Reporting Criteria</td><td>Reporting Period</td></tr>
<tr><td>- Report at least 9 PQRS measures covering at least 3 of the National Quality Strategy domains, AND
- Report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies, AND
- 1 of the 9 measures reported must be from the cross-cutting measures set if at least 1 Medicare patient is seen in a face-to-face encounter
- If less than 9 measures apply to the eligible professional, 1-8 measures, AND
- Report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies.
- Measures with 0% performance rate will not be counted.</td><td>12 month (January 1 - December 31)</td></tr>
<tr><td colspan="2">EHR Reporting</td></tr>
<tr><td>Reporting Criteria</td><td>Reporting Period</td></tr>
<tr><td>- Report at least 9 PQRS measures covering at least 3 of the National Quality Strategy domains. If the EHR does not contain patient data for 9 measures covering at least 3 domains, report all of the measures for which there is Medicare patient data.</td><td>12 month (January 1 - December 31)</td></tr>
<tr><td colspan="2">Qualified Clinical Data Registry</td></tr>
<tr><td>Reporting Criteria</td><td>Reporting Period</td></tr>
<tr><td>- Report at least 9 measures available for reporting under a QCDR covering at least 3 of the National Quality Strategy domains, AND
- Report each measure for at least 50% of the eligible professional’s patients.
- Of the measures reported via a clinical data registry, at least two reported measures must be outcomes measures. OR
- If 2 outcomes measures are not available, report on at least 1 outcomes measures and at least 1 of the following types of measures: resource use, patient experience of care, efficiency/appropriate use or patient safety.</td><td>12 month (January 1 - December 31)</td></tr>
<tr><td>Registry Reporting – Measures Groups</td><td></td></tr>
<tr><td>Reporting Criteria</td><td>Reporting Period</td></tr>
<tr><td>- Report 1 measures group,
AND
- Report the measures group for at least 20 patients (11 of which are Medicare beneficiaries)</td><td>12 month (January 1- December 31)</td></tr>
</table>

PQRS Reporting for Group Practices

GPRO Web Interface – 25-99 Eligible Professionals	
Reporting Criteria	Reporting Period
- Report on all measures included in the web interface; AND - Populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample or preventive care measure. - If the pool of beneficiaries is less than 248 patients, report on 100 percent of the assigned beneficiaries. - If a group practice has no Medicare patients for which any of the GPRO measures are applicable, the criteria for satisfactory reporting will not be met.	12 month (January 1 - December 31)
Registry and EHR	
Reporting Criteria	Reporting Period
- Report at least 9 measures available for reporting under a QCDR covering at least 3 of the National Quality Strategy domains, AND - Report on at least 1 cross-cutting measure if at least 1 Medicare patient is seen in a face-to-face encounter - If less than 9 measures apply to the eligible professional, 1-8 measures, AND - Report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. - Measures with 0% performance rate will not be counted.	12 month (January 1 - December 31)
CMS-Certified Survey Vendor	
Reporting Criteria – 3 Options	Reporting Period
1. GPRO chooses to use **qualified registry** in conjunction with CAHPS for PQRS: Report all CAHPS for PQRS survey measures and at least 6 additional measures, covering at least 2 of the NQS domains and including at least 1 cross-cutting measure if the group sees at least 1 Medicare patient in a face-to-face encounter. 2. GPRO chooses to use a **direct EHR product** in conjunction with the survey: Report all CAHPS for PQRS survey measures and at least 6 additional measures. If less than 6 measures apply, all applicable measures must be reported. 3. GPRO chooses to use the GPRO web interface in conjunction with the survey: Report all CAHPS for PQRS survey measures and all measures included in the GPRO web interface. AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If there are less than 248 beneficiaries, report on 100 percent of the assigned beneficiaries.	12 month (January 1 - December 31)