An Overview of the Physician Quality Reporting System (PQRS)

Presented by:
Lindsey Wiley, MHA, CHTS-IM, CHTS-TS
HIT Manager, OFMQ
An Important Reminder

For audio, you **must** use your phone:

**Step 1:** Call (866) 906-0123.

**Step 2:** Enter code 2071585#.

**Step 3:** **Mute your phone!!!**

= AUDIO
Mission of OFMQ

OFMQ is a not-for-profit, consulting company dedicated to advancing healthcare quality. Since 1972, we’ve been a trusted resource through collaborative partnerships and hands-on support to healthcare communities.
OFMQ Areas of Expertise

- Analytics
- Case Review
- Education
- IT Consulting
- Health Information Technology
- National Quality Measures
- Quality Improvement
HIT Service Lines

- Security Risk Assessment - Level 1, 2, and 3
- Meaningful Use Assistance
- Meaningful Use Audit Support
- Risk Management Consulting and Development
- Staff IT Security Training
- Website Development & Secure Email
- IT Consulting
Lindsey Wiley, MHA, CHTS-IM, CHTS-TS

Lindsey works with healthcare providers and hospitals to advance the use of electronic health records (EHR) to improve patient care and health outcomes. She consults with physician practices and hospitals to successfully implement and meaningfully use EHRs, including assistance associated with vendor products, hardware, software and system configuration and troubleshooting, staffing considerations, workflow analysis, EHR utilization, security and privacy, and quality data reporting from EHR systems.
Targeted Audience

Presentation focuses on eligible professionals who are:

• Billing Medicare Part B fee for service
• Utilizing EHR technology
• Submitting data for individual providers or a group of providers 25 or less
• Not participating in the Medicare Shared Savings Program, Comprehensive Primary Care Initiative, or Pioneer Accountable Care Organizations
Objectives

• Overview of the Physician Quality Reporting Program
• Review eligible providers
• Review reporting options
• Review reporting criteria
• Discuss payment adjustments
• Discuss PQRS vs CQM for Meaningful Use
• Relation of PQRS to Value-Based Care
History

- Original called PQRI
- Initial period was July-December 2007 included a 1.5% incentive
- Incentive payments increased to 2% in 2009 and 2010; initial phases of Physician Compare
- Registry reporting was added
- Approx. 15% participation across all specialties
History

• 2010 program became permanent and now called PQRS
• Incentives were available through 2014 and penalties began in 2015
• Improved feedback to physicians
• CMS begins integrating CQM reporting in MU/PQRS
## History

<table>
<thead>
<tr>
<th>PQRS Program Year</th>
<th>Incentive Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>1.5% subject to cap</td>
</tr>
<tr>
<td>2008</td>
<td>1.5%</td>
</tr>
<tr>
<td>2009</td>
<td>2.0%</td>
</tr>
<tr>
<td>2010</td>
<td>2.0%</td>
</tr>
<tr>
<td>2011</td>
<td>1.0%</td>
</tr>
<tr>
<td>2012</td>
<td>0.5%</td>
</tr>
<tr>
<td>2013</td>
<td>0.5%</td>
</tr>
<tr>
<td>2014</td>
<td>0.5% Last year to earn an incentive payment</td>
</tr>
</tbody>
</table>
An Important Message from the Centers for Medicare & Medicaid Services (CMS) About the Physician Quality Reporting System (PQRS)

Dear Medicare Professional:

You are receiving this letter because our records indicate that you were eligible and able to participate in the Physician Quality Reporting System (PQRS) during 2014 under the following Tax Identification Number/National Provider Identifier (TIN/NPI) combination, TIN/NPI:

(For security purposes, only the last six digits of the TIN/NPI are included.) Our records further indicate that you did not meet the criteria to avoid the 2016 PQRS payment adjustment (based on professional services rendered in 2014) under this TIN/NPI combination.

Because you did not meet the criteria to avoid the 2016 PQRS payment adjustment under this TIN/NPI combination, CMS will reduce all MPFS payments for services rendered January 1, 2016 through December 31, 2016 and billed using this TIN/NPI combination by 2.0%. Please note that this adjustment is separate from any additional adjustment that may be applied under the Physician Value-Based Payment Modifier program and the Medicare Electronic Health Record (EHR) Incentive Program.
What is PQRS?

• Started in 2007 by CMS as a voluntary program called PQRI- Physician’s Quality Reporting Initiative
  • Providers were paid an incentive for reporting on selected quality measures based on their Medicare fee for service claims

• In 2011 the initiative evolved into PQRS-Physicians Quality Reporting System

• 2014 was the last year to receive an incentive

• 2015 payment adjustments began (1.5% for performance year 2013)

• 2016 payment adjustments begin (2.0% for performance year 2014)

Source: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html
CMS Defines PQRS

A quality reporting program that uses negative payment adjustments to promote reporting of quality information by individual eligible professionals (EPs) and group practices. Those who do not satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (MPFS) services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board, Medicare Secondary Payer, and Critical Access Hospitals [CAH] method II) will be subject to a negative payment adjustment under PQRS. Medicare Part C–Medicare Advantage beneficiaries are not included.

What Determines PQRS Eligibility?

Eligible Professionals

Eligible Professionals are defined as all Medicare physicians, practitioners, and therapists providing covered professional services paid under or based on the Medicare Physician Fee Schedule (MPFS). Those services are eligible for PQRS negative payment adjustments. Individual EPs, EPs in group practices participating via GPRO (PQRS group practices), Accountable Care Organizations (ACOs) reporting PQRS via the GPRO Web Interface, and Comprehensive Primary Care (CPC) practice sites are eligible to participate in PQRS.

Eligible and Able to Participate

• Medicare Physicians
  • Doctor of Medicine
  • Doctor of Osteopathy
  • Doctor of Podiatric Medicine
  • Doctor of Optometry
  • Doctor of Oral Surgery
  • Doctor of Dental Medicine
  • Doctor of Chiropractic

• Practitioners
  • Physician Assistant
  • Nurse Practitioner*
  • Clinical Nurse Specialist*
  • Certified Registered Nurse Anesthetist* (and Anesthesiologist Assistant)
  • Certified Nurse Midwife*
  • Clinical Social Worker
  • Clinical Psychologist
  • Registered Dietician
  • Nutrition Professional
  • Audiologists
  *Includes Advanced Practice Registered Nurse-APRN

• Therapists
  • Physical Therapist
  • Occupational Therapist
  • Qualified Speech-Language Therapist

CAH Professionals
(Critical Access Hospital)

EPs who reassign benefits to a Critical Access Hospital that bills professional services at a facility level such as CAH Method II billing are eligible to participate in all methods of reporting including claims based via the CMS-1450 form or electronic equivalent.
Reporting Options

12 month reporting period-
January to December

Reporters may choose from the following reporting options to submit their quality data:

• Reporting electronically using a certified electronic health record (EHR)
• Qualified Registry
• Qualified Clinical Data Registry (QCDR)
• PQRS group practice via GPRO Web Interface
• CMS-Certified Survey Vendor (CAHPS)
• Claims

“All EPs who do not meet the criteria for satisfactory reporting or participating for 2015 PQRS will be subject to the 2017 negative payment adjustment with no exceptions” (CMS, 2015).

Common Clinical Quality Measures

- CMS165 NQF 0018 Controlling High Blood Pressure (effective clinical care)
- CMS138 NQF 0028 Tobacco Use: Screening and Cessation Intervention (Community/Population Health)
- CMS69 NQF 0421 Body Mass Index (BMI) Screening and Follow-Up (Community/Population Health)
- CMS 130 NQF 0034 Colorectal Cancer Screening (effective clinical care)
- CMS 147 NQF 0041 Preventive Care and Screening Influenza Immunization (Community/Population Health)
- CMS 127 NQF 0043 Pneumonia Vaccination Status for Older Adults (Community/Population Health)
- CMS 68 NQF 0419 Documentation of Current Meds in the Medical Record (Patient Safety) (cross cutting measure)
- CMS 122 NQF 0059 Diabetes Hemoglobin A1c Poor Control (effective clinical care)
- CMS 123 NQF 0056 Diabetes Foot Exam (effective clinical care)

Each measure is categorized in a NQS domain
Participate in 2015 to Avoid the 2017 PQRS Payment Adjustment

EPs that do not satisfactorily report in 2017 will have a -2% PQRS adjustment in 2017 for Medicare Part B payments

- **Individual Measures**-
  - Report 9 measures (1 cross cutting) across 3 NQS domains via EHR or Registry on 50% of Medicare patients seen in a face to face encounter in 2015

- **Measure Group**-
  - Report on 20 patients with at least 11 patient being Medicare Part B FFS
  - List of measure groups on next slide


# Measures Groups

<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Category</th>
<th>Disease/Condition</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Chronic Kidney Disease</td>
<td>Preventive Care</td>
<td>Coronary Artery Bypass Graft</td>
</tr>
<tr>
<td>Acute Otitis Externa (AOE)</td>
<td>Cataracts</td>
<td>Hepatitis C</td>
<td>Heart Failure</td>
</tr>
<tr>
<td>Optimizing Patient Exposure to Ionizing Radiation</td>
<td>HIV/AIDS</td>
<td>Asthma</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td>Dementia</td>
<td>Parkinson’s Disease</td>
<td>Sinusitis</td>
</tr>
<tr>
<td>Cardiovascular Prevention (Million Hearts)</td>
<td>Oncology</td>
<td>Total Knee Replacement</td>
<td>General Surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Diabetic Retinopathy</td>
</tr>
</tbody>
</table>
Specialty Measure Sets

• CMS is collaborating with specialty societies to ensure that the measures represented within Specialty Measure Sets accurately illustrate measures associates within a particular clinical area (suggested, NOT required); the following were established in 2015:

1. Cardiology
2. Emergency Medicine
3. Gastroenterology
4. General Practice/Family
5. Internal Medicine
6. Multiple Chronic Conditions
7. OB/GYN
8. Oncology/Hematology
9. Ophthalmology
10. Pathology
11. Surgery

• CMS is adding the following specialty measure sets in 2016:

1. Dermatology
2. Physical Therapy/ Occupational Therapy
3. Mental Health
4. Hospitalist
5. Urology
PQRS Updates for 2016

• 281 measures in the PQRS measures set and 18 measures in the GPRO Web Interface; 23 cross-cutting measures
• Added the Qualified Clinic Data Registry (QCDR) reporting option for groups
• They added 3 new measures groups (only for registry reporting):
  – Multiple Chronic Conditions
  – Cardiovascular Prevention (Million Hearts)
  – Diabetic Retinopathy
• 2018 PQRS payment adjustments is the last adjustment that will be issued under PQRS
  – Starting in 2019, adjustments to pay for quality reporting will be made under the Merit-Based Incentive Payment System (MIPS)
What if I Can’t Meet 9 Measures?

- You must report
- You are subject to Measure-Applicability Validation (MAV) process which will be used to determine if EP could have reported 9 measures covering at least 3 domains
In Addition

The **Value Based Modifier (VBM)** program will assess the PQRS quality data and Medicare cost data to calculate a provider’s overall VBM score and apply an upward, downward or neutral payment adjustment that will reflect payments in 2017.

- Solo EPs and physician groups of 2 to 9 EPs: exempt for 2017 (2018 -2% penalties phase in)
- Group practices with 10 or more EPs: up to a -4% adjustment in 2017
- VBM program is considered budget neutral- incentives are rewarded to the “high quality/low cost” practices that are funded by the “low quality/high cost” practices
Penalties for EPs that Do Not Participate in PQRS & VBM
(for groups of 1-9 EPs)
VBM adjustment is phased in- 2018

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Penalty applied in</th>
<th>PQRS Penalty</th>
<th>VBM Penalty</th>
<th>Total Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2015</td>
<td>1.5%</td>
<td>-</td>
<td>1.5%</td>
</tr>
<tr>
<td>2014</td>
<td>2016</td>
<td>2%</td>
<td>-</td>
<td>2%</td>
</tr>
<tr>
<td>2015</td>
<td>2017</td>
<td>2%</td>
<td>-</td>
<td>2%</td>
</tr>
<tr>
<td>2016</td>
<td>2018</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>2017</td>
<td>2019</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Penalties for Groups that Do Not Participate in PQRS & VBM
(groups of 10 + EPs)

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Penalty applied in</th>
<th>PQRS Penalty</th>
<th>VBM Penalty</th>
<th>Total Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2015</td>
<td>1.5%</td>
<td>-</td>
<td>1.5%</td>
</tr>
<tr>
<td>2014</td>
<td>2016</td>
<td>2%</td>
<td>-</td>
<td>2%</td>
</tr>
<tr>
<td>2015</td>
<td>2017</td>
<td>2%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>2016</td>
<td>2018</td>
<td>2%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>2017</td>
<td>2019</td>
<td>2%</td>
<td>4%</td>
<td>6%</td>
</tr>
</tbody>
</table>
# Adjustments for EPs & Groups that Do Participate in PQRS

<table>
<thead>
<tr>
<th>Physician Group Size</th>
<th>Reporting Year</th>
<th>Penalty Year</th>
<th>Providers/Groups that DO Successfully report PQRS</th>
<th>VBM Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-9</td>
<td>2015</td>
<td>2017</td>
<td>No Penalty</td>
<td>Neutral (0%) or Upward (up to 2%)</td>
</tr>
<tr>
<td>10+</td>
<td>2015</td>
<td>2017</td>
<td>No Penalty</td>
<td>Negative (up to -4%) Neutral (0%) or Upward (up to 4%) (Depends on calculated quality score- quality tiering)</td>
</tr>
</tbody>
</table>

Source: PQRSWizard.com
# 2016 Incentive Payments & 2018 Payment Adjustments

<table>
<thead>
<tr>
<th>PQRS</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Groups with 2-9 EPs &amp; Solo Practitioners</strong></td>
<td><strong>Groups with 10+ EPs</strong></td>
</tr>
<tr>
<td></td>
<td>Medicare Pay Adj (2018)</td>
<td>Total Medicare Payment Adjustments at Risk for Non-Participation in PQRS and Meaningful Use in 2018</td>
</tr>
</tbody>
</table>

## Physicians

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>MD &amp; DO</td>
<td>-2.0% of MPFS</td>
<td>+2.0 (x), +1.0(x), or neutral</td>
<td>-1.0% or -2.0% of MPFS</td>
<td>-2.0% of MPFS</td>
<td>$2,000-4,000 (based on when EP 1st demo MU)</td>
<td>-4.0% of MPFS</td>
<td>$8,500 or $21,250 (based on when EP did A/I/U)</td>
<td>Physicians in groups of 2-9 EPs &amp; Solo physicians: -1.0%, -2.0% of MPFS</td>
</tr>
<tr>
<td>DDM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Physicians in groups of 10+ EPs: -3.0%</td>
</tr>
<tr>
<td>Oral Sur</td>
<td>-2.0% of MPFS</td>
<td>-1.0% or -2.0% of MPFS</td>
<td>-2.0% of MPFS</td>
<td>-4.0% of MPFS</td>
<td></td>
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<tr>
<td>Pod.</td>
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<tr>
<td>Opt.</td>
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<tr>
<td>Chiro.</td>
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</tr>
</tbody>
</table>
## 2016 Incentive Payments & 2018 Payment Adjustments

<table>
<thead>
<tr>
<th>Practitioners</th>
<th>PQRS</th>
<th>Value Modifier</th>
<th>EHR</th>
<th>Total Medicare Payment Adjustments at Risk for Non-Participation in PQRS and Meaningful Use in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pay Adj. ('18)</td>
<td>Groups with Non-Physician EPs only and Solo Practitioners</td>
<td>Groups with Physicians + PAs, NPs, CNSs, &amp; CRNAs</td>
<td>Groups with 2-9 EPs</td>
</tr>
<tr>
<td>PAs</td>
<td>-2.0% of MPFS</td>
<td>+2.0 (x), +1.0(x), or neutral</td>
<td>-2% of MPFS</td>
<td>-1% or -2% of MPFS</td>
</tr>
<tr>
<td>NPs</td>
<td>-2.0% of MPFS</td>
<td>+2.0 (x), +1.0(x), or neutral</td>
<td>-2% of MPFS</td>
<td>-1% or -2% of MPFS</td>
</tr>
<tr>
<td>CNSs</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>CRNAs</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Note: MPFS stands for Medicare Physician Fee Schedule.*

The color codes indicate different categories and adjustments. For example, red indicates a decrease, green indicates an increase, and yellow indicates a neutral or no change. The table uses various shades to highlight different segments and adjustments within each category.
## 2016 Incentive Payments & 2018 Payment Adjustments

<table>
<thead>
<tr>
<th>Practitioners</th>
<th>PQRS</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
<th>Total Medicare Payment Adjustments at Risk for Non-Participation in PQRS &amp; Meaningful Use in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Social Worker</td>
<td>-2.0% of MPFS</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>$8,500 or $21,250 (based on when EP did A/I/ U)</td>
</tr>
<tr>
<td>Registered Dietician</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Nutrition Professional</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Audiologists</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Therapists

<table>
<thead>
<tr>
<th>Therapists</th>
<th>PQRS</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
<th>Total Medicare Payment Adjustments at Risk for Non-Participation in PQRS &amp; Meaningful Use in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapist</td>
<td>-2.0% of MPFS</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Qualified Speech-Language Therapist</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### 2015-2017 PQRS Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>December 31, 2015</td>
<td>Reporting for the 2015 PQRS program year ends for both group practices and individuals</td>
</tr>
<tr>
<td>2016</td>
<td>March 11, 2016</td>
<td>Last day to submit 2015 CQMs for PQRS</td>
</tr>
</tbody>
</table>

Is it too late to start for 2015?
First Steps

- Determine eligibility
- Choose Reporting option
  - Report as an individual provider via - EHR or Registry
- Choose measures
  - Depends on provider specialty, reporting methods, and vendor measure availability
  - Suggest Diabetes Measure Group for Family Practice and Internal Medicine (report 6 measures on 20 patients via registry)
    - Diabetes Hemoglobin A1c Poor Control
    - Diabetes attention to Nephropathy
    - Diabetes Eye Exam
    - Diabetes Foot Exam
    - Tobacco Use: Screening and Cessation Intervention
    - Preventive Care and Screening Influenza Immunization
Contact the QualityNet Help Desk for help with:

- General CMS PQRS information
- PQRS Portal password issues
- PQRS feedback report availability and access
- PQRS-EIDM registration questions
- PQRS-EIDM login issues

Monday – Friday; 7:00 a.m.–7:00 p.m. CST

Phone: 1-866-288-8912
TTY: 1-877-715-6222

Email: Qnetsupport@hcqis.org

Stay informed about the latest PQRS news by subscribing to the PQRS listserv at: https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_520
Physician Compare

As outlined in the 2015 MPFS final rule, CMS will publicly report the individual EP and PQRS group practice quality measure data collected via all reporting mechanisms. This information is targeted for publication on Physician Compare in 2016.

PQRS and CQM
PQRS and CQM

- Clinical Quality Measures (CQM) help measure and track the quality of health care services provided by eligible professionals and eligible hospitals.
- The purpose of reporting CQMs help to ensure our health care system is delivering effective, safe, efficient, patient-centered, equitable, and timely care.
- CQMs are required to be reported if participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.
- CQM data must be exported electronically from certified EHR technology.
- If you are participating in PQRS then you do not have to report CQM data for meaningful use (MU), however if you are just doing MU and reporting CQMs then that will NOT count for your PQRS requirement.
CQM

• Eligible Professionals will need to report 9 CQM’s and eligible hospitals and CAH’s will need to report 16 CQM’s
• CQM’s must cover at least 3 of the 6 available National Quality Strategy domains which represent the Department of Health and Human Services’ priorities for healthcare quality improvement and include the following:
  • Patient and Family Engagement
  • Patient Safety
  • Care Coordination
  • Population/Public Health
  • Efficient Use of Healthcare Resources
  • Clinical Process/Effectiveness
All of this Leads to...
Value-Based Payment Modifier

• Provides differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared to the cost of care during a performance period.
• Adjustments will be made on a per claim basis to Medicare payments for items and services under the Medicare PFS.
• Gradual Implementation
  • 2015- applying the Value Modifier based on performance in 2013 for groups of 100 or more
  • 2016- applying Value Modifier to groups of physicians with 10 or more Eps based on 2014 performance
  • 2017- applying Value Modifier to all physicians and groups of physicians
## OFMQ PQRS Consulting

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>BASIC</th>
<th>MODERATE</th>
<th>COMPLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consulting Description</td>
<td>Basic consulting will include a one-time visit to the practice that may be up to 3 hours long and will consist of educating the staff/provider on the PQRS requirements, submission, IACs registration, and any other related guidelines.</td>
<td>Includes everything from Basic, as well as measure selection guidance, IACs registration assistance, EHR workflow configuration, education, training, and information on submitting your PQRS measures.</td>
<td>Includes everything from Moderate, as well as seeing you through submission. A consultant will help you run your reports, provide validation assistance, and support you through the submission of your PQRS data.</td>
</tr>
<tr>
<td>Number of Visits</td>
<td>1 Visit</td>
<td>Up to 4 Visits</td>
<td>Up to 6 Visits</td>
</tr>
</tbody>
</table>

Contact Jimmi Norris at OFMQ at 405 397-6552 or jnorris@ofmq.com
Thank You!
Reference Materials

- PQRS GPRO Registration- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
Reference Materials

- [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/PhysicianFeedbackProgram/valuebasedpaymentmodifier.html#WhatistheValue-BasedPaymentModifier(Value Modifier)](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/PhysicianFeedbackProgram/valuebasedpaymentmodifier.html#WhatistheValue-BasedPaymentModifier(Value Modifier))
- PQRS Wizard- [www.pqrswizard.com](http://www.pqrswizard.com)
We Are Here To Help!

Email: ofmqhit@ofmq.com
      lwiley@ofmq.com
Call: (877) 963-6744
Visit: www.OFMQ.com

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Wednesday, June 29
Upcoming WebEx Events

Monthly HIT Educational WebEx | Wed, April 20 | 12:15pm
“Lessons Learned: HIPAA Violations and Office of Civil Rights Enforcement”

Monthly HIT Educational WebEx | Wed, May 11 | 12:15pm
“Population Health Management”

Register at www.ofmq.com/event-month
Thank you!