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42 C.F.R. § 414.90

Physician Quality Reporting System (PQRS).

(a) *Basis and scope.* This section implements the following provisions of the Act:

(1) 1848(a)—Payment Based on Fee Schedule.

(2) 1848(k)—Quality Reporting System.

(3) 1848(m)—Incentive Payments for Quality Reporting.

(b) *Definitions.* As used in this section, unless otherwise indicated—

Administrative claims means a reporting mechanism under which an eligible professional or group practice uses claims to report data on PQRS quality measures. Under this reporting mechanism, CMS analyzes claims data to determine which measures an eligible professional or group practice reports.

Certified survey vendor means a vendor that is certified by CMS for a particular program year to transmit survey measures data to CMS.

Covered professional services means services for which payment is made under, or is based on, the Medicare physician fee schedule as provided under section 1848(k)(3) of the Act and which are furnished by an eligible professional.

Direct electronic health record (EHR) product means an electronic health record vendor's product and version that submits data on PQRS measures directly to CMS.

Electronic health record (EHR) data submission vendor product means an entity that receives and transmits data on PQRS measures from an EHR product to CMS.

Eligible professional means any of the following:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C) of the Act.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Group practice means a physician group practice that is defined by a TIN, with 2 or more individual eligible professionals (or, as identified by NPIs) that has reassigned their billing rights to the TIN.

Group practice reporting option (GPRO) web interface means a web product developed by CMS that is used by group practices that are selected to participate in the group practice reporting option (GPRO) to submit data on PQRS

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quality measures.

Maintenance of Certification Program means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification Program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and professionalism. Such a program must include the following:

(i) The program requires the physician to maintain a valid unrestricted license in the United States.

(ii) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(iii) The program requires a physician to demonstrate, through a formalized secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(iv) The program requires successful completion of a qualified maintenance of certification program practice assessment.

Maintenance of Certification Program Practice Assessment means an assessment of a physician's practice that—

(i) Includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine.

(ii) Includes a survey of patient experience with care.

(iii) Requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under paragraph (h) of this section and then to remeasure to assess performance improvement after such intervention.

Measures group means a subset of six or more PQRS measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.

Physician Quality Reporting System (PQRS) means the physician reporting system under section 1848(k) of the Act for the reporting by eligible professionals of data on quality measures and the incentive payment associated with this physician reporting system.

Performance rate means the percentage of a defined population who receives a particular process of care or achieve a particular outcome for a particular quality measure.

Qualified clinical data registry means a CMS-approved entity that has self-nominated and successfully completed a qualification process that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. A qualified clinical data registry must perform the following functions:

(i) Submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its eligible professionals have satisfactorily participated in PQRS. A qualified clinical data registry must have in place mechanisms for the transparency of data elements and specifications, risk models, and measures.

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(ii) Submit to CMS, for purposes of demonstrating satisfactory participation, quality measures data on multiple payers, not just Medicare patients.

(iii) Provide timely feedback, at least four times a year, on the measures at the individual participant level for which the qualified clinical data registry reports on the eligible professional's behalf for purposes of the individual eligible professional's satisfactory participation in the clinical quality data registry.

(iv) Possess benchmarking capacity that measures the quality of care an eligible professional provides with other eligible professionals performing the same or similar functions.

Qualified registry means a medical registry or a maintenance of certification program operated by a specialty body of the American Board of Medical Specialties that, with respect to a particular program year, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate its compliance with the PQRS qualification requirements specified by CMS for that program year. The registry may act as a data submission vendor, which has the requisite legal authority to provide PQRS data (as specified by CMS) on behalf of an eligible professional to CMS. If CMS finds that a qualified registry submits grossly inaccurate data for reporting periods occurring in a particular year, CMS reserves the right to disqualify a registry for reporting periods occurring in the subsequent year.

Reporting rate means the percentage of patients that the eligible professional indicated a quality action was or was not performed divided by the total number of patients in the denominator of the measure.

(c) *Incentive payments.* For 2007 to 2014, with respect to covered professional services furnished during a reporting period by an eligible professional, an eligible professional (or in the case of a group practice under paragraph (i) of this section, a group practice) may receive an incentive if—

(1) There are any quality measures that have been established under the PQRS that are applicable to any such services furnished by such professional (or in the case of a group practice under paragraph (i) of this section, such group practice) for such reporting period; and

(2) If the eligible professional (or in the case of a group practice under paragraph (j) of this section, the group practice) satisfactorily submits (as determined under paragraph (g) of this section for the eligible professional and paragraph (i) of this section for the group practice) to the Secretary data on such quality measures in accordance with the PQRS for such reporting period, in addition to the amount otherwise paid under section 1848 of the Act, there also must be paid to the eligible professional (or to an employer or facility in the cases described in section 1842(b)(6)(A) of the Act or, in the case of a group practice under paragraph (i) of this section, to the group practice) from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Act an amount equal to the applicable quality percent (as specified in paragraph (c)(3) of this section) of the eligible professional's (or, in the case of a group practice under paragraph (i) of this section, the group practice's) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (i) of this section, by the group practice) during the reporting period.

(3) The applicable quality percent is as follows:

(i) For 2007 and 2008, 1.5 percent.

(ii) For 2009 and 2010, 2.0 percent.

(iii) For 2011, 1.0 percent.

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(iv) For 2012, 2013, and 2014, 0.5 percent.

(4) For purposes of this paragraph (c)—

(i) The eligible professional's (or, in the case of a group practice under paragraph (i) of this section, the group practice's) total estimated allowed charges for covered professional services furnished during a reporting period are determined based on claims processed in the National Claims History (NCH) no later than 2 months after the end of the applicable reporting period;

(ii) In the case of the eligible professional who furnishes covered professional services in more than one practice, incentive payments are separately determined for each practice based on claims submitted for the eligible professional for each practice;

(iii) Incentive payments to a group practice under this paragraph must be in lieu of the payments that would otherwise be made under the PQRS to eligible professionals in the group practice for meeting the criteria for satisfactory reporting for individual eligible professionals. For any program year in which the group practice (as identified by the TIN) is selected to participate in the PQRS group practice reporting option, the eligible professional cannot individually qualify for a PQRS incentive payment by meeting the requirements specified in paragraph (g) of this section.

(iv) Incentive payments earned by the eligible professional (or in the case of a group practice under paragraph (i) of this section, by the group practice) for a particular program year will be paid as a single consolidated payment to the TIN holder of record.

(5) The Secretary must treat an individual eligible professional, as identified by a unique TIN/NPI combination, as satisfactorily submitting data on quality measures (as determined under paragraph (g) of this section), if the eligible professional is satisfactorily participating (as determined under paragraph (h) of this section), in a qualified clinical data registry.

(d) *Additional incentive payment.* Through 2014, if an eligible professional meets the requirements described in paragraph (d)(2) of this section, the applicable percent for such year, as described in paragraphs (c)(3)(iii) and (iv) of this section, must be increased by 0.5 percentage points.

(1) In order to qualify for the additional incentive payment described in paragraph (d) of this section, an eligible professional must meet all of the following requirements:

(i) Satisfactorily submits data on quality measures, or, for 2014, in lieu of satisfactory reporting, satisfactorily participates in a qualified clinical data registry for purposes of this section for the applicable incentive year.

(ii) Have such data submitted on their behalf through a Maintenance of Certification program that meets:

(A) The criteria for a registry (as specified by CMS); or

(B) An alternative form and manner determined appropriate by the Secretary.

(iii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

(A) Participates in a maintenance of certification program for a year; and

(B) Successfully completes a qualified maintenance of certification program practice assessment for such year.

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(2) In order for an eligible professional to receive the additional incentive payment, a Maintenance of Certification Program must submit to the Secretary, on behalf of the eligible professional, information—

(i) In a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of paragraph (d)(1)(iii) of this section, which may be in the form of a structural measure.

(ii) If requested by the Secretary, on the survey of patient experience with care.

(iii) As the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

(e) *Payment adjustments.* For 2015 through 2018, with respect to covered professional services furnished by an eligible professional, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under section 1848(m)(3)(A) of the Act), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes for determining a payment based on such amount) must be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this paragraph (e).

(1) The applicable percent is as follows:

(i) For 2015, 98.5 percent.

(ii) For 2016 through 2018, 98 percent.

(2) The Secretary must treat an individual eligible professional, as identified by a unique TIN/NPI combination, as satisfactorily submitting data on quality measures (as determined under paragraph (h) of this section), if the eligible professional is satisfactorily participating, in a qualified clinical data registry.

(f) *Use of appropriate and consensus-based quality measures.* For measures selected for inclusion in the PQRS quality measure set, CMS will use group practice measures determined appropriate by CMS and consensus-based quality measures that meet one of the following criteria:

(1) Be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the Act. In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(2) For each quality measure adopted by the Secretary under this paragraph, the Secretary ensures that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of quality measures applicable to services they furnish.

(g) *Use of quality measures for satisfactory participation in a qualified clinical data registry.* For measures selected for reporting to meet the criteria for satisfactory participation in a qualified clinical data registry, CMS will use measures selected by qualified clinical data registries based on parameters set by CMS.

(h) *Satisfactory reporting requirements for the incentive payments.* In order to qualify to earn a PQRS incentive payment for a particular program year, an individual eligible professional, as identified by a unique TIN/NPI combination, must meet the criteria for satisfactory reporting specified by CMS under paragraph (h)(3) of (h)(5) of this section for such year by reporting on either individual PQRS quality measures or

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PQRS measures groups identified by CMS during a reporting period specified in paragraph (h)(1) of this section, using one of the reporting mechanisms specified in paragraph (h)(2) or (4) of this section, and using one of the reporting criteria specified in paragraph (h)(3) or (5) of this section.

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