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Physician Quality Reporting System

What You Need to Know for 2014

Since 2007, the Physician Quality Reporting System (PQRS) has been a *voluntary* federal program, offering Medicare incentive payments to physicians who report quality measure data to CMS. However, the Affordable Care Act requires that CMS phase out incentive payments and instead apply penalties by 2015 to physicians who fail to satisfy PQRS reporting requirements. As a result, ***2014 is the LAST year to qualify for a PQRS incentive payment*** and those who do not satisfy the program's requirements in 2014 will be ***subject to a penalty in 2016***.

Upcoming PQRS Incentives and Penalties

Action	Reporting Year	Affected Payment Year	Payment Adjustment
Satisfy reporting criteria for PQRS incentive	2014	2014	+0.5%
		2016	Avoid -2.0%
Satisfy reporting criteria for PQRS MOC bonus[1]	2014	2014	+0.5%
Satisfy reporting criteria to avoid PQRS penalty	2014	2014	No bonus
		2016	Avoid -2.0%
Take no action/fail to satisfy PQRS reporting criteria	2014	2014	No bonus
		2016	-2.0%

**Payment adjustments are applied to total allowed charges for covered Medicare Part B Physician Fee Schedule services provided during the reporting period.*

It is important to note that going forward, PQRS measure data also will be used, in combination with cost-of-care-data, to calculate a separate *performance-based* payment adjustment known as the Value-Based Payment Modifier (VBM). Group practices with ≥10 eligible professionals (EPs) who do not satisfy PQRS reporting requirements in 2014 may be subject to a ***separate payment adjustment of -2.0% under the VBM*** in 2016, ***for a total cut of -4.0%.*** More information about the VBM is available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Given the implications of these policies, it is critical that neurosurgeons understand the PQRS and its various reporting options.

How to Get Started

[1] For more information on how to qualify for the PQRS MOC supplemental bonus, which is authorized through 2014, see: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Maintenance_of_Certification_Program_Incentive.html

1. Review the PQRS reporting criteria to determine which reporting option is best for you.

Eligible professionals (EPs) can choose from multiple reporting options to satisfy PQRS reporting requirements, including:

- Reporting as an individual physician or as a group practice under the Group Practice Reporting Option (GPRO)
- Reporting individual measures or measures groups (i.e., sets of clinically relevant measures that must be reported together)
- Reporting measures data via claims, qualified registry, qualified electronic health record (EHR), Web Interface (WI), or qualified clinical data registry (QCDR) NEW for 2014

Please note that reporting requirements differ depending on the method selected. For instance, if reporting individual measures via claims as an individual physician, you must submit data on ***9 PQRS measures for at least 50% of applicable Medicare Part B patients*** to qualify for the 2014 incentive and to avoid the 2016 penalty. Alternatively, an individual physician selecting to report on a measures group via a qualified registry must report 1 measures group for at least 20 patients, a majority of which must be Medicare Part B patients. It is also important to note that for 2014, CMS offers less rigorous reporting options for physicians wishing to only avoid the penalty. Satisfying these requirements ***will not*** qualify a physician for the 2014 PQRS incentive.

When selecting a reporting method, you will want to select the one that is most relevant and meaningful to your patient population, but also the least burdensome to your practice. The various 2014 PQRS reporting options are listed in more detail in **Appendix A**. Additional information about the various PQRS reporting options is available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/

A note about registry reporting…

The NeuroPoint Alliance (NPA) is a PQRS qualified registry for 2014. Neurosurgeons who are participating in the NPA's National Neurosurgery Outcomes Database (N^2QOD) may qualify for the 2014 PQRS incentive and avoid the 2016 penalty by reporting the Perioperative Care measures group via the N^2QOD in 2014. More information about the N^2QOD is available at: http://www.neuropoint.org/NPA%20N2QOD.html.

A list of other 2014 qualified PQRS registries, some of which offer physicians the ability to report on any PQRS measure (for a fee), is available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2014QualifiedRegistryVendors.pdf.

Clinical Qualified Data Registries (QCDR) are a separate and new reporting option for 2014 that allow physicians to report on non-PQRS measures collected via specialty society registries. The NPA is not yet a QCDR, but is preparing to become one in the near future.

A note about Group Practice Reporting…

The PQRS Group Practice Reporting Option (GPRO) is available to those with 2 or more EPs, identified by individual National Provider Identifiers (NPIs), who reassign their billing rights to a single Tax Identification Number (TIN). The group, as whole, must satisfy the reporting requirements. Therefore, if a TIN reports satisfactorily as a group, all individual physicians under that TIN will be considered satisfactory PQRS reporters even if select individuals did not report measure data on their individual services. Note that if an EP is in a group practice that registers for the GPRO, it cannot also participate in the PQRS as an individual.

2. Select your measures

Appendix B lists select 2014 PQRS measures that may be relevant to a neurosurgeon. A complete list of 2014 PQRS measures, including more detailed measure specifications, is available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

Since certain measures can only be reported via certain methods, you will want to make sure there are a sufficient number of measures applicable to your practice that are available via your preferred reporting method.

The AANS/CNS recognize the current lack of performance measures with sufficient granularity to capture the subtleties of care provided by neurosurgeons. We continue to work to develop more appropriate and meaningful measures for inclusion in this and other federal reporting programs and hope to offer these measures through the NPA as early as next year.

3. Start Reporting or Register

There is no registration for *individuals* seeking to participate in the 2014 PQRS. If using the claims-based reporting option, simply start reporting the Quality-Data Codes (QDCs) listed in the measure specifications you have selected on applicable Medicare Part B claims. If using a third party entity to submit your measure data to CMS, such as a qualified registry or EHR vendor, check with the entity to determine whether it has its own set of registration and reporting deadlines.

Group practices wishing to report via the PQRS GPRO for the 2014 reporting year **must register online by September 30, 2014**. For more information on the GPRO, including how to register, please visit: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html

PQRS Maintenance of Certification Incentive Program

Eligible professionals and group practices are eligible to receive an additional 0.5% incentive payment under the 2014 PQRS for participating in a qualified Maintenance of Certification (MOC) Program and completing certain requirements more frequently than is required to

qualify for board certification. For more information, visit:
http://www.abns.org/content/PQRS%20Incentive.asp

Appendix A: PQRS Reporting Options

Requirements for Earning the 2014 PQRS Incentive: Options for Individual-Level Reporting

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria/Satisfactory Participation Criterion
12-month (Jan 1 — Dec 31)	Individual Measures	Claims	Report at least 9 measures covering at least 3 National Quality Strategy (NQS) domains, OR, if less than 9 measures covering at least 3 NQS domains apply, report 1-8 measures covering 1-3 NQS 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. Measures with a 0% performance rate are not counted.
12-month (Jan 1 — Dec 31)	Individual Measures	Qualified Registry	Report at least 9 measures covering at least 3 NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the EP, report 1-8 measures covering 1-3 NQS 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. Measures with a 0% performance rate would not be counted.
12-month (Jan 1 — Dec 31)	Individual Measures	Direct EHR product that is certified (CEHRT) or EHR data submission vendor that is CEHRT	Report 9 measures covering at least 3 of the NQS domains. If an EP's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report the measures for which there is Medicare patient data. An EP must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1 — Dec 31)	Measures Groups	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
6-month (Jul 1 – Dec 31)	Measures Groups	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
12-month (Jan 1 — Dec 31)	Individual measures selected by Qualified Clinical Data Registry (QCDR)	QCDR	Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50% of the EP's applicable patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted. The EP must report on at least 1 outcome measure.

Requirements to Avoid the 2016 PQRS Payment Adjustment: Options for Individual-Level Reporting

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria/Satisfactory Participation Criterion
12-month (Jan 1 — Dec 31)	Individual Measures	Claims	Report at least 9 measures covering at least 3 NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the EP, report 1-8 measures covering 1-3 NQS 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. Measures with a 0% performance rate would not be counted.
12-month (Jan 1 — Dec 31)	Individual Measures	Claims	Report at least 3 measures, OR, if less than 3 measures apply to the EP, report 1-2 measures;* AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
12-month (Jan 1 — Dec 31)	Individual Measures	Qualified Registry	Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the EP, report 1-8 measures covering 1-3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50% of the EPs Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1 — Dec 31)	Individual Measures	Qualified Registry	Report at least 3 measures covering at least 1 of the NQS domains, OR, if less than 3 measures apply to the eligible professional, report 1-2 measures covering at least 1 NQS domain for which there is Medicare patient data, AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1 — Dec 31)	Individual Measures	Direct EHR product that is CEHRT and EHR data submission vendor that is CEHRT	Report 9 measures covering at least 3 of the NQS domains. If an EP's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report the measures for which there is Medicare patient data. An EP must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1 — Dec 31)	Measures Groups	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
6-month (Jul 1 – Dec 31)	Measures Groups	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
12-month (Jan 1 — Dec 31)	Measures selected by Qualified Clinical Data Registry	Qualified Clinical Data Registry	Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50% of the EP's patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted. Of the measures reported via a qualified clinical data registry, the EP must report on at least 1 outcome measure.
12-month (Jan 1 — Dec 31)	Measures selected by Qualified Clinical Data Registry	Qualified Clinical Data Registry	Report at least 3 measures covering at least 1 NQS domain AND report each measure for at least 50% of the EP's applicable patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.

**Note: the 3 measure reporting option offers EPs an easier mechanism for avoiding the penalty, but does not qualify EPs for the PQRS incentive.*

Requirements for the 2014 PQRS Incentive: Options for Group Practice-Level Reporting via the Group Practice Reporting Option (GPRO)

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria/Satisfactory Participation Criterion
12-month (Jan 1 — Dec 31)	GPRO Web Interface (WI)*	25-99 EPs	Report on all 22 measures included in the GPRO WI; AND populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each of the 5 disease modules or 5 patient care modules. If the pool of eligible assigned beneficiaries is less than 218, then report

			on 100% of assigned beneficiaries.
12-month (Jan 1 — Dec 31)	GPRO WI	100+ EPs	Report on all measures included in the WI; AND populate data fields for the first 411 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 the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries. In addition, the group practice must also report all CG-CAHPS survey (patient experience) measures via certified survey vendor.
12-month (Jan 1 — Dec 31)	Qualified Registry	2 + EPs	Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1-8 measures covering 1-3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1 — Dec 31)	Direct EHR product that is CEHRT/ EHR data submission vendor that is CEHRT	2+ EPs	Report 9 measures covering at least 3 of the NQS domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1 — Dec 31)	CMS-certified survey vendor + qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface	25+ EPs	Report all CG-CAHPS survey measures via a CMS-certified survey vendor, AND report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.

The GPRO Web Interface is only available to larger group practices, which must report on a set of largely primary care-focused measures for a pre-assigned sample of the practice's patients.

Requirements for the 2016 PQRS Payment Adjustment: Options for Group-Level Reporting via the GPRO

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria/Satisfactory Participation Criterion
12-month (Jan 1 — Dec 31)	GPRO Web interface	25-99 EPs	Report on all measures included in the web interface; AND populate data fields for the first 218 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 the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.
12-month (Jan 1 — Dec 31)	GPRO Web interface	100+ EPs	Report on all measures included in the web interface; AND populate data fields for the first 411 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 the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries. In addition, the group practice must report all CG CAHPS survey measures via certified survey vendor.
12-month (Jan 1 — Dec 31)	Qualified Registry	2+ EPs	Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1—8 measures covering 1-3 NQS domains

			for which there is Medicare patient data, AND report each measure for at least 50% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1 — Dec 31)	Qualified Registry	2+ EPs	Report at least 3 measures covering at least 1 of the NQS domains, OR, if less than 3 measures covering 1 NQS domain apply to the group practice, report 1—2 measures covering 1 NQS domain for which there is Medicare patient data, AND report each measure for at least 50% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1 — Dec 31)	Direct EHR product that is CEHRT/ EHR data submission vendor that is CEHRT	2+ EPs	Report 9 measures covering at least 3 of the NQS domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1 — Dec 31	CMS-certified survey vendor + qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface	25+ EPs	Report all CG-CAHPS survey measures via a CMS-certified survey vendor, AND report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.

Appendix B: 2014 PQRS Measures Potentially Relevant to Neurosurgeons

Measure Title	Description	NQS Domain	Reporting Options
Individual Measures			
Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis	Communication/ Care Coordination	Claims, Registry
Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Percentage of patients aged 50 years and older with fracture of the hip, spine, or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed	Effective Clinical Care	Claims, Registry
Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months	Effective Clinical Care	Claims, Registry
Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months	Effective Clinical Care	Claims, Registry
Osteoarthritis (OA): Function and Pain Assessment	Percentage of patient visits for patients aged 21 years and older with a diagnosis of OA with assessment for function and pain	Person and Caregiver-Centered Experience/ Outcomes	Claims, Registry
Stroke and Stroke Rehabilitation: Venous Thromboembolism (VTE) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who were administered VTE prophylaxis the day of or the day after hospital admission	Effective Clinical Care	Claims, Registry
Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) who were	Effective Clinical Care	Claims, Registry

	prescribed antithrombotic therapy at discharge		
Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or TIA with documented permanent, persistent, or paroxysmal AF who were prescribed an anticoagulant at discharge	Effective Clinical Care	Registry
Stroke and Stroke Rehabilitation: Screening for Dysphagia	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who receive any food, fluids or medication by mouth (PO) for whom a dysphagia screening was performed prior to PO intake in accordance with a dysphagia screening tool approved by the institution in which the patient is receiving care	Effective Clinical Care	Claims, Registry
Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom occupational, physical, or speech rehabilitation services were ordered at or prior to inpatient discharge OR documentation that no rehabilitation services are indicated at or prior to inpatient discharge	Effective Clinical Care	Claims, Registry
Stroke and Stroke Rehabilitation: Thrombolytic Therapy	Percentage of patients aged 18 years and older with a diagnosis of acute ischemic stroke who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well	Effective Clinical Care	Registry
Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day 2)	Percent of asymptomatic patients undergoing CEA who are discharged to home no later than post-operative day 2	Communication/ Care Coordination	Registry
Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)	Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post- operative day #2	Effective Clinical Care	Registry
Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS)	Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital	Effective Clinical Care	Registry
Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing CEA	Percent of asymptomatic patients undergoing CEA who experience stroke or death following surgery while in the hospital	Effective Clinical Care	Registry
Radiology: Stenosis Measurement in Carotid Imaging Reports	Percentage of final reports for carotid imaging studies (neck magnetic resonance angiography [MRA], neck computed tomography angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement	Effective Clinical Care	Claims, Registry
Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	Percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or	Patient Safety	Claims, Registry

	exposure time		
Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis	Efficiency and Cost Reduction	EHR
Oncology: Medical and Radiation – Pain Intensity Quantified	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	Person and Caregiver-Centered Experience and Outcomes	Registry, EHR
Oncology: Medical and Radiation – Plan of Care for Pain	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain	Person and Caregiver-Centered Experience and Outcomes	Registry
Oncology: Cancer Stage Documented	Percentage of patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting who have a baseline American Joint Committee on Cancer (AJCC) cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period	Effective Clinical Care	Claims, Registry
Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies)	Percentage of patient visits with a diagnosis of epilepsy who had the type(s) of seizure(s) and current seizure frequency(ies) for each seizure type documented in the medical record	Effective Clinical Care	Claims, Registry
Epilepsy: Documentation of Etiology of Epilepsy or Epilepsy Syndrome	All visits for patients with a diagnosis of epilepsy who had their etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic	Effective Clinical Care	Claims, Registry
Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy	All female patients of childbearing potential (12-44 years old) diagnosed with epilepsy who were counseled about epilepsy and how its treatment may affect contraception and pregnancy at least once a year	Effective Clinical Care	Claims, Registry
Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older	Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months	Effective Clinical Care	Claims, Registry
Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months	Person and Caregiver-Centered Experience/Outcomes	Claims, Registry
Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months	Effective Clinical Care	Claims, Registry
Falls: Risk Assessment	Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months	Patient Safety	Claims, Registry
Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk at least once during the measurement period	Patient Safety	GPRO Web Interface, EHR
Falls: Plan of Care	Percentage of patients aged 65 years and older with a history of falls who had a plan of	Communication and Care	Claims, Registry

	care for falls documented within 12 months	Coordination	
Timing of Prophylactic Antiobiotic—Administering Physician	Percentage of surgical patients aged 18 years and older who receive an anesthetic when undergoing procedures with the indications for prophylactic parenteral antibiotics for whom administration of a prophylactic parenteral antibiotic ordered has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)	Patient Safety	Claims, Registry
Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the EP attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list ***must*** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency and route of administration	Patient Safety	Claims, Registry, EHR,
Medication Reconciliation	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and **seen within 30 days following discharge** in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented	Patient Safety	Claims, Registry, GPRO Web Interface
Use of High-Risk Medications in the Elderly	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	Patient Safety	EHR
Advance Care Plan	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	Communication/ Care Coordination	Claims, Registry
Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol	Percentage of patients, regardless of age, who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique [cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics per current guideline)] followed	Patient Safety	Claims, Registry
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up	Community/ Population Health	Claims, Registry, EHR, GPRO Web Interface

	plan is documented on the date of the positive screen		
Preventive Care and Screening: Unhealthy Alcohol Use – Screening	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method	Community/ Population Health	Registry
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is **outside of normal parameters**, a follow-up plan is documented during the encounter or during the previous six months of the encounter.	Community/ Population Health	Claims, Registry, EHR, GPRO Web Interface
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user	Community/ Population Health	Claims, Registry, EHR, GPRO Web Interface
Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented	Community/ Population Health	Claims, Registry, EHR, GPRO Web Interface
Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90mmHg) during the measurement period	Effective Clinical Care	Claims, Registry, EHR, GPRO Web Interface
Pain Assessment and Follow-Up	Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Community/ Population Health	Claims, Registry
Functional Outcome Assessment	Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies	Communication and Care Coordination	Claims, Registry
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lumbar spine in which the change in their Risk- Adjusted Functional Status is measured	Communication and Care Coordination	Registry
Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment in which the change in their Risk-Adjusted Functional Status is measured	Communication/ Care Coordination	Registry
CG-CAHPS Clinician/Group Survey	• Getting timely care, appointments, and information; • How well providers communicate; • Patient's rating of provider; • Access to specialists; • Health promotion & education; • Shared decision making; • Health status/functional status;	Communication/ Care Coordination	Certified Survey Vendor

	• Courteous and helpful office staff; • Care coordination; • Between visit communication; • Helping to take medication as directed; and • Stewardship of patient resources		
Perioperative Measures Group			
Timing of Prophylactic Parenteral Antibiotic – Ordering Physician	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required)	Patient Safety	Claims, Registry*
Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis	Patient Safety	Claims, Registry*
Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time	Patient Safety	Claims, Registry
VTE Prophylaxis (When Indicated in ALL Patients)	Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	Patient Safety	Claims, Registry
Back Pain Measures Group			
Back Pain: Initial Visit	The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who had back pain and function assessed during the initial visit to the clinician for the episode of back pain	Efficiency and Cost Reduction	Registry
Back Pain: Physical Exam	Percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received a physical examination at the initial visit to the clinician for the episode of back pain	Effective Clinical Care	Registry
Back Pain: Advice for Normal Activities	The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received advice for normal activities at the initial visit to the clinician for the episode of back pain	Effective Clinical Care	Registry
Back Pain: Advice Against Bed Rest	The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received advice against bed rest lasting four days or longer at the initial visit to the clinician for the episode of back pain	Effective Clinical Care	Registry

Optimizing Patient Exposure to Ionizing Radiation Group			
Utilization of a Standardized Nomenclature for CT Imaging Description	Percentage of CT imaging reports for all patients, regardless of age, with the imaging study named according to a standardized nomenclature and the standardized nomenclature is used in institution's computer systems	Communication/ Care Coordination	Registry
Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: CT and Cardiac Nuclear Medicine Studies	Percentage of CT and cardiac nuclear medicine (myocardial perfusion studies) imaging reports for all patients, regardless of age, that document a count of known previous CT (any type of CT) and cardiac nuclear medicine (myocardial perfusion) studies that the patient has received in the 12-month period prior to the current study	Patient Safety	Registry
Reporting to a Radiation Dose Index Registry	Percentage of total computed tomography (CT) studies performed for all patients, regardless of age, that are reported to a radiation dose index registry AND that include at a minimum selected data elements	Patient Safety	Registry
CT Images Available for Patient Follow-up and Comparison Purposes	Percentage of final reports for computed tomography (CT) studies performed for all patients, regardless of age, which document that Digital Imaging and Communications in Medicine (DICOM) format image data are available to non-affiliated external entities on a secure, media free, reciprocally searchable basis with patient authorization for at least a 12-month period after the study	Communication/ Care Coordination	Registry
Search for Prior CT Imaging Studies Through a Secure, Authorized, Media-Free, Shared Archive	Percentage of final reports of computed tomography (CT) studies performed for all patients, regardless of age, which document that a search for Digital Imaging and Communications in Medicine (DICOM) format images was conducted for prior patient CT imaging studies completed at non-affiliated external entities within the past 12-months and are available through a secure, authorized, media-free, shared archive prior to an imaging study being performed	Communication/ Care Coordination	Registry
Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines	Percentage of final reports for CT imaging studies of the thorax for patients aged 18 years and older with documented follow-up recommendations for incidentally detected pulmonary nodules (e.g., follow-up CT imaging studies needed or that no follow-up is needed) based at a minimum on nodule size AND patient risk factors	Communication/ Care Coordination	Registry
Parkinson's Measures Group			
Annual Parkinson's Disease Diagnosis Review	All patients with a diagnosis of Parkinson's disease who had an annual assessment including a review of current medications (e.g., medications that can produce Parkinson-like signs or symptoms) and a review for the presence of atypical features (e.g., falls at presentation and early in the disease course, poor response to levodopa, symmetry at onset, rapid progression [to Hoehn and Yahr stage 3 in 3 years], lack of tremor or dysautonomia) at least annually	Effective Clinical Care	Registry
Psychiatric Disorders or Disturbances Assessment	All patients with a diagnosis of Parkinson's disease who were assessed for psychiatric	Effective Clinical Care	Registry

	disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually		
Cognitive Impairment or Dysfunction Assessment:	All patients with a diagnosis of Parkinson's disease who were assessed for cognitive impairment or dysfunction at least annually	Effective Clinical Care	Registry
Querying about Sleep Disturbances	All patients with a diagnosis of Parkinson's disease (or caregivers, as appropriate) who were queried about sleep disturbances at least annually.	Effective Clinical Care	Registry
Rehabilitative Therapy Options	All patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed at least annually	Effective Clinical Care	Registry
Parkinson's Disease Medical and Surgical Treatment Options Reviewed	All patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate who had the Parkinson's disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually	Effective Clinical Care	Registry