the amount the primary care practitioner would otherwise be paid for the primary care services under Part B.

(2) The payment described in paragraph (b)(1) of this section is made to the eligible primary care practitioner or, where the physician has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

[75 FR 73617, Nov. 29, 2010]

§ 414.90 Physician Quality Reporting System.

(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—

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.

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 single Taxpayer Identification Number (TIN) with two or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

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; and

(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 four or more Physician Quality Reporting System 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 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.

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.

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 Physician Quality Reporting System 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 Physician Quality Reporting System data (as specified by CMS) on behalf of an eligible professional to CMS.

Qualified electronic health record product means an electronic health record vendor’s product and version that, with respect to a particular program year, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate the product’s compliance with the Physician Quality Reporting System qualification requirements specified by CMS for a program year. The requirements and process for an electronic health record product to be qualified for the purpose of the Physician Quality Reporting System is separate from the standards, implementation specifications, and certification criteria established for the EHR Incentive Program specified in part 495.

(c) Incentive payments. With respect to covered professional services furnished during a reporting period by an eligible professional, if—

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

(2) The eligible professional (or in the case of a group practice under paragraph (g) of this section, the group practice) satisfactorily submits (as determined under paragraph (i) of this section for eligible professionals and paragraph (g) of this section for group practices) to the Secretary data on such quality measures in accordance with the Physician Quality Reporting System 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 (g) 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 (g) 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 (g) of this section, by the group practice) during the applicable reporting period. For purposes of this paragraph,

(i) The eligible professional’s (or, in the case of a group practice under paragraph (g) 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 (g) of this section, by the group practice) during the applicable 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 an 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 earned by an eligible professional (or in the case of a group practice under paragraph (g) of this section, by a group practice) for a particular program year will be paid as
a single consolidated payment to the TIN holder of record.

(3) Applicable quality percent. The applicable quality percent is as follows:
   (i) For 2011, 1.0 percent; and
   (ii) For 2012, 2013, and 2014, 0.5 percent.

(d) Additional incentive payment. (1) 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)(i) and (ii) of this section, must be increased by 0.5 percentage points.

   (2) In order to qualify for the additional incentive payment described in paragraph (d)(1) of this section, an eligible professional must meet the following requirements:
      (i) The eligible professional must—
         (A) Satisfactorily submit data on quality measures for purposes of this section for a year; and
         (B) Have such data submitted on their behalf through a Maintenance of Certification program (as defined in paragraph (b) of this section) that meets:
            (1) The criteria for a registry (as specified by CMS); or
            (2) An alternative form and manner determined appropriate by the Secretary.
      (ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—
         (A) Participates in a maintenance of certification program (as defined in paragraph (b) of this section) for a year; and
         (B) Successfully completes a qualified maintenance of certification program practice assessment (as defined in paragraph (b) of this section) for such year.
      (iii) A Maintenance of Certification Program submits to the Secretary, on behalf of the eligible professional, information—
         (A) In a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of paragraph (d)(2)(ii) of this section, which may be in the form of a structural measure;
         (B) If requested by the Secretary, on the survey of patient experience with care (as described in paragraph (b) of this section); and
      (C) 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) Use of consensus-based quality measures. For each program year, CMS will publish the final list of measures and the final detailed measure specifications for all quality measures selected for inclusion in the Physician Quality Reporting System quality measure set for a given program year on a CMS Web site by no later than December 31 of the prior year.

   (1) General rule. Subject to paragraph (e)(2) of this section, for purposes of reporting data on quality measures for covered professional services furnished during a year, subject to paragraph (f) of this section, the quality measures specified under this paragraph must 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.

   (2) Exception. 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, such as the AQA alliance.

   (3) Opportunity to provide input on measures. 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.

(f) Requirements for individual eligible professionals to qualify to receive an incentive payment. In order to qualify to earn a Physician Quality Reporting System 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 for such year by reporting on either individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups identified by CMS during a reporting period specified in paragraph (f)(1) of this section and using one of the reporting mechanisms specified in paragraph (f)(2) of this section. Although an eligible professional may attempt to qualify for the Physician Quality Reporting System incentive payment by reporting on both individual Physician Quality Reporting System quality measures and measures groups, using more than one reporting mechanism (as specified in paragraph (f)(2) of this section), or reporting for more than one reporting period, he or she will receive only one Physician Quality Reporting System incentive payment per TIN/NPI combination for a program year.

(1) Reporting periods. For purposes of this paragraph, the reporting period with respect to program year 2011 is—

(i) The 12-month period from January 1 through December 31 of such program year; or

(ii) The 6-month period from July 1 through December 31 of such program year.

(2) Exceptions. In program year 2011, the 6-month reporting period is not available for EHR-based reporting of individual Physician Quality Reporting System quality measures or for reporting by group practices under the process described in paragraph (g) of this section.

(3) Reporting mechanisms. For program year 2011, an eligible professional who wishes to participate in the Physician Quality Reporting System must report information on the individual Physician Quality Reporting System quality measures or for reporting by group practices under the process described in paragraph (g) of this section.

(i) Reporting the individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups to CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional’s Medicare Part B claims for covered professional services furnished during the applicable reporting period.

(ii) Reporting the individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups to a qualified registry (as specified in paragraph (b) of this section) in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected registry will submit information, as required by CMS, for covered professional services furnished by the eligible professional during the applicable reporting period to CMS on the eligible professional’s behalf; or

(iii) Reporting the individual Physician Quality Reporting System quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from a qualified EHR product (as defined in paragraph (b) of this section) by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period. Prior to actual data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing real or dummy clinical quality data extracted from the qualified EHR product selected by the eligible professional using a secure data submission method, as required by CMS.

(g) Requirements for group practices to qualify to receive an incentive payment. A group practice (as defined in paragraph (b) of this section) will be treated as satisfactorily submitting data on quality measures under Physician Quality Reporting System for covered professional services for a reporting period, if, in lieu of reporting Physician Quality Reporting System measures, the group practice—

(1) Meets the participation requirements specified by CMS for the Physician Quality Reporting System group practice reporting option or is a group practice of any size (including solo practitioners) or comprised of multiple TINs participating in a Medicare approved demonstration project that is
§ 414.92 Electronic Prescribing Incentive Program.

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

(1) The determination of measures applicable to services furnished by eligible professionals under the Physician Quality Reporting System;

(2) The determination of the payment limitation; and

(3) The determination of any Physician Quality Reporting System incentive payment and the Physician Quality Reporting System payment adjustment.

(i) Informal review. Eligible professionals (or in the case of reporting under paragraph (g) of this section, group practices) may seek an informal review of the determination that an eligible professional (or in the case of reporting under paragraph (g) of this section, group practices) did not satisfactorily submit data on quality measures under the Physician Quality Reporting System.

(1) To request an informal review, an eligible professional (or in the case of reporting under paragraph (g) of this section, group practices) must submit a request to CMS within 90 days of the release of the feedback reports. The request must be submitted in writing or via e-mail and summarize the concern(s) and reasons for requesting an informal review and may also include information to assist in the review.

(2) CMS will provide a written response within 60 days of the receipt of the original request.

(i) All decisions based on the informal review will be final.

(ii) There will be no further review or appeal.

(j) Public reporting of an eligible professional’s or group practice’s Physician Quality Reporting System data. For each program year, CMS will post on a public Web site, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (g) of this section, group practices) who satisfactorily submitted Physician Quality Reporting System quality measures.

(75 FR 73617, Nov. 29, 2010)