Frequently Asked Questions
Balancing Medicare Incentive Programs and Penalties: What You Need to Know as a Neurologist

- **Physician Quality Reporting System (PQRS)**
- **Medicare Electronic Prescribing (eRx) Incentive Program**
- **Medicare & Medicaid EHR Incentive Programs (“Meaningful Use”)**
- **Participating in Multiple Programs**

**Physician Quality Reporting System (PQRS)**

1. **What is PQRS?**
   - The Physician Quality Reporting System (PQRS) is CMS' pay for performance program, which began in 2007
   - PQRS provides for a combination of incentive payments and penalties to eligible providers to encourage participation in the program
   - A program that provides an incentive for eligible providers reporting on clinical quality measures via claims, qualified registry, or qualified Electronic Health Record (EHR)
   - A program with clinical quality measures reportable as individual measures or as measures groups
   - A program with different reporting periods depending on the type of reporting done

2. **How can I avoid the payment penalty in 2015?**
   Those eligible providers who do not successfully report on quality measures in 2013 will be subject to a 1.5 percent payment penalty in 2015. An Eligible Professional (EP) must successfully report on at least one individual measures in order to avoid this penalty. If the eligible provider wishes to also earn an incentive payment for the 2013 program year they must report on 3 or more individual measures or 1 or more measures group.

3. **I am grandfathered regarding my board certification. Am I required to complete the maintenance of certification (MOC) bonus of PQRS in addition to routine PQRS reporting?**
   No, the MOC incentive is optional for those also participating in the 12 month reporting option for PQRS. You are not required to participate in the MOC incentive program.

4. **Can I participate in PQRS if I do not have an electronic health record (EHR)?**
   Yes, there are 3 ways to participate in PQRS:
   1. Claims based reporting
   2. Registry based reporting
   3. EHR based reporting
   Eligible Professionals choosing to participate in the program should check the measure specifications for which methods are applicable for a particular measure or measures group.

5. **Do the eligible patient population for PQRS include Medicare HMO patients?**
   PQRS applies to covered Physician Fee Schedule services provided to Medicare Part B fee-for-service beneficiaries, which includes Railroad Retirement Board and Medicare as the secondary payer.

Updated 04/02/13
6. **For 2013 measure reporting, if reporting on only one measure, will I avoid a penalty but not earn the incentive payment?**

Eligible Professionals who successfully report on at least one valid measure via claims, qualified registry, or qualified EHR or at least one valid measures group via claims or qualified registry will be able to avoid the penalty.

7. **Are neurohospitalists required to participate in PQRS?**

Some EPs are not able to participate in the PQRS program; it depends on how their services are billed out. EPs who may be not be eligible to participate in the PQRS program include those that provide Part B services, but bill Medicare at the facility or institution level (Part A), professionals who do not bill Medicare at an individual NPI level, and professionals who have reassigned benefits to a Critical Access Hospital (CAH) which bills outpatient services at a facility level. Also, services payable under fee schedules or other methodologies other than the PFS are also not included in PQRS. If a neurohospitalist meets any of these criteria they are not required to participate in the program.

8. **My EHR does not automatically report to a registry for my measures for PQRS. Can I just enter data manually into a registry via the one I can sign up for on the AAN website?**

Yes, you may choose to elect to report via the PQRIwizard registry (www.aan.pqriwizard.com) if you are not able to report via your EHR.

9. **We do core measures fulfillment for stroke of hospital patients, does that count towards PQRS for stroke for Medicare? We do have an outpatient office practice also.**

This could possibly fulfill the PQRS requirements. Depending on the measures used, you will need to double check the specifications under PQRS. Also, unless your EHR vendor is on the EHR direct list you will still need to report either via claims or a qualified registry depending on the measures.

10. **How is measure 126, Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation reported? Am I supposed to report CPT II code G8485 first?**

There are specific ICD-9-CM and CPT codes assigned to each measure, and they are to be used when reporting each measure. When reporting on measure 126, diabetic foot and ankle care, peripheral neuropathy you would report the applicable ICD-9-CM code along with the applicable CPT code as a line item on the claim. An additional line would be reported for the Quality Data Code with either a zero dollar charge or a nominal charge if your billing software cannot accept a line item with a zero dollar charge.

11. **Do I report non-Medicare patients to the registry for PQRS?**

For a measures group reported via a qualified registry an EP must report on 20 or more eligible patients. Under the 2013 program, greater than 50 percent of those patients must be Medicare patients, the remainder can be from another carrier. All applicable patients, whether Medicare or not, must be reported on via the registry in order to receive credit for successful reporting.

12. **How many patients do I need to report to a PQRS registry?**

If reporting on a measures group via a qualified registry then you must report on at least 20 applicable patients, if reporting on individual measures via a qualified registry then you must report on 80 percent of all applicable patients for a given measure.
13. How do nurse practitioners (NPs) report PQRS if they bill incident to the providers they work under?
Nurse Practitioners are considered an eligible provider under the PQRS program; any time they are performing a quality measure which they are also performing a billable service (i.e. an E/M service) they will need to ensure they are also including the applicable quality data code.

14. In PQRS, do all measures have to be in the same disease category or can I pick and choose measures?
If participating using individual measures you may pick and choose amongst measures. If choosing to report on a measures group you must report all measures in the group for all applicable patients. For example, choosing the Parkinson’s disease measures group means you must report all six measures in the group for all Parkinson’s patients.

15. Do you have to report PQRS for both hospital and outpatient?
It is not required that you report for both inpatient and outpatient. Each EP should choose the individual measures or measures group which best suits their patient population. Each measure will have coding assigned to it dictating the place of service in which the measure(s) should be performed.

16. Some of the coding I used last year has changed for this reporting year. How do I continue to report on these measures for 2013?
Measure specifications can change from year to year. CMS recommends all EPs participating in PQRS review the specifications each program year prior to submitting quality measures.

17. Is the dementia composite code G8761 indicating that you completed all the individual dementia quality measures reliable or should we report each dementia measure individually?
If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the composite G-code for registry-based submissions.

Satisfactory reporting on the dementia measures group requires that all measures for each patient within the eligible professional’s patient sample to be reported a minimum of once during the reporting period.

18. If we decide to report PQRS measures on stroke diagnoses only, and submit three measures reporting, does it satisfy for reporting and incentive?
In order to qualify for the incentive payment, an EP must successfully report on at least three individual measures, this will also help EPs avoid the 2015 penalty.

19. If you are only trying to avoid the penalty for PQRS, I understand you only need to report on one measure “successfully”. Does that mean I must report that one measure on 50 percent of all my Medicare patients?
If an EP is only looking to avoid a penalty in 2015 there are several different ways to do so:
• Meet the requirements for satisfactorily reporting for incentive eligibility as defined in the 2013 PQRS Measure Specifications
• Report at least one valid measure via claims, registry, or qualified Electronic Health Record (EHR, including data submission vendors and direct EHRs)
OR
• Report at least one valid measures group via claims or registry
• Elect to participate in the administrative claims-based reporting mechanism by October 15, 2013

20. What is the difference between registry reporting and claim reporting?
Registry based reporting is usually done via a web interface where the EP enters patient specific information regarding the performance of specific quality measures. An EP must report on 20 unique patients for a measures group or must report on 80 percent of his or her eligible patient population for three or more individual measures.

Claims based reporting is done via a claim form utilizing the appropriate quality data code as a line item in addition to the qualifying service. The quality data code should be reported with either a zero dollar charge or a penny charge. The line item will not be paid. Those EPs reporting via claims must report on at least 50 percent of all patients eligible for the measure in order to be considered a successful reporter.

21. When reporting for PQRS, which of our Medicare patients do we only need to report on?
For all methods of reporting under the PQRS program those services covered by the Physician Fee Schedule (PFS) furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer) will be included in the PQRS program. Beginning in 2015, the program also applies a penalty to eligible professionals who do not satisfactorily report data on quality measures for covered professional services.

22. Do you need to sign up for PQRS?
There is no registration required by CMS to participate in the PQRS program. Qualified registries may require registration and/or payment, if reporting through a registry. EPs should check to find out what is required to utilize that specific registry.

23. For the PQRS for Epilepsy measure 268 Counseling for Women of Child Bearing Potential, if the patient is a man or a woman of non-child bearing age, what do I do about 4340f? How do I report it?
If a patient is a male or of non-child bearing age (as defined by the measure) they would not be eligible for this measure as they are not included in the denominator criteria. The only exceptions allowed by this measure are for those females age 12-44 years with a documented medical reason for not performing the measure.

24. How do I start PQRS? What is first step? Who in office usually does this?
A potential participant must first determine if they are eligible to participate in the program. CMS has a list of Eligible Professionals available on their website. After determining if an EP is eligible to participate they should then decide which individual measures or measures groups they will report on and how they will report on them either via claims based reporting or registry based reporting.

25. Why can Parkinson’s measures only be submitted by registry and not via claims?
The AAN nominated the Parkinson’s disease measures for inclusion in the PQRS program; they were included for the first time in the 2012 reporting period. During the nomination process the AAN requested that the measures were reportable via claims or registry to allow the maximum number of EPs to participate using these measures. When the final rule was published CMS recommended
that these measures were reportable only via a qualified registry. Based on CMS data those utilizing a qualified registry to report on PQRS measures have a higher successful reporting rate.

**Medicare Electronic Prescribing (eRx) Incentive Program**
http://www.aan.com/go/practice/pay/eRx

26. What is the Medicare eRx Incentive Program?
The Medicare eRx Incentive Program is an incentive program for eligible professionals who are successful electronic prescribers as defined by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). This incentive program began on January 1, 2009, and is a separate program and in addition to the Physician Quality Reporting System (PQRS) program. Beginning in 2012, eligible professionals who did not meet the requirements for the Medicare eRx Incentive Program will be subject to a penalty. The penalty applies to all of the eligible professional’s Part B−covered professional services under the Medicare Physician Fee Schedule (MPFS). The penalty will increase with each new reporting period.

27. Is the G8553 code used for all medications sent via electronic prescription?
For claims-based reporting, report the G8553 code when at least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.

28. Will I use the G8553 code if I cannot submit electronically due to the drug being a schedule drug, but it is printed for the patient?
No, if the prescription is not submitted electronically you should not report the G8553 code. Use the G8553 code when least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.

29. Is eRx limited to only Medicare recipients or can it include other insurance carriers such as Medicaid and commercial carriers?
Reporting is specific to Medicare patients.

30. If a physician plans to retire in the middle of 2013, will he be subject to the Medicare eRx Incentive Program penalty because he has not met the minimum requirement of 10 eligible cases between 01/01/2013-06/30/2013?
A physician who retires in 2013 will not be subject to penalties for not meeting the reporting requirements during the reporting period of 01/01/2013-06/30/2013. The 2013 penalty would be applied to all of the eligible professional’s Part B-covered professional services under the Medicare Physician Fee Schedule (MPFS) during the 2014 calendar year. Since the retired physician will not be practicing in 2014, he or she will not be assessed penalties for lack of participation in the 2013 program.

31. Can a physician assistant receive the incentive payment for the Medicare eRx Incentive Program?
A physician assistant is eligible to participate in the Medicare eRx Incentive Program for the incentive payment. Eligible professionals must have prescribing authority in order to participate. A physician assistant is also subject to penalties if not successful at reporting the eRx Incentive Program measure.
32. We see many patients with mail away pharmacies and we find it difficult to get to the required number of electronic prescriptions. Is anything being done to adjust for that?

There are hardship exemptions available that may be applicable. Hardship exemption categories for the 2013 penalty include:

- The EP or group practice practices in a rural area with limited high speed internet access
- The EP or group practice practices in an area with limited available pharmacies for eRx
- Inability to eRx due to local, state, or federal law or regulation
- EP who prescribe fewer than 100 prescriptions during a 6–month, penalty reporting period (1/1/2012–6/30/2012)

All hardship Exemptions can be submitted through the Communications Support Page at https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234

33. Can I submit the G8553 code for a controlled substance if I send the request electronically but am required to send a signed prescription via fax?

For the purposes of the Medicare eRx Incentive Program measure, an eRx event includes all prescriptions electronically prescribed during a patient visit. Faxes initiated from the eligible professional's office do not qualify as electronic prescribing for the Medicare eRx Incentive Program.

34. How can those who do not qualify for the Medicare eRx Incentive avoid the eRx penalty?

If a provider does not meet the minimum eligibility requirements, no further action is required and the provider DOES NOT need to alert CMS. CMS will make the determination after the reporting period is over, based on claims data. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Eligible-Professionals.html

35. For the 2012 eRx incentive, what is the deadline to submit data to CMS?

Claims-Based Reporting:
Submit both a denominator CPT code and the numerator G–code on the original claim form. All measure–specific coding should be reported on the claim(s) representing the eligible encounter. Claims that are resubmitted for the sole purpose of adding or correcting an eRx code will NOT be accepted.

For details on EHR-based or registry reporting, visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html.

36. How many G8553 codes do I have to report for 2013?

To earn the 2013 incentive:
To earn an incentive for the 2013 year, you must generate at least one eRx associated with a patient visit on 25 or more unique events during the reporting period of 01/01/2013–12/31/2013.

To avoid a future penalty based on reporting in 2013 (penalty will be assessed during CY 2014):
Eligible neurologists who did not meet the 12–month reporting deadline in calendar year 2012 have the option of a 6–month reporting period from 01/01/2013–06/30/13 to avoid the 2013 eRx penalty. The 6–month reporting must be claims–based, and the G8553 code can be submitted for any visit if there was an eRx event. An eRx must be generated on 10 or more unique events during the 6-month reporting period.
37. If I am using an EHR do I have to add G8553 on every encounter?
   If you are reporting via claims, you would report the G8553 code when at least one prescription
   created during the encounter was generated and transmitted electronically using a qualified eRx
   system.

38. Can I report the G8553 code if I give narcotic and electronic prescriptions on the same visit?
   You would report the G8553 code if at least one prescription created during the encounter was
   generated and transmitted electronically using a qualified eRx system (not faxed from the eligible
   professional’s office).

39. Why are Medicare HMOs not paying for the eRx incentives?
   CMS has determined only traditional Medicare patients count. Medicare Advantage (MA) and other
   private insurance claims do not count as part of the Medicare eRx Incentive Program.

40. Is there an appeal process to stop eRx penalties?
    For all inquiries regarding the eRx Incentive Program penalty, including if an eligible professional
    believes a penalty was erroneously applied, please contact the Help Desk Support.

    QualityNet Help Desk – Monday– Friday, 7:00 AM – 7:00 PM CST
    Phone: 1-866-288-8912
    TTY: 1-877-715-6222
    Email: Qnetsupport@sdps.org

41. What is the Medicare EHR Incentive Program?
    The Medicare (and Medicaid) EHR Incentive Program will provide incentive payments to eligible
    professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement,
    upgrade or demonstrate Meaningful Use of certified EHR technology. Participating neurologists
    must implement and demonstrate Meaningful Use through certified EHR technology, as defined
    by the Office of the National Coordinator for Health Information Technology (ONC).

42. How well do free EHR programs work?
    The AAN does not endorse any specific EHR vendors. However, the AAN has joined with
    AmericanEHR Partners to provide members with guidance and resources to assist in purchasing and
    implementing EHRs in their practices. This partnership will provide neurologists across the United
    States with free access to the necessary tools to identify, compare, implement, and effectively use
    EHRs and other health care technologies. For more information, visit

43. What does “attest” mean and how do I know I have successfully attested?
    Once an eligible neurologist has successfully registered for the Medicare EHR Incentive Program and
    met the Meaningful Use criteria using certified EHR technology, successful attestation is necessary
    to start earning incentive payments. To attest, eligible neurologists will need to have met
    Meaningful Use for a consecutive 90-day reporting period in the first year. For each additional year,
    eligible neurologists will have to meet Meaningful Use requirements for the entire year (with the
exception of 2014, where all EPs regardless of their reporting year will only need to attest for a consecutive 90-day reporting period).

44. **Am I required to register my EHR?**
   Yes. During attestation, CMS requires each eligible professional, eligible hospital and critical access hospital to provide a CMS EHR Certification ID that identifies the certified EHR technology being used to demonstrate Meaningful Use. This unique CMS EHR Certification ID or Number can be obtained by entering your certified EHR technology product information at the Certified Health IT Product List (CHPL) on the ONC website: [http://healthit.hhs.gov/chpl](http://healthit.hhs.gov/chpl)

To learn which EHR systems and modules are certified for the Medicare and Medicaid EHR Incentive Programs, please visit the above website.

45. **How does Medicare or Medicaid know which program I have chosen to participate in (ex. How does Medicare know I am participating in the Medicaid EHR Incentive Program)?**
   Eligible professionals will indicate which program they are participating in using the CMS Registration & Attestation System. For more information, visit the CMS website: [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html)

46. **How is Meaningful Use criteria for Medicaid different than the Medicare EHR Incentive Program?**
   It is recommended that Medicaid eligible professionals check with their state on any changes to Meaningful Use criteria. States can seek prior approval from CMS to require that up to four public health-related menu objectives be core objectives for their Medicaid eligible professionals.


47. **Can we begin participation in the Medicaid EHR Incentive Program in 2015 after Medicare EHR Incentive Payments end?**
   EPs may switch once between programs after a payment has been made and only before 2015.

48. **We do not think we are eligible for the Medicare EHR Incentive Program. Do we have to let CMS know that in order to not get penalized? If yes, how?**
   If you are not eligible for the Medicare EHR Incentive Program, notifying CMS is not required. However, you are encouraged to verify eligibility requirements:

   **Eligible professionals include:**
   - Doctor of medicine or osteopathy
   - Doctor of dental surgery or dental medicine
   - Doctor of podiatry
   - Doctor of optometry
   - Chiropractor

   **Eligible Hospitals include:**
   - "Subsection (d) hospitals" in the 50 states or DC that are paid under the Inpatient Prospective Payment System (IPPS)
   - Critical Access Hospitals (CAHs)
   - Medicare Advantage (MA-Affiliated) Hospitals

   For more information on eligibility and to use the Eligibility Wizard, visit [http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp](http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp)
49. If I am participating in the Medicaid EHR Incentive Program, can I still be penalized by Medicare?
There are no payment penalties for Medicaid providers who fail to demonstrate Meaningful Use. However, if you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you must demonstrate Meaningful Use according to defined timelines to avoid the penalties. You may demonstrate Meaningful Use under either Medicare or Medicaid. Eligible professionals who are in their first year of the Medicaid EHR Incentive Program (receiving an incentive payment for adopting, implementing, or upgrading my Certified EHR Technology) may still be subject to a penalty under the Medicare EHR Incentive Program, as the first year of the Medicaid program does not require demonstrating Meaningful Use.

50. If we earned the Medicare EHR Incentive Program payment of $18,000 in 2012, but choose to not participate in the program in 2013, will they take back the $18,000 payment?
No, if you successfully earned the Medicare EHR Incentive payment in 2012, you will not need to return that incentive payment for not earning an incentive payment in 2013.

51. If I begin participation in Stage 1 of the Medicare EHR Incentive Program in 2013, when do I need to begin Stage 2? If providers start in 2014, do they automatically start in Stage 2, and skip Stage 1?
See the below schedule of stage 1-3. With the exception of those who began participation in 2011 who will meet three consecutive years of Meaningful Use under Stage 1 criteria, all providers will meet two years of Meaningful Use under Stage 1 criteria before moving to Stage 2 in their third year of participation.

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52. If I started with participating in the Medicaid EHR Incentive Program and want to change to the Medicare EHR Incentive Program, can I do that and how?
EPs may switch once between programs after a payment has been made and only before 2015. To switch from participation in the Medicaid EHR Incentive Program to the Medicare EHR Incentive Program, you must register and attest under the Medicare Program, which can be done on the CMS webpage at [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html).

53. Does each individual provider in a group practice have to register and attest?
CMS does allow an eligible professional to designate a third party to register and attest on his or her behalf. To do this, the third party user working on behalf of an eligible professional must have an Identity and Access Management System (I&A) web user account (User ID/Password), and be associated to the eligible professional's National Provider Identifier (NPI). Visit the CMS webpage at [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html) for more information.
For participation in the Medicaid EHR Incentive Program, please note that states will not necessarily offer the same functionality for registration and attestation, so it is advised to check with your state. Information is available for each state on the CMS webpage at [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/MedicaidStateInfo.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/MedicaidStateInfo.html).

54. If we attested in 2012, do we receive the incentive payment in 2013?
   If you successfully attested in 2012, you will receive an incentive payment approximately four to eight weeks after you attested. However, EPs who have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year will not receive incentive payments within that timeframe. Instead, payment will be held until the EP meets the threshold in allowed charges for the calendar year ($24,000 in 2012; $20,000 in 2013) in order to maximize the amount of the EHR incentive payment they receive.

55. If NP/PA data is included in the physician’s Meaningful Use data, can they report Meaningful Use separately?
   Nurse Practitioners (NPs) and Physician Assistants (PAs) are not eligible to participate in the Medicare EHR Incentive Program. An NP or PA* may be eligible to participate in the Medicaid EHR Incentive Program.
   A PA is who furnishes services in a Federally Qualified Health Center of Rural Health Clinic that is led by a physician assistant would be eligible for the Medicaid EHR Incentive Program.

**Participating in Multiple Programs**

56. Do I have to specify G8553 on patient visits (for the Medicare eRx Incentive Program) if I am already electronically prescribing to meet the Medicare EHR Incentive Program requirements?
   Yes, the Medicare eRx Incentive Program and the Medicare EHR Incentive Program are two separate programs and have different reporting requirements. To ensure you avoid future penalties in the Medicare eRx Incentive Program, it is advised to continue reporting the G8553 code.

57. Do we have to fulfill PQRS measures in addition to the Medicare EHR Incentive Program clinical quality measures objective to avoid penalties? Can the same data be used to report for both programs?
   Yes, the PQRS and Medicare EHR Incentive Programs are two separate programs and have different reporting requirements.

   There is an option to participate in the Physician Quality Reporting System (PQRS)-Medicare EHR Incentive Pilot Program. This voluntary program requires participants to report clinical quality measures (CQMs) for a full 12-month calendar year (regardless of the eligible professional's year of participation in the Medicare EHR Incentive Program).

   Those who wish to participate in this pilot program will be able to indicate within the EHR Incentive Program attestation module their intent to fulfill the Meaningful Use (MU) objective of reporting CQMs by participating in the pilot. It will allow those who are participating in both MU and PQRS to report their clinical quality measures once.
   Note: If you plan to report zeroes for the Meaningful Use CQM objective, you will not be able to participate in the PQRS-Medicare EHR Incentive Program Pilot Program.
58. Will successful reporting of CQMs for the Medicare EHR Incentive Program earn an incentive for PQRS?
No, the PQRS and Medicare EHR Incentive Programs are two separate programs that have different reporting requirements.

59. As a member of a larger multispecialty group, reporting as a group, do I get penalties or incentives based on the group results or on my individual practice?
For the Medicare eRx Incentive Program 2013 Penalty:
The eRx penalty (applied for not being a successful electronic prescriber) will result in an individual eligible professional, or CMS-selected group practice participating in eRx GPRO, receiving 98.5 percent of his or her Medicare Part B PFS allowed charges amount that would otherwise apply to such services (or 1.5 percent less reimbursement) for all charges with dates of service from January 1 through December 31, 2013.

For PQRS:
If reporting as a group any incentives or penalties are calculated based on the group NPI number though specific individuals within the group may be responsible for performing certain quality measures.

For the Medicare/Medicaid EHR Incentive Program:
There is not a group practice reporting option for the EHR Incentive Program.

60. We opened our practice in December 2011. Are there any hardship exemptions available that we can apply for? Also if we apply for an exemption can we apply for incentives?
For the Medicare eRx Incentive Program:
There is not a hardship exemption addressing new practices.

For PQRS:
There are no formal exemptions for reporting through the PQRS; there are however specific instances as to why an eligible provider may not be able to report, this information is contained in the following document http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_List-of-EligibleProfessionals_022813.pdf.

For the Medicare EHR Incentive Program:
Newly practicing EPs who would not have had time to become meaningful users can apply for a two-year limited exception to penalties. Thus EPs who begin practice in calendar year 2015 would receive an exception to the penalties in 2015 and 2016, but would have to begin demonstrating Meaningful Use in calendar year 2016 to avoid penalties in 2017. Specifically for a practice that opened in 2011, under the two-year limited exception, they would still need to meet the requirements to avoid the 2015 penalty.

61. If I qualified for Meaningful Use for 2012 do I report PQRS via claims?
Participation in Meaningful Use does not affect what method you should choose to report for PQRS.