A Guide for Understanding the
2007 Re-Run Physician Quality Reporting Initiative (PQRI) Incentive Payment
June 30, 2009

This document describes how the 2007 Re-Run PQRI incentive payment was calculated. Only Medicare Part B claims that contained an individual National Provider Identifier (NPI) were included in the 2007 re-run incentive payment calculation. Only those eligible professionals (EPs) previously not incentive–eligible and became eligible following the back-end system analysis and re-run of 2007 PQRI data, will potentially receive an incentive payment in November 2009. Medicare Part B claims that contained a legacy UPIN and no NPI were NOT included in the incentive payment calculation.

Incentive amounts were calculated using the following steps for each incentive-eligible provider (NPI within a practice [i.e., TIN/NPI]). Incentive payments were aggregated for all newly incentive-eligible NPIs within the TIN and distributed at the TIN level in a lump-sum payment.

Step 1: Apply the 1% Completion Factor

- The 2007 Medicare Part B Physician Fee Schedule (PFS) total estimated allowed charges were increased by 1% to account for claims that were submitted by EPs on or before February 29, 2008, but were not included in the National Claims History (NCH) database as final-action claims when the data was obtained for 2007 PQRI re-run analyses.

Step 2: Calculate the Average Payment per Measure (APM)
[NOTE: Only relevant to incentive payments that were capped]

- The CMS national APM was calculated and used for calculating an individual EP Cap amount.
- The APM was the same value for all measures and all EPs.
- The APM applies to and was calculated for all Medicare Part B PFS total estimated allowed charges on claims that included one or more valid reporting instances.
- The sum was calculated for all identified Medicare Part B PFS total estimated allowed charges on claims with valid reporting instances ONCE per claim (using unduplicated claim's charges).
- The sum of national charges was divided by the number of reporting instances identified.

Step 3: Calculate the 2007 PQRI Cap for Each Incentive-Eligible TIN/NPI

- 2007 PQRI had a Cap (maximum) on the incentive amount.
- For each incentive-eligible TIN/NPI, the Cap was calculated as:
    - Cap = 3 x APM x Instances of quality-measure reporting
        - Includes a "valid" reporting instance (defined on page 2).
- Cap amount was calculated for all newly incentive-eligible TIN/NPIs, but only applied to a small percentage of EPs whose Cap was smaller than their 1.5% Medicare Part B PFS total estimated allowed charges.
- The newly eligible TIN/NPI incentive payment amount was the lesser of the 1.5% of the Medicare Part B PFS total estimated allowed charges for the TIN/NPI and the Cap amount calculated for the TIN/NPI.

Step 4: Calculate the Incentive for Each Incentive-Eligible TIN/NPI

- All Medicare Part B PFS total estimated allowed charges (with the 1% completion factor) on claims for each newly incentive-eligible TIN/NPI combinations were identified for inclusion or exclusion (See list below).
- The 1.5% incentive amount was calculated by:
    - Adding Medicare Part B PFS total estimated allowed charges (with the completion factor applied) for each TIN/NPI; then
    - Multiplying by 0.015, giving the 1.5% incentive amount
    - TIN/NPI re-run incentive = Lesser of the Cap or 1.5% incentive amount

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Completion Factor
A percentage increase that was applied to the Medicare Part B PFS total estimated allowed charges to account for claims submitted by EPs on or before February 29, 2008, but were not included in the NCH database as final-action claims when the data was obtained for 2007 PQRI re-run analyses.

Identified Inclusions for Medicare Part B PFS Total Estimated Allowed Charges:
- First expense date and last expense date were between 7/1/2007 and 12/31/2007
- NCH processing date on or before 2/29/2008
- Claims must be marked as "final" in the Part B claims database
- Split claims in the NCH file HCPCS service lines were rejoined
- Line-items identified by HCPCS and modifier(s) were subject to the PFS
- Technical components of diagnostic services and anesthesia services (note: radiopharmaceuticals will be included in the basis of total allowed charges on which the 1.5% bonus incentive was calculated)

Identified Exclusions for Medicare Part B PFS Total Estimated Allowed Charges:
- Denied claims or denied line items
- Amount billed above the PFS for assigned and non-assigned claims
- Clinical laboratory services
- Pharmaceuticals billed by physicians
- Rural Health Center/Federally Qualified Health Center services
- Ambulatory Surgical Center (ASC) facility charges

Incentive Earned Calculation by Individual EPs Satisfying 2007 Re-Run PQRI Reporting Criteria
The newly-earned incentive by each individual EP satisfying reporting criteria for 2007 was the ***lesser*** of ***either:***
1.5% of the EPs total estimated allowed Medicare Part B PFS charges for covered professional services billed under the individual's NPI during the July-December, 2007 reporting period;

OR

EPs total valid instances of PQRI reporting (NPI correctly submitted QDC) x the national average per measure payment amount x 300%.

Key Terms as Used in PQRI Analysis and Documentation:
"TIN" – Taxpayer Identification Number or "Tax ID Number"
For PQRI, "TIN" includes all of the following types of identifiers:
(1) Individual Social Security Number/Social Security Account Number (SSN/SSAN);
(2) Employer Identification Number (EIN), also known as a "Tax ID Number", typically held by businesses or other organizations with employees; and
(3) Individual Taxpayer Identification Number (I-TIN), issued by the IRS to individuals who do not need an EIN and do not wish to use their individual SSN/SSAN for certain business transactions.

Medicare Part B PFS Total Estimated Allowed Charges
For purposes of PQRI analysis, the Medicare Part B PFS total estimated allowed charges were used to account for claims submitted by EPs on or before February 29, 2008, but were not included in the NCH database as final-action claims when the data was obtained for 2007 PQRI re-run analyses. The Part B PFS allowed charges are listed in the Incentive Payment Summary. For more information on the PFS and Physician Reimbursement Rules, please refer to the CMS website at:
http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1321fc.pdf.

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NPI – National Provider Identifier

The individual NPI representing the EP was used to determine PQRI incentive eligibility for the 2007 PQRI re-run. The Medicare Carrier/MAC routes to each TIN a lump-sum incentive payment equal to the sum of incentive earned by each EP who satisfactorily reported under that TIN for the 2007 PQRI reporting period.

TIN/NPI

The key unit of analysis for the 2007 PQRI re-run incentive payment eligibility and amount was the individual NPI within a TIN. *(If an individual EP furnished services for which reimbursement was claimed under more than one TIN, the EPs PQRI reporting rates and allowed charges were analyzed under each TIN separately).*

Valid Instance of PQRI Reporting

A PQRI measure's quality-data (CPT Category II or G-) code submitted on a claim that also contained any combination of applicable CPT Category I service code and ICD-9-CM diagnosis code that defines a reportable instance for the measure, as identified by the measure's detailed specifications. *(The full, detailed specifications for all 2007 PQRI quality measures, as implemented in 2007, are available for download from the CMS PQRI web site at:* http://www.cms.hhs.gov/apps/ama/license.asp?file=/PQRI/downloads/2007PQRIMeasure_Specifications.pdf.)

See posted frequently asked questions (FAQs) related to the 2007 PQRI re-run on the CMS PQRI web site for more information and search by using keyword "re-run".