User Guide

2007 Re-Run and 2008 Physician Quality Reporting Initiative (PQRI) Feedback Reports

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User Guide

2007 Re-Run and 2008 Physician Quality Reporting Initiative (PQRI) Feedback Reports

Purpose

The Physician Quality Reporting Initiative (PQRI) Feedback Report User Guide is designed to assist eligible professionals (EPs) and their authorized users in accessing and interpreting the 2007 re-run and 2008 PQRI feedback reports. Only those EPs who are newly incentive-eligible for the 2007 re-run will potentially receive an incentive payment in November 2009. For the 2007 re-run, reports reflect data from the Medicare Part B claims received for the dates of service July 1, 2007 – December 31, 2007 that were processed into National Claims History (NCH) by February 29, 2008. The 2008 PQRI incentive payment will occur in October 2009. The 2008 PQRI feedback reports reflect data from the Medicare Part B claims received for the dates of service January 1, 2008 – December 31, 2008 that were processed into NCH by February 27, 2009.

PQRI Program Overview

The 2006 Tax Relief and Health Care Act (TRHCA) authorized a physician quality reporting system, including an incentive payment for EPs who satisfactorily reported data on quality measures for Medicare Part B Physician Fee Schedule (PFS) covered professional services furnished to Medicare Fee-for-Service beneficiaries during the second half of 2007. CMS named this program the PQRI. For 2007, EPs who met statutory criteria for satisfactory submission of quality data on claims for covered professional services furnished during the reporting period (July 1, 2007 – December 31, 2007) were eligible to earn a lump-sum incentive payment equivalent to 1.5% of their total estimated allowable charges. TRHCA required EPs to report at least three applicable measures (<3 if applicable) in at least 80% of the cases in which each measure was reportable. 2007 PQRI was a *pay-for-reporting program* that included claims-based reporting of data on 74 individual quality measures.

The Medicare, Medicaid, and SCHIP Extension Act (MMSEA) authorized CMS to make PQRI incentive payments for satisfactorily reporting quality measures data in 2008. EPs who met the criteria for satisfactory submission of quality measures data for services furnished during the reporting period, January 1, 2008 – December 31, 2008, will earn an incentive payment equal to 1.5% of their total estimated allowed charges for Medicare Part B PFS covered professional services furnished during that same period (the 2008 calendar year).

2008 PQRI continued as a pay-for-reporting program that included claims- and registry-based reporting of data on 119 individual quality measures as well as the addition of four measures groups. MMSEA authorized CMS to establish two alternative reporting periods, reporting of measures groups, and to allow submission of data on PQRI quality measures through clinical data registries. The two alternative reporting periods were: January 1, 2008 – December 31, 2008 and July 1, 2008 – December 31, 2008. There were nine options for satisfactorily reporting quality measures data for the 2008 PQRI that differed based on the reporting period, the reporting option (individual measures or measures groups), and the data collection method (claims, qualified registry) that an EP selected.

The initial feedback reports and incentive payments for EPs who participated in the 2007 PQRI were distributed in the summer of 2008. CMS investigated issues that were reported by EPs following the delivery of the 2007 PQRI feedback reports and incentive payments and identified several unanticipated technical issues that could be corrected by conducting back-end system analytic modifications and re-running 2007 PQRI data. Only those EPs who did not previously receive an incentive payment for 2007, but became newly-incentive eligible after the re-run will potentially receive a 2007 PQRI incentive. For more information on the 2007 re-run and 2008 PQRI, please visit the PQRI section of the CMS website at http://www.cms.hhs.gov/PQRI.

Report Overview

The 2007 re-run and 2008 PQRI feedback reports are packaged at the Taxpayer Identification Number (Tax ID Number, or TIN) level, with individual-level reporting (by National Provider Identifier or NPI level) and performance information for each EP who reported at least one valid PQRI quality-data code (QDC) on a claim submitted under that TIN for services furnished during the reporting period. Reports include information on reporting rates, clinical performance, and incentives earned by individual professionals, with summary information on reporting success and incentives earned at the practice (TIN) level. Reports include information on the measure-applicability validation (MAV) process and any impact it may have had on the EP's incentive eligibility.

The 2007 re-run included one reporting period for claims-based measures submitted under that TIN for services furnished from July 1, 2007 – December 31, 2007. EPs who are considered solo practitioners may access their feedback reports through the PQRI Portal at http://www.qualitynet.org/pqri. EPs who submitted under multiple TINs may have earned an incentive either under one or more than one TIN.

2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternative reporting periods. All Medicare Part B claims submitted with PQRI QDCs and all registry data received for services furnished from January 1, 2008 – December 31, 2008 (for the 12-month reporting period) and for services furnished from July 1, 2008 – December 31, 2008 (for the 6-month reporting period) were analyzed to determine whether the EP earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. Valid submissions are where a QDC is submitted and all measure-eligibility criteria is met (i.e., correct age, gender, diagnosis and CPT). For those NPIs satisfactorily reporting multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive.

Note: *This report may contain a partial or "masked" Social Security Number/Social Security Account Number (SSN/SSAN) as part of the TIN field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner the SSN is potentially associated with. Please ensure that these reports are handled appropriately and disposed of properly to avoid a potential Personally Identifiable Information (PII) exposure or Identity Theft risk*.

System Requirements

Minimum hardware and software requirements to effectively access and view the PQRI feedback reports are listed below.

Compatible Operating System

- Any operating system, such as Microsoft® Windows XP Professional or Microsoft® Vista, should be compatible, as long as an Internet browser is available

Software

- Microsoft® Internet Explorer 6.0 and above, Mozilla® Firefox 2.0 and above, or Apple® Safari 2.0 and above
- Adobe® Acrobat® Reader 5.0 and above

Internet Connection and Download Time

- Reports will be accessible via any Internet connection. It is possible that some reports may be as large as 15MB. Downloading large report files may require additional time.

Participant Feedback Report Content and Appearance

Four tables may be included in the 2007 re-run and the 2008 PQRI feedback reports. PQRI feedback reports will be generated for each TIN with at least one EP reporting a QDC. The TIN level feedback report is only accessible by the TIN. It is up to the TIN to distribute the information in Tables 2 – 4 to the individual NPI. The length of the feedback report will depend on the number of TIN/NPIs participating in PQRI. A total incentive payment amount will be calculated for all TIN/NPIs. A breakdown of each individual NPI and their earned incentive amount will also be included.

Table 1: Earned Incentive Summary for Taxpayer Identification Number (Tax ID)

Each TIN will receive only one report.

- **Total Tax ID Earned Amount:** The total incentive amount earned by the Tax ID. The actual incentive payment may vary slightly from this amount.
- **NPI Total Earned Incentive Amount:** The 1.5% incentive amount earned for each TIN/NPI.

For definition of terms related to 2007 re-run and 2008 PQRI feedback reports see **Appendix A**. Also refer to the footnotes within each table for additional content detail.

Example 1.1

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the Eligible Professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as Eligible Professionals (EPs) submitting at least one valid QDC via claims or submitting data via a qualified registry. Valid submissions are where a QDC is submitted and all measure-eligibility criteria is met (i.e. correct age, gender, diagnosis and CPT). For those NPIs satisfactorily reporting multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. The methods reported and amounts earned for each TIN/NPI are summarized below.
More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Total incentive amount earned for all NPIs reporting under one TIN.

Total amount earned by each NPI after the 1.5% incentive.

Total amount earned by each NPI before the 1.5% incentive.

Table 1: Earned Incentive Summary for Taxpayer Identification Number (Tax ID)
Sorted by Earned Incentive Yes/No and sub-sorted by NPI Number

Tax ID Name«: John Q. Public Clinic
Tax ID Number: XXXXX6789

Total Tax ID Earned Incentive Amount for NPIs (listed below): $14,150.00	Distribution of Total Incentive Earned Among Carriers and/or A/B MACs That Processed Payments		
	Carrier and/or A/B MAC Identification #	Proportion of Incentive¤ per Carrier and/or A/B MAC	Tax ID Earned Incentive Amount Under Carrier and/or A/B MAC
	12345	90.0%	$12,735.00
	6789	10.0%	$1,415.00

NPI	NPI Name«	Earned Incentive●				Total # Measures with QDCs Submitted^	Total # Measures Denominator Eligible with QDCs~	Total # Measures Satisfactorily Reported‡	Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
		Method of Reporting	Reporting Period	Yes/No	Rationale					
1000000002	Smith, Susie	Individual measure(s) reporting via registry	6 months	Yes	Sufficient # of measures reported at 80%	10	8	5	$100,000.00	$1,500.00
1000000003	Not Available	Individual measure(s) reporting via registry	12 months	Yes	Sufficient # of measures reported at 80%	6	4	3	$133,333.33	$2,000.00
1000000004	Not Available	80% Measures Groups beneficiaries via claims	6 months	Yes	Sufficient # of beneficiaries reported at 80%	8	6	4	$63,333.33	$950.00
1000000006	Not Available	80% Measures Groups patients via registry	12 months	Yes	Sufficient # of patients reported at 80%	8	5	4	$166,666.66	$2,500.00
1000000008	Beans, John	Consecutive Measures Groups patients via registry	6 months	Yes	Sufficient # of consecutive patients reported	7	6	4	$53,333.33	$800.00
1000000009	Smithson, Steve	Consecutive Measures Groups patients via registry	12 months	Yes	Sufficient # of consecutive patients reported	12	10	9	$166,666.66	$2,500.00
1000000011	Jones, Josie	80% Measures Groups patients via registry	6 months	Yes	Sufficient # of patients reported at 80%	7	5	4	$93,333.33	$1,400.00
1000000012	Doe, John	Individual measure(s) reporting via claims	12 months	Yes	Sufficient # of measures reported at 80%	6	4	3	$80,000.00	$1,200.00
1000000013	Not Available	Consecutive Measures Groups beneficiaries via claims	6 months	Yes	Sufficient # of consecutive beneficiaries reported	9	8	5	$86,666.66	$1,300.00
									Total:	$14,150.00

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.
¤The percentage of the total incentive amount earned by the TIN/NPI combinations, split across carriers based on the proportionate split of the Tax ID's total estimated allowed Medicare Part B Physician Fee Schedule (PFS) charges billed across the carriers. (100% of incentive will be distributed by a single carrier if a single carrier processed all claims within the reporting period for the Tax ID).
●An NPI satisfactorily reporting at least one claims-based reporting method or at least one registry-based reporting method and passing the applicable validation process is eligible to receive a PQRI incentive. More information regarding the incentive calculations is available on the CMS website.
^The number of quality-data codes (QDCs) submitted, but are not necessarily valid. Only valid submissions count towards reporting success.
~The number of measures for which the TIN/NPI reported at least one valid quality-data code (QDC).
‡The total number of measures the TIN/NPI reported at a satisfactory rate; satisfactory rate is for ≥ 80% of instances.
□The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) charges associated with services rendered during the reporting period. The PFS claims included were based on the six or twelve month reporting period for the method by which the NPI was incentive eligible.
*The amount of the incentive is based on the total estimated allowed Medicare Part B Physician Fee Schedule (PFS) charges for services performed within the length of the reporting period for which a TIN/NPI was eligible. If N/A, the NPI was not eligible to receive an incentive.
Note: The registry information is based on data calculated and supplied by the 2008 PQRI participating registries.

Figure 1.1 Screenshot of Table 1: Earned Incentive Summary for Taxpayer Identification Number (Tax ID)

Table 2: NPI Reporting Detail

Each TIN/NPI who submitted any claims for Medicare Part B Physician Fee Schedule (PFS) covered professional services for which one or more PQRI quality measures applied will receive Table 2. This report reflects measures that were reported satisfactorily by each TIN/NPI.

- **Total # Measures Denominator Eligible with QDCs:** The number of measures for which a TIN/NPI reported a valid quality-data code (QDC).
- **Total # Measures Satisfactorily Reported:** The total number of measures the TIN/NPI reported at a satisfactory rate; satisfactory rate is reporting on 80% or more of eligible instances.
- **Reporting Rate:** For each measure with eligible instances, the TIN/NPI's reporting rate is calculated by finding the quotient of the number of numerator eligible reporting instances divided by the number of denominator eligible instances.

For definition of terms related to 2007 re-run and 2008 PQRI feedback reports see **Appendix A**. Also refer to the footnotes within each table for additional content detail. All eligible TIN/NPIs will have detailed reports generated for them.

Example 2.1

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the Eligible Professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. Valid submissions are where a quality-data code is submitted and all measure-eligibility is met (i.e. correct age, gender, diagnosis and CPT). For those NPIs satisfactorily reporting by multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. The results below include: a Participation Summary table listing all of the individual NPI's reporting methods attempted, an Incentive Detail table listing the reporting method upon which the incentive is based, and a Reporting Detail table listing all of the measures reported by the individual NPI's with the reporting rates. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 2: NPI Reporting Detail
Sorted by Reporting Rate and sub-sorted by Reporting Denominator: Applicable Cases

Tax ID Name«: John Q. Public Clinic
Tax ID Number: XXXXX6789
NPI Number: 1000000012

This shows all of the methods in which an NPI attempted to report.

Detail from Table 1 for the reporting method in which the NPI earned an incentive.

The reporting detail shows the four measures reported and that the NPI satisfactorily reported on three of the four resulting in three measures having a reporting rate at or above 80%.

Participation Summary

All Methods Reported	Reporting Period	Registry Associated	Qualified for Incentive	Reporting Period Used for Incentive◊◊
Individual measure(s) reporting via claims	12 months	N/A	Yes	Yes
Individual measure(s) reporting via registry	6 months	ICLOPS	Yes	No
Individual measure(s) reporting via registry	12 months	STS	No	N/A

Incentive Detail for Individual Measure(s) Reporting via Claims

NPI	NPI Name«	Earned Incentive●				Total # Measures with QDCs Submitted^	Total # Measures Denominator Eligible with QDCs~	Total # Measures Satisfactorily Reported‡	Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
		Method of Reporting	Reporting Period	Yes/No	Rationale					
1000000012	Doe, John	Individual measure(s) reporting via claims	12 months	Yes	Sufficient # of measures reported at 80%	6	4	3	$80,000.00	$1,200.00

Reporting Detail

Measure #	Measure Title (Measure #)▲	Measure Type■	Reporting Denominator: Applicable Casesℓ	Numerator: Valid QDCs Reported◊	Reporting Rate»	Measure Validation Clinical Focus Area‡
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation (#51)	Patient-Process	200	180	90.0%	COPD Care
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy (#32)	Episode	90	74	82.2%	Stroke Discharge
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy (#52)	Patient-Process	500	400	80.0%	COPD Care
#33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge (#33)	Episode	70	42	60.0%	Stroke Discharge

Only applicable to EPs submitting individual measures via claims.

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollm changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indic does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.
◊◊The method of reporting deemed most advantageous will be indicated with a "Yes". If the NPI did not qualify for incentive through any reporting methods, the reporting method that was most advantageous would be populated with N/A.
●An NPI satisfactorily reporting at least one claims-based reporting method or at least one registry-based reporting method and passing the applicable validation process is eligible to receive a PQRI incentive. More information regarding the incentive calculations is available on the CMS website.
^The number of quality-data codes (QDCs) submitted, but are not necessarily valid. These instances do not count towards reporting success.
~The number of measures for which the TIN/NPI reported a valid quality-data code (QDC).
‡The total number of measures the TIN/NPI reported at a satisfactory rate; satisfactory rate is for ≥ 80% of instances.
□The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) charges associated with services rendered during the reporting period. The PFS claims included were based on the six or twelve month reporting period for the method by which the NPI was incentive eligible.
*The amount of the incentive is based on the total estimated allowed Medicare Part B Physician Fee Schedule (PFS) charges processed within the length of the longest reporting period satisfied by the eligible professional.
▲Reference number for each measure, according to the 2008 PQRI Quality Measures Specifications document on the CMS PQRI website.
■The analytic category for each measure that determines how the measure will be calculated for PQRI. Measure types can be found in the PQRI Feedback Report User Guide.
ℓThe number of instances the TIN/NPI was eligible to report the measure. The number of eligible denominator instances found in claims.
◊The number of reporting instances where the quality-data codes (QDCs) submitted met the measure specific reporting criteria.
»A satisfactorily-reported measure has a reporting rate of 80% or greater.
‡Eligible professionals may find that they have opportunities to report measures in areas that are clinically-related to measures they have chosen to report. The clinical focus area, according to the measure-applicability validation (MAV) process, for each measure is indicated. Please note that some measures may be generally applicable and are not part of a clinical focus area. A detailed description of the MAV process is available on the CMS website.

Figure 2.1 Screenshot of Table 2 for Individual Measures via Claims: NPI Reporting Detail

Example 2.2

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the Eligible Professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. Valid submissions are where a quality-data code is submitted and all measure-eligibility is met (i.e. correct age, gender, diagnosis and CPT). For those NPIs satisfactorily reporting by multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. The results below include: a Participation Summary table listing all of the individual NPI's reporting methods attempted, an Incentive Detail table listing the reporting method upon which the incentive is based, and a Reporting Detail table listing all of the measures reported by the individual NPI's with the reporting rates. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 2: NPI Reporting Detail
Sorted by Reporting Rate

Tax ID Name«: John Q. Public Clinic
Tax ID Number: XXXXX6789
NPI Number: 1000000003

This column will display all methods in which the NPI reported, whether satisfactorily or not.

If the reporting method is through a registry, this will be populated. If not, it will say N/A.

The rationale indicates the reason an NPI was or was not incentive eligible.

Participation Summary

All Methods Reported	Reporting Period	Registry Associated	Qualified for Incentive	Reporting Period Used for Incentive◊◊
Individual measure(s) reporting by registry	12 months	ACC	Yes	Yes
80% Measures Groups patients via registry	12 months	SVS	Yes	No

Incentive Detail for Individual Measure(s) Reporting via Registry

NPI	NPI Name«	Earned Incentive●					Total # Measures with QDCs Submitted^	Total # Measures Denominator Eligible with QDCs~	Total # Measures Satisfactorily Reported‡	Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
		Method of Reporting	Reporting Period	Registry Associated	Yes/No	Rationale					
1000000003	Not Available	Individual measure(s) reporting via registry	12 months	ACC	Yes	Sufficient # of measures reported at 80%	6	4	3	$133,333.33	$2,000.00

Reporting Detail

Measure #	Measure Title (Measure #)▲	Measure Type■	Reporting Denominator: Applicable Cases	Reporting Rate
#31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage (#31)	Episode	520	86.7%
#35	Stroke and Stroke Rehabilitation: Screening for Dysphagia (#35)	Episode	450	84.9%
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services (#36)	Episode	410	82.0%
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy (#32)	Episode	375	72.0%

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.

◊◊The method of reporting deemed most advantageous will be indicated with a "Yes". If the NPI did not qualify for incentive through any reporting methods, the reporting method that was most advantageous would be populated with N/A.

●An NPI satisfactorily reporting at least one claims-based reporting method or at least one registry-based reporting method and passing the applicable validation process is eligible to receive a PQRI incentive. More information regarding the incentive calculations is available on the CMS website.

^The number of quality-data codes (QDCs) submitted, but are not necessarily valid. These instances do not count towards reporting success.

~The number of measures for which the TIN/NPI reported a valid quality-data code (QDC).

‡The total number of measures the TIN/NPI reported at a satisfactory rate; satisfactory rate is for ≥ 80% of instances.

□The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) charges associated with services rendered during the reporting period. The PFS claims included were based on the six or twelve month reporting period for the method by which the NPI was incentive eligible.

*The amount of the incentive is based on the total estimated allowed Medicare Part B Physician Fee Schedule (PFS) charges processed within the length of the longest reporting period satisfied by the eligible professional.

▲Reference number for each measure, according to the 2008 PQRI Quality Measures Specifications document on the CMS PQRI website.

■The analytic category for each measure that determines how the measure will be calculated for PQRI. Measure types can be found in the PQRI Feedback Report User Guide.

Figure 2.2 Screenshot of Table 2 for Individual Measures via Registry: NPI Reporting Detail (2008 only)

Example 2.3

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the Eligible Professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. Valid submissions are where a quality-data code is submitted and all measure-eligibility is met (i.e. correct age, gender, diagnosis and CPT). For those NPIs satisfactorily reporting by multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. The results below include: a Participation Summary table listing all of the individual NPI's reporting methods attempted, an Incentive Detail table listing the reporting method upon which the incentive is based, and a Reporting Detail table listing all of the measures reported by the individual NPI's with the reporting rates. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

www.cms.hhs.gov/pqri

Table 2: NPI Reporting Detail
Sorted by # of Beneficiaries Eligible

Tax ID Name«: John Q. Public Clinic
Tax ID Number: XXXXX6789
NPI Number: 1000000004

There are nine different reporting methods for 2008 – three through claims and six through registries. These are listed in Appendix A.

Participation Summary				
All Methods Reported	Reporting Period	Registry Associated	Qualified for Incentive	Reporting Period Used for Incentive◊◊
80% Measures Groups beneficiaries via claims	6 months	N/A	Yes	Yes

Incentive Detail for 80% Measures Groups Beneficiaries via Claims							
		Earned Incentive●					
NPI	NPI Name«	Method of Reporting	Reporting Period	Yes/No	Rationale	Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
1000000004	Not Available	80% Measures Groups beneficiaries via claims	6 months	Yes	Sufficient # of beneficiaries reported at 80%	$63,333.33	$950.00

NPI reported ESRD Measures Group. The reporting detail shows all of the measures within that measures group and the breakdown of QDCs submitted for the measures.

Reporting Detail				
Measure #	Measures Groups (with Measures Titles and #)►	# of Beneficiaries Eligible♦	# of Beneficiaries Reported●●	% of Eligible Beneficiaries Reported
N/A	**End Stage Renal Disease Measures Group►►**	250	215	86.0%
#78	Vascular Access for Patients Undergoing Hemodialysis (#78)	250	220	88.0%
#79	Influenza Vaccination in Patients with ESRD (#79)	250	225	90.0%
#80	Plan of Care for ESRD Patients with Anemia (#80)	250	215	86.0%
#81	Plan of Care for Inadequate Hemodialysis in ESRD Patients (#81)	250	215	86.0%
#82	Plan of Care for Inadequate Peritoneal Dialysis (#82)	250	215	86.0%

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.
●An NPI satisfactorily reporting at least one claims-based reporting method or at least one registry-based reporting method and passing the applicable validation process is eligible to receive a PQRI incentive. More information regarding the incentive calculations is available on the CMS website.

□The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) charges associated with services rendered during the reporting period. The PFS claims included were based on the six or twelve month reporting period for the method by which the NPI was incentive eligible.
*The amount of the incentive is based on the total estimated allowed Medicare Part B Physician Fee Schedule (PFS) charges processed within the length of the longest reporting period satisfied by the eligible professional.
►Each measure within the measures group is analyzed as a patient-process measure. Patient-process measures can be found in the 2008 PQRI Feedback Report User Guide.
►►This count is for all measures reported within the measures group.
♦The # of beneficiaries meeting the denominator inclusion criteria for at least one measure within the measures group.
●●The # of beneficiaries for which this TIN/NPI submitted one or more Quality-Data Code(s) (QDCs) corresponding with the eligible measures within the measures group.

Figure 2.3 Screenshot of Table 2 for Measures Groups via Claims: NPI Reporting Detail (2008 only)

Example 2.4

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the Eligible Professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. Valid submissions are where a quality-data code is submitted and all measure-eligibility is met (i.e. correct age, gender, diagnosis and CPT). For those NPIs satisfactorily reporting by multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. The results below include: a Participation Summary table listing all of the individual NPI's reporting methods attempted, an Incentive Detail table listing the reporting method upon which the incentive is based, and a Reporting Detail table listing all of the measures reported by the individual NPI's with the reporting rates. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

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Table 2: NPI Reporting Detail
Sorted by # of Patients Eligible

Tax ID Name«: John Q. Public Clinic
Tax ID Number: XXXXX6789
NPI Number: 1000000006

Participation Summary				
All Methods Reported	Reporting Period	Registry Associated	Qualified for Incentive	Reporting Period Used for Incentive◊◊
80% Measures Groups patients via registry	12 months	Cedaron	Yes	Yes

Incentive Detail for 80% Measures Groups Patients via Registry								
		Earned Incentive●					Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
NPI	NPI Name«	Method of Reporting	Reporting Period	Registry Associated	Yes/No	Rationale		
1000000006	Not Available	80% Measures Groups patients via registry	12 months	Cedaron	Yes	Sufficient # of patients reported at 80%	$166,666.66	$2,500.00

Reporting Detail			
Measure #	Measures Groups (with Measures Titles and #)►	# of Patients Eligible**	% of Eligible Patients Reported
N/A	**End Stage Renal Disease Measures Group►►**	462	93.0%
#78	Vascular Access for Patients Undergoing Hemodialysis (#78)	462	85.0%
#79	Influenza Vaccination in Patients with ESRD (#79)	462	80.0%
#80	Plan of Care for ESRD Patients with Anemia (#80)	462	82.0%
#81	Plan of Care for Inadequate Hemodialysis in ESRD Patients (#81)	462	90.0%
#82	Plan of Care for Inadequate Peritoneal Dialysis (#82)	462	93.0%

ESRD is one of four Measures Groups used in 2008 PQRI. The measures within this particular Measures Group are listed as well.

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.
●An NPI satisfactorily reporting at least one claims-based reporting method or at least one registry-based reporting method and passing the applicable validation process is eligible to receive a PQRI incentive. More information regarding the incentive calculations is available on the CMS website.
□The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) charges associated with services rendered during the reporting period. The PFS claims included were based on the six or twelve month reporting period for the method by which the NPI was incentive eligible.
*The amount of the incentive is based on the total estimated allowed Medicare Part B Physician Fee Schedule (PFS) charges processed within the length of the longest reporting period satisfied by the eligible professional.
►Each measure within the measures group is analyzed as a patient-process measure. Patient-process measures can be found in the 2008 PQRI Feedback Report User Guide.
►►This count is for all measures reported within the measures group.
**The # of patients meeting the denominator inclusion criteria for at least one measure within the measures group.

Figure 2.4 Screenshot of Table 2 for Measures Groups via Registry: NPI Reporting Detail (2008 only)

Example 2.5

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the Eligible Professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. Valid submissions are where a quality-data code is submitted and all measure-eligibility is met (i.e. correct age, gender, diagnosis and CPT). For those NPIs satisfactorily reporting by multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. The results below include: a Participation Summary table listing all of the individual NPI's reporting methods attempted, an Incentive Detail table listing the reporting method upon which the incentive is based, and a Reporting Detail table listing all of the measures reported by the individual NPI's with the reporting rates. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 2: NPI Reporting Detail
Sorted by Number of Beneficiaries Reported

Tax ID Name«: John Q. Public Clinic
Tax ID Number: XXXXX6789
NPI Number: 1000000013

The NPI reported two different methods. It qualified through only one method; therefore, the incentive will be paid based on that method. Since the NPI did not qualify for the other method, N/A will show in the "Reporting Period Used for Incentive" field.

Participation Summary

Other Methods Reported	Reporting Period	Registry Associated	Qualified for Incentive	Reporting Period Used for Incentive◊◊
Consecutive Measures Groups beneficiaries via claims	6 months	N/A	Yes	Yes
Individual measure(s) reporting via registry	6 months	Cedaron	No	N/A

Incentive Detail for Consecutive Measures Groups Beneficiaries via Claims

NPI	NPI Name«	Earned Incentive●				Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
		Method of Reporting	Reporting Period	Yes/No	Rationale		
1000000013	Not Available	Consecutive Measures Groups beneficiaries via claims	6 months	Yes	Sufficient # of consecutive beneficiaries reported	$86,666.66	$1,300.00

Reporting Detail

Measure #	Measures Groups (with Measures Titles and #)►	# of Beneficiaries EligibleΔΔ	# of Beneficiaries Reported◊◊
N/A	**Diabetes Mellitus Measures Group►►**	15	15
#1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus (#1)	15	15
#2	Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus (#2)	15	15
#3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus (#3)	15	15
#18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy (#18)	15	15
#19	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (#19)	15	15
#117	Dilated Eye Exam in Diabetic Patient (#117)	15	15
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients (#119)	15	15
#126	Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation (#126)	15	15
#127	Diabetic Foot and Ankle Care, Evaluation of Footwear (#127)	15	15

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive
◊◊The method of reporting deemed most advantageous will be indicated with a "Yes". If the NPI did not qualify for incentive through any reporting methods, the reporting method that was most advantageous would be populated with N/A.
●An NPI satisfactorily reporting at least one claims-based reporting method or at least one registry-based reporting method and passing the applicable validation process is eligible to receive a PQRI incentive. More information regarding the incentive calculations is available on the CMS website.
□The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) charges associated with services rendered during the reporting period. The PFS claims included were based on the six or twelve month reporting period for the method by which the NPI was incentive eligible.
*The amount of the incentive is based on the total estimated allowed Medicare Part B Physician Fee Schedule (PFS) charges processed within the length of the longest reporting period satisfied by the eligible professional.
►Each measure within the measures group is analyzed as a patient-process measure. Patient-process measures can be found in the 2008 PQRI Feedback Report User Guide.
►►This count is for all measures reported within the measures group.
ΔΔThe # of consecutive beneficiaries meeting the denominator inclusion criteria for at least one measure within the measures group.
◊◊The # of consecutive beneficiaries for which this TIN/NPI submitted one or more Quality-Data Code(s) (QDCs) corresponding with the eligible measures within the measures group.

Figure 2.5 Screenshot of Table 2 for Measures Groups via Claims: NPI Reporting Detail (2008 only)

Example 2.6

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the Eligible Professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. Valid submissions are where a quality-data code is submitted and all measure-eligibility is met (i.e. correct age, gender, diagnosis and CPT). For those NPIs satisfactorily reporting by multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. The results below include: a Participation Summary table listing all of the individual NPI's reporting methods attempted, an Incentive Detail table listing the reporting method upon which the incentive is based, and a Reporting Detail table listing all of the measures reported by the individual NPI's with the reporting rates. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 2: NPI Reporting Detail
Sorted by # of Patients Eligible

Tax ID Name«: John Q. Public Clinic
Tax ID Number: XXXXX6789
NPI Number: 1000000009

Participation Summary				
All Methods Reported	Reporting Period	Registry Associated	Qualified for Incentive	Reporting Period Used for Incentive◊◊
Consecutive Measures Groups patients via registry	12 months	ICLOPS	Yes	Yes

Incentive Detail for Consecutive Measures Groups Patients via Registry								
		Earned Incentive●						
NPI	NPI Name«	Method of Reporting	Reporting Period	Registry Associated	Yes/No	Rationale	Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
1000000009	Smithson, Steve	Consecutive Measures Groups patients via registry	12 months	ICLOPS	Yes	Sufficient # of consecutive patients reported	$166,666.66	$2,500.00

Reporting Detail			
Measure #	Measures Groups (with Measures Titles and #)►	# of Patients Eligible°°°	% of Eligible Patients Reported
N/A	**Preventive Care Measures Group►►**	30	100.0%
#39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older (#39)	30	100.0%
#48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older (#48)	30	100.0%
#110	Preventive Care and Screening: Influenza Immunization for Patients > 50 Years Old (#110)	30	100.0%
#111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older (#111)	30	100.0%
#112	Preventive Care and Screening: Screening Mammography (#112)	30	100.0%
#113	Preventive Care and Screening: Colorectal Cancer Screening (#113)	30	100.0%
#114	Preventive Care and Screening: Inquiry Regarding Tobacco Use (#114)	30	100.0%
#115	Preventive Care and Screening: Advising Smokers to Quit (#115)	30	100.0%
#128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (#128)	30	100.0%

The NPI satisfactorily reported for all of the measures within this Measures Group for at least 30 consecutive patients.

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●An NPI satisfactorily reporting at least one claims-based reporting method or at least one registry-based reporting method and passing the applicable validation process is eligible to receive a PQRI incentive. More information regarding the incentive calculations is available on the CMS website.
□The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) charges associated with services rendered during the reporting period. The PFS claims included were based on the six or twelve month reporting period for the method by which the NPI was incentive eligible.
*The amount of the incentive is based on the total estimated allowed Medicare Part B Physician Fee Schedule (PFS) charges processed within the length of the longest reporting period satisfied by the eligible professional.
►Each measure within the measures group is analyzed as a patient-process measure. Patient-process measures can be found in the 2008 PQRI Feedback Report User Guide.
►►This count is for all measures reported within the measures group.
°°°The # of consecutive patients, as specified by the registry, meeting the denominator inclusion criteria for at least one measures within the measures group.

Figure 2.6 Screenshot of Table 2 for Measures Groups via Registry: NPI Reporting Detail (2008 only)

Table 3: NPI QDC Submission Error Detail

For the 2007 re-run and 2008 PQRI, only NPIs reporting through claims-based measure submission with QDC submission errors will receive Table 3. This would only apply to EPs who are submitting at least one insufficient QDC.

For definition of terms related to 2007 re-run and 2008 PQRI feedback reports see **Appendix A**. Also refer to the footnotes within each table for additional content detail.

Example 3.1

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. The individual NPI's quality-data code (QDC) submission error results are below. There will be one NPI detail report for each TIN/NPI participating in PQRI. Participation is defined as Eligible Professionals (EPs) submitting at least one valid QDC via claims or submitting data via a qualified registry. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Disclaimer stating that the last five columns of the detail table are mutually exclusive.

Table 3: NPI QDC Submission Error Detail
Sorted by Measure

Incorrect CPT, Incorrect DX, Incorrect CPT and DX, Only QDC on Claim, and Only QDC and Incorrect DX are all mutually exclusive. If there is an incorrect CPT code and also an incorrect diagnosis, it will only fall into the "Both Incorrect CPT and DX" cell for that measure and will not fall into the other two cells.

Tax ID Name«: John Q. Public Clinic
NPI Name«: Doe, John
NPI Number: 1000000012
Method of Reporting: Individual measure(s) reporting via claims for 12 months

NPIs will only receive this table if they submitted measures with a percent valid less than 100%.

QDC Submission Error Detail												
			QDC Occurrences			QDC Exceptions (Denominator Mismatches)						
Measure #	Measure Title (Measure #)▲	Measure Type■	Actual # Reported[Ω]	Numerator: Valid QDCs Reported◊	% of Valid QDCs Accepted≈	Gender	Age	Only Incorrect CPT	Only Incorrect DX	Both Incorrect CPT and DX[F]	Only QDC on Claim (no CPT)[⌂]	Only QDC and Incorrect DX[ξ]
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy (#32)	Episode	99	74	74.7%	0	0	13	5	4	1	2
#33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge (#33)	Episode	54	42	77.8%	0	0	8	2	0	2	0
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation (#51)	Patient-Process	210	180	85.7%	0	0	21	2	7	0	0
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy (#52)	Patient-Process	410	400	97.6%	0	0	3	7	0	0	0
#53	Asthma: Pharmacologic Therapy (#53)	Patient-Process	50	0	0.0%	0	25	12	32	4	2	0
#64	Asthma Assessment (#64)	Patient-Process	25	0	0.0%	0	15	14	2	8	0	1

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.
ΩNumber of quality-data code (QDC) submissions for a measure whether or not the QDC submission was valid and
◊Number of valid and appropriate quality-data code (QDC) submissions for a measure.
≈The percentage of reported quality-data codes (QDCs) that were valid.
FNumber of invalid quality-data code (QDC) submissions resulting from a combination of incorrect CPT code and incorrect diagnosis code (DX).
⌂Number of invalid quality-data code (QDC) submissions due to a missing qualifying denominator code since all lines were QDCs.
ξNumber of invalid QDC submissions due to a missing qualifying denominator code since all lines were quality-data codes (QDCs) and the diagnosis codes (DXs) were incorrect.
Note: A QDC submission attempt may be counted for age, gender, and one of the following: Incorrect CPT, Incorrect DX, Both Incorrect CPT and DX, Only QDC on Claim (no CPT), and Only QDC and Incorrect DX (i.e. a submission attempt may be counted for age, gender, and incorrect DX).

Figure 3.1 Screenshot of Table 3: NPI QDC Submission Error Detail

Table 4: NPI Performance Detail

Each TIN/NPI will receive Table 4 if they are newly-incentive eligible for the 2007 re-run through claims-based reporting and/or participating in the 2008 PQRI through any reporting method. Note: This information is provided for informational and performance improvement purposes. Performance rates do not affect the incentive payment for the 2007 re-run or 2008 PQRI.

- **Clinical Performance Rate:** For each measure, the TIN/NPI's clinical performance rate reported is calculated by finding the quotient of the Clinical Performance Met (Numerator) for the measure divided by the Performance Denominator for the measure. For "poor control" or "inappropriate care" measures, it is desirable to have a lower rate. For all other PQRI measures, it is desirable to have a higher rate. Performance exclusion modifiers and/or codes recognized by a given measure in the measure specification exclude that instance from the performance denominator and are not included when calculating the performance rate.
- **Clinical Performance Not Met:**
  - **QDC Reported:** The number of QDC(s) reported to indicate that clinical performance was not met. This includes instances where a CPT II code with an 8P modifier or G-code was used as a performance failure for the measure.
- **Insufficient QDC Information:** The number of instances where clinical performance was not met due to insufficient QDC information from the TIN/NPI combination. Insufficient QDC submission can be a result of an incorrect modifier for a measure (i.e., submitting a 2P when it is not an appropriate exclusion according to the measure specification) and/or not submitting all required QDCs for a measure numerator (i.e., only submitting one QDC when two are required).

For definition of terms related to 2007 re-run and 2008 PQRI feedback reports see **Appendix A**. Also refer to the footnotes within each table for additional content detail. Only individuals (within the TIN) submitting valid QDCs will have detailed reports generated for them.

Example 4.1

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the eligible professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. For those NPIs satisfactorily reporting multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. There will be one NPI performance detail report for each TIN/NPI participating in PQRI. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 4: NPI Performance Detail
Sorted by Clinical Performance Rate

Numerator Eligible Reporting Instances = 1P + 2P + 3P + Other + Clinical Performance Denominator
Clinical Performance Denominator = Clinical Performance Numerator + QDC Reported + Insufficient QDCs

Insufficient QDC submission can be a result of an incorrect modifier for a measure (i.e., submitting a 2P when it is not an appropriate exclusion according to the measure specification) and/or not submitting all required QDCs for a measure numerator (i.e., only submitting one QDC when two are required).

Tax ID Name«: John Q. Public Clinic
NPI Name«: Doe, John
NPI Number: 1000000012
Method of Reporting: Individual measure(s) reporting via claims for 12 months

Performance Information														
			Numerator Eligible Instances Excluded							Clinical Performance Not Met		National Comparison for Performance◊◊◊		
Measure #	Measure Title (Measure #)▲	Numerator: Valid QDCs Reported◊	Medical (1P)	Patient (2P)	System (3P)	Other««	Clinical Performance Denominator¤¤	Clinical Performance Numerator Met‖	Clinical Performance Rate□□□	QDC Reported¤	Insufficient QDC Information[ℓ]	25th Percentile	50th Percentile	75th Percentile
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation (#51)	180	53	15	12	0	100	80	80.0%	20	0	23.2%	51.0%	84.3%
#33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge (#33)	42	6	4	0	0	32	18	56.3%	14	0	74.0%	81.4%	90.8%
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy (#52)	400	7	3	1	14	375	175	46.7%	102	98	0.0%	34.2%	72.1%
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy (#32)	74	18	2	0	0	54	15	27.8%	39	0	34.3%	52.8%	94.7%

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.
▲Reference number for each measure, according to the 2008 PQRI Quality Measures Specifications document on the CMS PQRI website.
◊The number of reporting instances where the quality-data codes (QDCs) submitted met the measure specific reporting criteria.
««Includes instances where a CPT II code, G-code, or 8P modifier is used as a performance exclusion for the measure.
¤¤The performance denominator is determined by subtracting the number of eligible instances excluded from the numerator eligible reporting instances. Valid reasons for exclusions may apply and are specific to each measure. The 2008 PQRI Quality Measures Specifications document is available on the CMS PQRI website.
‖The number of instances the TIN/NPI submitted the appropriate quality-data code(s) (QDCs) satisfactorily meeting the performance requirements for the measure.
□□□The Clinical Performance Rate is calculated by dividing the Clinical Performance Numerator by the Clinical Performance Denominator.
¤Includes instances where a CPT II code with an 8P modifier or G-code is used to indicate the quality action was not provided for a reason not otherwise specified.
ℓThe number of instances where clinical performance was not met due to insufficient quality-data code (QDC) information/numerator coding not complete for the measure from the TIN/NPI combination (e.g. two numerator codes are necessary for the measure, only one was submitted; inappropriate CPT II modifier submitted for the measure).
◊◊◊The National Comparison for Performance includes performance information for all TIN/NPI combinations submitting at least one quality-data code (QDC) for the measure. The 25th percentile indicates that 25% of the TIN/NPI combinations participating nationally are performing at or below this rate, the 50th percentile indicates that 50% of the TIN/NPI combinations participating nationally are performing at or below this rate, and the 75th percentile indicates that 75% of the TIN/NPI combinations participating nationally are performing at or below this rate.
Note: For the Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus (#1) measure, a lower performance rate indicates better performance.
Note: The registry information is based on data aggregated across 2008 PQRI participating registries.

Figure 4.1. Screenshot of Table 4 for Individual Measures via Claims: NPI Performance Detail

Example 4.2

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the eligible professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. For those NPIs satisfactorily reporting multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. There will be one NPI performance detail report for each TIN/NPI participating in PQRI. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 4: NPI Performance Detail
Sorted by Clinical Performance Rate

For measure #120, the # of eligible patients is the sum of the eligible instances excluded, the performance numerator met and performance not met. 32 + 385 + 45 = 462

NPI Name«: Jones, Joe
NPI Number: 1000000222
Tax ID Name«: Not Available
Method of Reporting: 80% Measures Groups patients via registry for 12 months

Performance Information						
Measure #	Measures Groups (with Measures Titles and #)►	# of Eligible Patients	Eligible Instances Excluded	Clinical Performance Numerator Met‖	Clinical Performance Not Met	Clinical Performance Rate
N/A	**Chronic Kidney Disease Measures Group**					
#120	ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD (#120)	462	32	385	45	89.5%
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile) (#121)	462	24	323	115	80.7%
#122	Blood Pressure Management (#122)	462	15	352	95	78.7%
#123	Receiving Erythropoiesis-Stimulating Agents (ESA) (#123)	462	22	365	75	73.7%

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.
►Each measure within the measures group is analyzed as a patient-process measure. Patient-process measures can be found in the 2008 PQRI Feedback Report
‖The number of instances the TIN/NPI submitted the appropriate quality-data code(s) (QDCs) satisfactorily meeting the performance requirements for the measure.

Figure 4.2. Screenshot of Table 4 for Measures Groups via Registry: NPI Performance Detail (2008 only)

Example 4.3

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the eligible professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. For those NPIs satisfactorily reporting multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. There will be one NPI performance detail report for each TIN/NPI participating in PQRI. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 4: NPI Performance Detail

Sorted by Clinical Performance Rate and sub-sorted by Number of Eligible Beneficiaries

The clinical performance rate is a result of the clinical performance numerator met divided by the clinical performance denominator. For measure #78, it's 173 divided by 198 for 87.4%.

NPI Name«: Jones, Joe
NPI Number: 1000000222
Tax ID Name«: Heart Clinic
Method of Reporting: 80% Measures Groups beneficiaries via claims for 6 months

Performance Information											
			Eligible Instances Excluded						Clinical Performance Not Met		
Measure #	Measures Groups (with Measures Titles and #)►	# of Eligible Beneficiaries	Medical (1P)	Patient (2P)	System (3P)	Other««	Clinical Performance Denominator¤¤	Clinical Performance Numerator Met‖	QDC Reported¤	Insufficient QDC Information	Clinical Performance Rate□□□
N/A	**End Stage Renal Disease (ESRD) Measures Group**										
#79	Influenza Vaccination in Patients with End Stage Renal Disease (ESRD) (#79)	250	8	15	4	0	223	203	8	12	91.0%
#78	Vascular Access for Patients Undergoing Hemodialysis (#78)	250	12	8	19	13	198	173	4	9	87.4%
#81	Plan of Care for Inadequate Hemodialysis in ESRD Patients (#81)	250	4	12	6	7	221	170	14	25	76.9%
#80	Plan of Care for ESRD Patients with Anemia (#80)	250	5	11	0	4	230	175	15	16	76.1%

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.

►Each measure within the measures group is analyzed as a patient-process measure. Patient-process measures can be found in the 2008 PQRI Feedback Report User Guide.

««Includes instances where an 8P modifier, G-code, or CPT II code is used as a performance exclusion for the measure.

¤¤The performance denominator is determined by subtracting the number of eligible instances excluded from the number of eligible beneficiaries. Valid reasons for exclusions may apply, these are specific to each measure. The PQRI Coding for Quality Handbook containing measure specific information is available on the CMS website.

¤Includes instances where an 8P modifier, G-code or CPT II code is used to indicate the quality action was not provided for a reason not otherwise specified.

‖The number of instances theTIN/NPI submitted the appropriate quality-data code(s) (QDCs) satisfactorily meeting the performance requirements for the measure.

□□□The Clinical Performance Rate is calculated by dividing the Clinical Performance Numerator by the Performance Denominator.

Figure 4.3. Screenshot of Table 4 for Measures Groups via Claims: NPI Performance Detail (2008 only)

Example 4.4

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the eligible professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. For those NPIs satisfactorily reporting multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. There will be one NPI performance detail report for each TIN/NPI participating in PQRI. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 4: NPI Performance Detail

Sorted by Performance Rate and sub-sorted by Number of Eligible Beneficiaries

This indicates when an NPI submits a modifier or QDC as a performance exclusion.

NPI Name«: Billey, Bill
NPI Number: 1000000231
Tax ID Name«: South Public Clinic
Method of Reporting: Consecutive Measures Groups beneficiaries via claims for 6 months

Performance Information											
			Eligible Instances Excluded						Clinical Performance Not Met		
Measure #	Measures Groups (with Measures Titles and #)►	# of Eligible Beneficiaries	Medical (1P)	Patient (2P)	System (3P)	Other««	Clinical Performance Denominator ¤¤	Clinical Performance Numerator Met‖	QDC Reported¤	Insufficient QDC Information	Clinical Performance Rate□□□
N/A	**Diabetes Mellitus Measures Group**										
#117	Dilated Eye Exam in Diabetic Patient (#117)	15	1	2	0	0	12	12	0	0	100.0%
#1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus (#1)◙	15	0	0	0	0	15	12	2	0	80%◙
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients (#119)	15	0	1	0	0	14	11	1	0	78.6%
#3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus (#3)	15	0	0	0	0	15	11	1	1	73.3%
#2	Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus (#2)	15	0	0	0	0	15	10	4	0	66.7%

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.

►Each measure within the measures group is analyzed as a patient-process measure. Patient-process measures can be found in the 2008 PQRI Feedback Report User Guide.

««Includes instances where an 8P modifier, G-code, or CPT II code is used as a performance exclusion for the measure.

¤¤The performance denominator is determined by subtracting the number of eligible instances excluded from number of eligible beneficiaries. Valid reasons for exclusions may apply, these are specific to each measure. The PQRI Coding for Quality Handbook containing measure specific information is available on the CMS website.

‖The number of instances the TIN/NPI submitted the appropriate quality-data code(s) (QDCs) satisfactorily meeting the performance requirements for the measure.

¤Includes instances where an 8P modifier, G-code or CPT II code is used to indicate the quality action was not provided for a reason not otherwise specified.

□□□The Clinical Performance Rate is calculated by dividing the Clinical Performance Numerator by the Performance Denominator.

◙A lower performance rate indicates better performance for poor control measures.

Figure 4.4. Screenshot of Table 4 for Measures Groups via Claims: NPI Performance Detail (2008 only)

Example 4.5

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the eligible professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. For those NPIs satisfactorily reporting multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. There will be one NPI performance detail report for each TIN/NPI participating in PQRI. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 4: NPI Performance Detail
Sorted by Clinical Performance Rate

This table gives performance information for an NPI reporting the Diabetes Mellitus Measures Group.

NPI Name«: Billey, Bill
NPI Number: 1000000231
Tax ID Name«: Not Available
Method of Reporting: Consecutive Measures Groups patients via registry for 12 months

Performance Information						
Measure #	Measures Groups (with Measures Titles and #)►	# of Eligible Patients	Eligible Instances Excluded	Clinical Performance Numerator Met‖	Clinical Performance Not Met	Clinical Performance Rate
N/A	**Diabetes Mellitus Measures Group**					
#117	Dilated Eye Exam in Diabetic Patient (#117)	30	4	21	5	80.8%
#1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus (#1)◙	30	0	24	6	80.0%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients (#119)	30	1	23	6	79.3%
#3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus (#3)	30	6	21	3	77.8%
#2	Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus (#2)	30	0	23	7	76.7%

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.
►Each measure within the measures group is analyzed as a patient-process measure. Patient-process measures can be found in the 2008 PQRI Feedback Report User Guide.
‖The number of instances the TIN/NPI submitted the appropriate quality-data code(s) (QDCs) satisfactorily meeting the performance requirements for the measure.
◙A lower performance rate indicates better performance for poor control measures.

Figure 4.5. Screenshot of Table 4 for Measures Groups via Registry: NPI Performance Detail (2008 only)

Example 4.6

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the eligible professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as EPs submitting at least one valid QDC via claims or submitting data via a qualified registry. For those NPIs satisfactorily reporting multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. There will be one NPI performance detail report for each TIN/NPI participating in PQRI. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 4: NPI Performance Detail
Sorted by Clinical Performance Rate

This registry reported three measures with these clinical performance rates.

NPI Name«: Billey, Bill
NPI Number: 1000000231
Tax ID Name«: Not Available
Method of Reporting: Individual Measures via registry for 12 months

Performance Information						
Measure #	Measures Titles and #►	# of Eligible Patients	Eligible Instances Excluded	Clinical Performance Numerator Met‖	Clinical Performance Not Met	Clinical Performance Rate
#117	Dilated Eye Exam in Diabetic Patient (#117)	220	33	180	7	81.8%
#1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus (#1)◙	184	22	150	12	81.5%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients (#119)	167	42	118	7	70.7%

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment, only the system's ability to populate this field in the report.

►Each measure within the measures group is analyzed as a patient-process measure. Patient-process measures can be found in the 2008 PQRI Feedback Report User Guide.

‖The number of instances the TIN/NPI submitted the appropriate quality-data code(s) (QDCs) satisfactorily meeting the performance requirements for the measure.

◙A lower performance rate indicates better performance for poor control measures.

Figure 4.6. Screenshot of Table 4 for Individual Measures via Registry: NPI Performance Detail (2008 only)

Accessing Feedback Reports from the PQRI Portal

2007 re-run and 2008 PQRI feedback reports will be available through a PQRI Portal on a secured website, My QualityNet (http://www.qualitynet.org), downloadable as an Adobe® Acrobat® PDF in the fall of 2009. This User Guide assumes that you already have an Individuals Authorized Access to the CMS Computer Services **(IACS) account** for a PQRI role, which is required to log on to the PQRI Portal (see http://www.cms.hhs.gov/IACS/). MLN articles with additional IACS information can be found on the CMS website at:

- http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf – first article in this series provides an overview of the IACS-Provider Community (IACS-PC) registration process as well as registration instructions for Security Officials (SOs) and individual practitioners
- http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf – second article addresses questions and gives remaining instructions for registering provider organizations including registering as a Backup Security Official (BSO), User Group Administrator (UGA), and End User (EU). It also discusses approving user requests.
- http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf – third article discussing the final steps in accessing CMS enterprise applications has been released on this issue

If you have completed IACS vetting for a PQRI role and the TIN has a report, an e-mail will be sent to you alerting you to the report's availability. The PQRI Portal via QualityNet is the secured entry point to access the reports. Your report is safely stored online for a limited time and accessible only to you (and those you specifically authorize) through the IACS web application.

Follow these four steps for logging on to the PQRI Portal. Note: For more in-depth instructions, see the PQRI Portal User Guide on the QualityNet website (http://www.qualitynet.org).

Logging in to the PQRI Portal

Step 1: Go to PQRI Portal via QualityNet

Go to the PQRI Portal at http://www.qualitynet.org/pqri and click the Sign In button.

Step 2: Login (using IACS Username and Password)

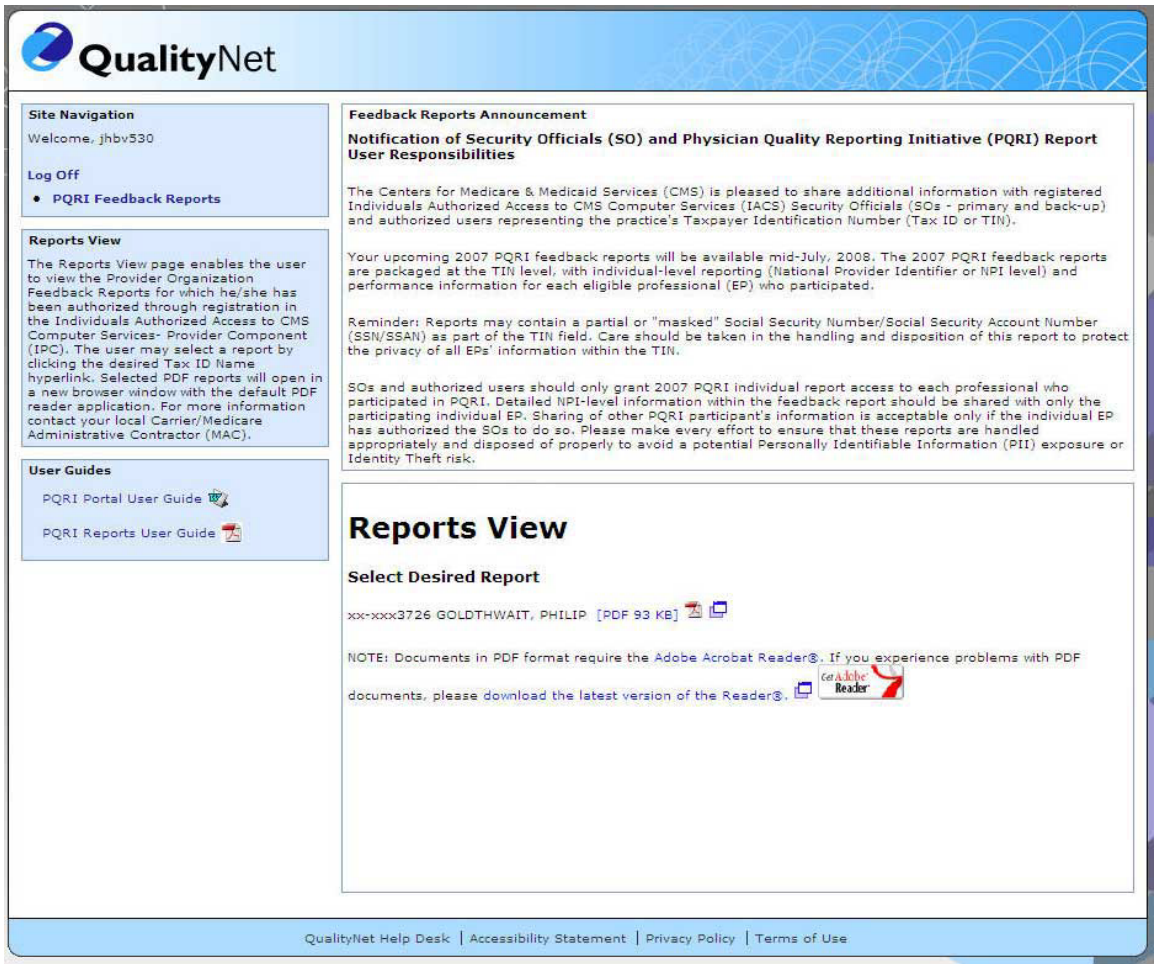
Enter **IACS Username** and **Password** to log in to the PQRI Portal. If you do not have an IACS account for a PQRI role, click the Register link and follow the IACS registration steps.

Step 3: Accept Terms and Conditions

A warning screen appears. You will need to accept the Terms and Conditions to proceed.

Step 4: Authenticated PQRI User Community

You will see this screen once you have logged in successfully.



Key Facts about PQRI Incentive Eligibility and Amount Calculation

Measure Applicability Validation (MAV) and Incentive Eligibility

As required by the Tax Relief and Health Care Act of 2006 (TRHCA), the 2007 re-run and 2008 PQRI included a validation process to ensure that each EP satisfactorily reported the minimum number of measures. EPs who satisfactorily submitted QDCs for fewer than three PQRI measures for at least 80% of their patients, eligible for each measure reported, are subject to MAV to determine whether they should have submitted QDCs for additional measure(s). For more information, refer to PQRI FAQs on the CMS PQRI website and the 2007 MAV document at http://www.cms.hhs.gov/PQRI/Downloads/PQRI_Validation.pdf and the 2008 MAV document at http://www.cms.hhs.gov/PQRI/Downloads/2008_Measure-Applicability_Validation_Process_for_Claims-Based_Participation.pdf.

Lump-Sum Incentive Payment

Payment Calculations

- The 1.5% incentive will be based on CMS' estimate of all Medicare Part B PFS allowed charges for covered professional services: (1) furnished during the applicable 2007 or 2008 reporting period, (2) processed by the Carrier or A/B Medicare Administrative Contractor (MAC) no more than two months past the end of the reporting period, and (3) paid under or based on the PFS. PQRI incentive payments will be aggregated at the TIN level.
- For the incentive payment calculation, an EP eligible for the incentive is defined as a TIN/NPI who meets the PQRI criteria for satisfactory reporting for the applicable program year.
- The analysis of satisfactory reporting will be performed at the individual TIN/NPI level to identify each EP's services and quality data.
    - Incentive payments earned by individual EPs will be issued to the TIN under which he or she earned an incentive, based on the Medicare Part B PFS covered professional services claims submitted under the TIN, aggregating individual EPs' incentives to the TIN level.
    - For EPs who submit claims under multiple TINs, CMS plans to group claims by TIN for analysis and payment purposes. As a result, a professional who submits claims under multiple TINs may earn a PQRI incentive under one of the TINs and not the other(s), or may earn an incentive under each TIN. The PQRI financial incentive earned by any individual professional under a given TIN, based on the claims associated with that TIN, will be included in that TIN's aggregate PQRI incentive payment.
    - EPs who submit claims under one TIN or more than one TIN may earn a PQRI incentive payment under one of the TINs and not the other(s), or may earn an incentive payment under each TIN.
- For further information related to the incentive payment please refer to the 2007 PQRI Program and the 2008 PQRI Program pages on the CMS PQRI website (http://www.cms.hhs.gov/pqri).

Distribution

- Incentive payments will be issued to the TIN by the Carrier or A/B MAC in November of 2009 for the 2007 re-run and in October 2009 for 2008 electronically or via check, based on how the TIN normally receives payment for Medicare Part B PFS covered professional services furnished to Medicare beneficiaries.
- Incentive payments for the 2007 re-run and 2008 PQRI will be distributed separately.
- If a TIN submits claims to multiple Medicare claims-processing contractors (Carriers or A/B MACs), each contractor may be responsible for a proportion of the TIN incentive payment equivalent to the proportion of Medicare Part B PFS claims the contractor processed for the 2007 and 2008 PQRI reporting periods. *(Note: if splitting an incentive across contractors would result in any contractor issuing a PQRI incentive payment less than $20 to the TIN, the incentive will be issued by fewer contractors than may have processed PFS claims from the TIN for the reporting period).*

Frequent Concerns

- If your lump-sum incentive payment doesn't arrive, contact your Carrier or A/B MAC.
- If your incentive payment amount does not match what is reflected in your PQRI feedback report, contact your Carrier or A/B MAC. The incentive amount may differ by a penny or two from what is reflected in the feedback report due to rounding.
- The incentive payment and the PQRI feedback report will be issued separately. The payment, with the remittance advice, will be issued by the Carrier or A/B MAC and identified as a lump-sum PQRI incentive payment. CMS will provide the 2007 and 2008 PQRI feedback reports through a separate process.
- The Electronic Remittance Advice sends only a 2-character code (LS – lump sum) to accompany the incentive payment.

- The Paper Remittance Advice states: “This is a PQRI 2007 incentive payment.” or “This is a PQRI 2008 incentive payment.”
- PQRI participants will not receive claim-level detail in the feedback reports.
- 2007 re-run and 2008 PQRI feedback reports will be available October 2009.
- PQRI feedback report availability is not based on whether or not an incentive payment was earned. Feedback reports will be available for every TIN under which at least one EP (identified by his or her NPI submitting Medicare Part B PFS claims) reported at least one PQRI measure a minimum of once during the reporting period.
- Feedback reports are not permanently stored in the PQRI Portal and will be available for a limited time through the portal.

Help/Troubleshooting

Following are helpful hints and troubleshooting information:

- Adobe® Acrobat® Reader is required to view the feedback report in PDF format. You can download a free copy of the latest version of Adobe® Acrobat® Reader from http://www.adobe.com/products/acrobat/readstep2.html?promoid=BUIGO.
- The report may not function optimally, correctly, or at all with some older versions of Microsoft® Windows, Microsoft® Internet Explorer, Mozilla® Firefox, or Adobe® Acrobat® Reader.
- Users may need to turn off their web browser’s Pop-up Blocker or temporarily allow Pop-up files in order to download the PQRI feedback report.
- If you need assistance with the **IACS registration process** (i.e., forgot ID, password resets, etc.), contact the External Users Services (EUS) Help Desk at 1-866-484-8049, TTY/TDD at 1-866-523-4759 (Monday-Friday 7:00 a.m.-7:00 p.m. EST) or via e-mail at EUSSupport@cgi.com.
- For **PQRI assistance including accessing the PQRI Portal**, contact the PQRI Help Desk at 866-288-8912 or qnetsupport@sdps.org (Monday-Friday 7:00 a.m.-7:00 p.m. CT).
- Contact your Carrier or A/B MAC with general payment questions. The Provider Contact Center Toll-Free Numbers Directory offers information on how to contact the appropriate provider contact center and is available for download at: http://www.cms.hhs.gov/MLNGenInfo/01_Overview.asp.

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Appendix A: 2007 Re-Run and 2008 PQRI Feedback Report Definitions

Table 1: Earned Incentive Summary for Taxpayer Identification Number (Tax ID)

Term	Definition
Tax ID Name	Legal business name associated with a Taxpayer Identification Number (TIN).
Tax ID Number	The masked TIN, whether individual or corporate TIN, Employer Identification Number, or individual professional's Social Security Number.
Total Tax ID Earned Incentive Amount for NPIs	The total incentive amount earned by the TIN.
Carrier and/or A/B MAC Identification #	Carrier and/or A/B MAC number to which the TIN bills their claims.
Proportion of Incentive per Carrier and/or A/B MAC	The percentage of the total incentive amount earned by the TIN/NPI, split across carriers based on the proportionate split of the TIN's total estimated allowed Physician Fee Schedule covered charges billed across the carriers (100% of incentive will be distributed by a single carrier if a single carrier processed all claims for the TIN for all dates of service for the applicable reporting period).
Tax ID Earned Incentive Amount Under Carrier and/or A/B MAC	The total incentive amount earned by NPIs within the Tax ID (TIN) billing to each carrier. More information regarding incentive calculations can be found on the CMS website, http://www.cms.hhs.gov/pqri.
NPI	National Provider Identifier of the eligible professional billing under the TIN.
NPI Name	Eligible professional's name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization's or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment; only the system's ability to populate this field in the report.

Term	Definition
Earned Incentive Detail	• **Method of Reporting:** The method of reporting attempted by the NPI. For those NPIs participating in PQRI by multiple reporting methods, the most advantageous method is displayed. The nine reporting methods are: o 12 months – individual measures via claims o 12 months – individual measures via registry o 12 months – consecutive measures groups via registry o 12 months – 80% measures groups via registry o 6 months – consecutive measures groups via claims o 6 months – 80% measures groups via claims o 6 months – individual measures via registry o 6 months – consecutive measures groups via registry o 6 months – 80% measures groups via registry • **Reporting Period:** The 12 or 6 month time period for which an eligible professional can submit quality data for PQRI. • **Yes/No:** "Yes" if the TIN/NPI is eligible for the incentive payment and "No" if the TIN/NPI is not eligible for the incentive payment. • **Rationale:** The rationale for those NPIs who were or were not eligible for incentive. o Sufficient # of measures reported at 80% o Sufficient # of beneficiaries reported at 80% o Sufficient # of patients reported at 80% o Sufficient # of consecutive patients reported o Sufficient # of consecutive beneficiaries reported o Insufficient # of beneficiaries reported o Insufficient % of patients reported o Insufficient # of measures reported at 80% o Did not pass MAV More information regarding incentive calculations can be found on the CMS website, http://www.cms.hhs.gov/pqri.
Total # Measures with QDCs Submitted	The number of QDCs submitted for a particular measure, but not necessarily valid. Only valid submissions count towards reporting success.
Total # Measures Denominator Eligible with QDCs	The total number of measures for which TIN/NPI reported at least one valid quality-data code (QDC). o **Quality-Data Code:** Specified CPT Category II codes with or without modifiers (and G-codes where CPT II codes are not yet available) used for submission of PQRI data. CMS *PQRI Quality Measures Specifications* document contains all codes associated with each PQRI measure and instructions for data submission through the administrative claims system. This document can be found on the 2007 PQRI Program or 2008 Program page on the CMS website, http://www.cms.hhs.gov/pqri.
Total # Measures Satisfactorily Reported (≥ 80%)	The total number of measures the TIN/NPI reported at a satisfactory rate (for ≥ 80% of instances).
Total Estimated Allowed Medicare Part B PFS Charges	The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) allowed charges associated with covered professional services rendered during the reporting period. The PFS claims included were based on the 12 or 6 month reporting period for the method by which the NPI was incentive eligible.
NPI Total Earned Incentive Amount	The 1.5% incentive for each incentive-eligible professional's TIN/NPI. Note that it is possible for TIN/NPI to not have been subject to MAV, and still receive an incentive because they reported ≥ 80% of the time on three or more measures.

Table 2: NPI Participation Detail

Term	Definition
Tax ID Name	Legal business name associated with a TIN.
Tax ID Number	The masked Taxpayer Identification Number, whether individual or corporate TIN, Employer Identification Number, or individual professional's Social Security Number.
All Methods Reported	All reporting methods attempted by the NPI.
Reporting Period	The 12 or 6 month time period for which an eligible professional can submit quality data for PQRI.
Registry Associated	The registry submitting PQRI quality data on behalf of the NPI. Note: This does not apply to the 2007 re-run.
Qualified for Incentive	"Yes" if satisfactorily met reporting criteria and "No" if did not satisfactorily meet reporting criteria.
Reporting Period Used for Incentive	The method of reporting deemed most advantageous will be indicated with a "Yes". If the NPI did not qualify for incentive through any reporting methods, the reporting method that was most advantageous would be populated with N/A.
NPI	National Provider Identifier of the individual eligible professional billing under the TIN.
NPI Name	Eligible professional's name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization's or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2008 PQRI incentive payment; only the system's ability to populate this field in the report.
Earned Incentive	• **Method of Reporting:** The method of reporting attempted by the NPI. For those NPIs participating in PQRI by multiple reporting methods, the most advantageous method is displayed. The nine reporting methods are: o 12 months – individual measures via claims o 12 months – individual measures via registry o 12 months – consecutive measures groups via registry o 12 months – 80% measures groups via registry o 6 months – consecutive measures groups via claims o 6 months – 80% measures groups via claims o 6 months – individual measures via registry o 6 months – consecutive measures groups via registry o 6 months – 80% measures groups via registry • **Reporting Period:** The 12 or 6 month time period for which an eligible professional can submit quality data for PQRI. • **Yes/No:** "Yes" if the TIN/NPI is eligible for the incentive payment and "No" if the TIN/NPI is not eligible for the incentive payment. • **Rationale:** The rationale for those NPIs who were or were not eligible for incentive. o Sufficient # of measures reported at 80% o Sufficient # of beneficiaries reported at 80% o Sufficient # of patients reported at 80% o Sufficient # of consecutive patients reported o Sufficient # of consecutive beneficiaries reported o Insufficient # of beneficiaries reported o Insufficient % of patients reported o Insufficient # of measures reported at 80% o Did not pass MAV More information regarding incentive calculations can be found on the CMS website, http://www.cms.hhs.gov/pqri.

Term	Definition
Total # Measures with QDCs Submitted	The number of QDCs submitted, but not necessarily valid. Only valid submissions count towards reporting success.
Total # Measures Denominator Eligible with QDCs	The total number of measures for which the TIN/NPI reported at least one valid QDC. • **Quality-Data Code:** Specified CPT Category II codes with or without modifiers (and G-codes where CPT II codes are not yet available) used for submission of PQRI data. CMS PQRI Quality Measures Specifications document contains all codes associated with each PQRI measure and instructions for data submission through the administrative claims system. This document can be found on the CMS website, http://www.cms.hhs.gov/pqri.
Total # Measures Satisfactorily Reported (≥ 80%)	The total number of measures the TIN/NPI reported at a satisfactory rate (for ≥ 80% of instances).
Total Estimated Allowed Medicare Part B PFS Charges	The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) allowed charges associated with covered professional services rendered during the reporting period. The PFS claims included were based on the 12 or 6 month reporting period for the method by which the NPI was incentive eligible.
NPI Total Earned Incentive Amount	The 1.5% incentive for each incentive-eligible professional's TIN/NPI. Note that it is possible for a TIN/NPI to not have been subject to MAV, and still receive an incentive because they reported ≥ 80% of the time on three or more measures.
Measure Title (Measure #)	2007 re-run and 2008 PQRI measure title and number.
Measure Type	The analytic category for each measure that determines how the measure will be calculated for PQRI. • Patient-Intermediate - Report a minimum of once per reporting period per individual eligible professional (NPI). • Patient-Process - Report a minimum of once per reporting period per individual eligible professional (NPI). • Patient-Periodic - Report once per time frame specified in the measure for each individual eligible professional (NPI) during the reporting period. • Episode - Report once for each occurrence of a particular illness/condition by each individual eligible professional (NPI) during the reporting period. • Procedure - Report each time a procedure is performed by the individual eligible professional (NPI) during the reporting period. • Visit - Report each time the patient is seen by the individual eligible professional (NPI) during the reporting period. • Selective Visit - Report each time the patient is seen by the individual eligible professional (NPI) according to the time frame specified in the measure during the reporting period.
	Measure Type / **Measures**
	Patient-Intermediate / 1, 2, 3, 128
	Patient-Process / 4, 5, 6, 7, 8, 9, 12, 14, 18, 19, 39, 41, 47, 48, 49, 50, 51, 52, 53, 64, 67, 68, 69, 70, 71, 72, 73, 74, 77, 78, 79, 83, 84, 85, 86, 87, 88, 89, 90, 101, 103, 108, 110, 111, 112, 113, 114, 115, 117, 118, 119, 120, 121, 126, 127, 133, 134
	Patient-Periodic / 80, 81, 82, 123
	Procedure / 10, 11, 20, 21, 22, 23, 30, 45, 76, 95, 99, 100, 102, 105
	Episode / 24, 28, 31, 32, 33, 34, 35, 36, 40, 43, 44, 46, 54, 55, 56, 57, 58, 59, 65, 66, 75, 91, 93, 96, 97, 98, 104, 106, 116, 132
	Visit / 92, 94, 109, 122, 124, 125, 130, 131
	Selective Visit / 107, 129
Reporting Denominator: Applicable Cases	For each measure, the number (#) of instances (visits or patients depending on the measure specifications) the TIN/NPI was eligible to report the measure.
Numerator: Valid QDCs Reported	The number of reporting instances the TIN/NPI correctly reported the necessary QDCs for the measure.

Term	Definition
Reporting Rate	For each measure with eligible instances, the TIN/NPI is calculated by finding the quotient of the number of numerator eligible reporting instances divided by the number of denominator eligible instances.
Measure Validation Clinical Focus Area	The clinical focus area, according to the measure-applicability validation (MAV) process, for each measure is indicated. Please note that some measures may be generally applicable, and are not part of a clinical focus area. • **Measure-Applicability Validation (MAV):** o If an eligible professional submits QDCs for only one or two PQRI measures for the 2007 re-run or 2008 reporting period, achieves a reporting rate of at least 80% on each measure submitted, and does not submit QDCs for any other PQRI measure, the completeness of their selection of measures may be subject to the MAV process. o Any NPI reporting on at least three measures for ≥ 80% of instances, or on one or two measures for ≥ 80% of instances and not found to have been eligible to report additional applicable measures by the MAV process is eligible to receive a PQRI incentive. More information regarding the MAV process and the clinical focus areas can be found on the CMS website, http://www.cms.hhs.gov/pqri.
Measures Groups	2008 PQRI Measures Groups submitted by the NPI.
# of Beneficiaries Eligible	The number of eligible beneficiaries meeting the denominator specifications for at least one measure within the measures group (if applicable).
# of Beneficiaries Reported	The number of eligible beneficiaries for which a valid QDC was submitted for the measures group (if applicable).
% of Eligible Beneficiaries Reported	The percentage of eligible beneficiaries for which a valid QDC was submitted for the measures group (if applicable).
# of Patients Eligible	The number of consecutive patients, as specified by the registry, meeting the denominator inclusion criteria for at least one measure within the measures group (if applicable).
% of Eligible Patients Reported	The percentage of eligible patients for which a valid QDC was submitted for the measures group.

Table 3: NPI QDC Submission Error Detail

Term	Definition
Tax ID Name	Legal business name associated with a TIN.
NPI Name	The legal name for an NPI identified in the CMS Provider Enrollment Chain Ownership System (PECOS) database. If the professional's enrollment record is not yet established in PECOS at the time the report was produced, "N/A" will be populated in this field. To establish an enrollment record in the PECOS database, a professional must have submitted an initial or updated Medicare enrollment form (CMS-855) since October 2003.
NPI Number	Individual National Provider Identifier of the eligible professional billing under the TIN.
Method of Reporting	The method of reporting attempted by the NPI. For those NPIs participating in PQRI by multiple reporting methods, the most advantageous method is displayed.
Measure Title (Measure #)	2007 re-run and 2008 PQRI measure title and number.

<table>
<tr><th>Term</th><th>Definition</th></tr>
<tr><td>Measure Type</td><td>The analytic category for each measure that determines how the measure will be calculated for PQRI.
Patient-Intermediate - Report a minimum of once per reporting period per individual eligible professional (NPI).
Patient-Process - Report a minimum of once per reporting period per individual eligible professional (NPI).
Patient-Periodic - Report once per time frame specified in the measure for each individual eligible professional (NPI) during the reporting period.
Episode - Report once for each occurrence of a particular illness/condition by each individual eligible professional (NPI) during the reporting period.
Procedure - Report each time a procedure is performed by the individual eligible professional (NPI) during the reporting period.
Visit - Report each time the patient is seen by the individual eligible professional (NPI) during the reporting period.
Selective Visit - Report each time the patient is seen by the individual eligible professional (NPI) according to the time frame specified in the measure during the reporting period.
<table>
<tr><th>Measure Type</th><th>Measures</th></tr>
<tr><td>Patient-Intermediate</td><td>1, 2, 3, 128</td></tr>
<tr><td>Patient-Process</td><td>4, 5, 6, 7, 8, 9, 12, 14, 18, 19, 39, 41, 47, 48, 49, 50, 51, 52, 53, 64, 67, 68, 69, 70, 71, 72, 73, 74, 77, 78, 79, 83, 84, 85, 86, 87, 88, 89, 90, 101, 103, 108, 110, 111, 112, 113, 114, 115, 117, 118, 119, 120, 121, 126, 127, 133, 134</td></tr>
<tr><td>Patient-Periodic</td><td>80, 81, 82, 123</td></tr>
<tr><td>Procedure</td><td>10, 11, 20, 21, 22, 23, 30, 45, 76, 95, 99, 100, 102, 105</td></tr>
<tr><td>Episode</td><td>24, 28, 31, 32, 33, 34, 35, 36, 40, 43, 44, 46, 54, 55, 56, 57, 58, 59, 65, 66, 75, 91, 93, 96, 97, 98, 104, 106, 116, 132</td></tr>
<tr><td>Visit</td><td>92, 94, 109, 122, 124, 125, 130, 131</td></tr>
<tr><td>Selective Visit</td><td>107, 129</td></tr>
</table></td></tr>
<tr><td>QDC Occurrences</td><td>Actual # Reported: Number of QDC submissions for a measure, whether or not the QDC submission was valid and appropriate
Numerator: Valid QDCs Reported: Number of valid and appropriate QDC submissions for a measure
% of Valid QDCs Accepted: The percentage of reported QDCs that were valid</td></tr>
<tr><td>Gender</td><td>Number of QDC submissions that were not accepted due to not meeting the gender requirements for the measure.</td></tr>
<tr><td>Age</td><td>Number of QDC submissions that were not accepted due to not meeting the age requirements for the measure.</td></tr>
<tr><td>Only Incorrect CPT</td><td>Number of invalid QDC submissions resulting from an incorrect CPT code.</td></tr>
<tr><td>Only Incorrect DX</td><td>Number of invalid QDC submissions resulting from an incorrect diagnosis code.</td></tr>
<tr><td>Both Incorrect CPT and DX</td><td>Number of invalid QDC submissions resulting from a combination of incorrect CPT code and incorrect diagnosis code.</td></tr>
<tr><td>Only QDC on Claim (no CPT)</td><td>Number of invalid QDC submissions due to a missing qualifying denominator code since all lines were QDCs.</td></tr>
<tr><td>Only QDC and Incorrect DX</td><td>Number of invalid QDC submissions due to a missing qualifying denominator code since all lines were QDCs and the diagnosis code was incorrect.</td></tr>
</table>

Note: A QDC submission attempt may be counted for age, gender and one of the following: Incorrect CPT, Incorrect DX, Incorrect CPT and DX, Only QDC on Claim, and Only QDC and Incorrect DX. Incorrect CPT, Incorrect DX, Incorrect CPT and DX, Only QDC on Claim, and Only QDC and Incorrect DX are all mutually exclusive. If there is an incorrect CPT code and also an incorrect diagnosis, it will only fall into the "Both Incorrect CPT and DX" cell for that measure and will not fall into the other two cells.

Table 4: NPI Performance Detail

NOTE: Performance information is provided for the EP's use to assess and improve their clinical performance. Performance rates do not affect 2007 re-run or 2008 PQRI incentive payment eligibility or amount at the individual EP or practice level.

Term	Definition
Tax ID Name	Legal business name associated with a TIN.
NPI Name	The legal name for an NPI identified in the CMS Provider Enrollment Chain Ownership System (PECOS) database. If the professional's enrollment record is not yet established in PECOS at the time the report was produced, "N/A" will be populated in this field. To establish an enrollment record in the PECOS database, a professional must have submitted an initial or updated Medicare enrollment form (CMS-855) since October 2003.
NPI Number	Individual National Provider Identifier of the eligible professional billing under the TIN.
Method of Reporting	The method of reporting attempted by the NPI. For those NPIs participating in PQRI by multiple reporting methods, the most advantageous method is displayed.
Measure Title (Measure #)	2007 re-run and 2008 PQRI measure title and number.
Numerator: Valid QDCs Reported	The number of instances the TIN/NPI correctly reported the necessary QDCs for the measure.
Numerator Eligible Instances Excluded	The number of instances the TIN/NPI submitted a modifier or QDC as performance exclusion for the measure. • **Medical 1P:** For each measure, the number (#) of instances the TIN/NPI submitted modifier 1P. • **Patient 2P:** For each measure, the number (#) of instances the TIN/NPI submitted modifier 2P. • **System 3P:** For each measure, the number (#) of instances the TIN/NPI submitted modifier 3P. • **Other:** For each measure, the number (#) of instances the TIN/NPI submitted a G-code or CPT II code as a performance exclusion for the measure.
Clinical Performance Denominator	The performance denominator is determined by subtracting the number of Eligible Instances Excluded from the total number of Eligible Instances. Valid reasons for exclusions may apply; these are specific to each measure. Measure specific information is available within the Measures/Codes page on the CMS website, http://www.cms.hhs.gov/pqri.
Clinical Performance Numerator Met	Number of instances the TIN/NPI submitted the appropriate QDC(s) satisfactorily meeting the performance requirements for the measure. Please note that some measures look at "poor control" or "inappropriate care". For these measures, it is desirable to have a small number.

Term	Definition
Clinical Performance Rate	The TIN/NPI's clinical performance rate is calculated by finding the quotient of the Clinical Performance Met for the measure divided by the Performance Denominator for the measure. For "poor control" or "inappropriate care" measures, it is desirable to have a lower rate. Note: Instances reported with recognized performance exclusions (modifiers and/or QDC codes) are not included when calculating the performance rate. In other words, these exclusions serve as denominator exclusions for the purpose of measuring performance. For each PQRI measure for a particular program year, the recognized performance exclusions are identified in the relevant PQRI Measure Specifications which are available for download from the CMS PQRI website.
Clinical Performance Not Met	The number of instances where clinical performance was not met due to improper code submission or the clinical action was not provided. • **QDC Reported:** The number of QDCs reported to indicate that clinical performance was not met. This includes instances where a CPT II code with an 8P modifier or G-code was used as a performance failure for the measure. • **Insufficient QDC Information:** The number of instances where clinical performance was not met due to insufficient QDC information from the TIN/NPI combination. Insufficient QDC submission can be a result of an incorrect modifier for a measure (i.e., submitting a 2P when it is not an appropriate exclusion according to the measure specification) and/or not submitting all required QDCs for a measure numerator (i.e., only submitting one QDC when two are required).
National Comparison for Performance	The National Comparison for Performance includes performance information for all EP's TIN/NPI combinations submitting at least one QDC for the measure. Performance rates are sorted in ascending order (i.e., lowest to highest) then: • The **25th percentile** indicates that 25% of all participating TIN/NPI combinations are performing at or below this rate. • The **50th percentile** indicates that 50% of all participating TIN/NPI combinations are performing at or below this rate. • The **75th percentile** indicates that 75% of all participating TIN/NPI combinations are performing at or below this rate.