User Guide

2009
Physician Quality Reporting Initiative (PQRI)
Feedback Reports

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Purpose

The Physician Quality Reporting Initiative (PQRI) Feedback Report User Guide is designed to assist eligible professionals and their authorized users with accessing and interpreting the 2009 PQRI feedback reports. The 2009 PQRI incentive payment will occur in October/November 2010. The 2009 PQRI feedback reports reflect data from the Medicare Part B claims received for the dates of service January 1, 2009 – December 31, 2009 that were processed into the National Claims History (NCH) by February 28, 2010.

PQRI Program Overview

The 2006 Tax Relief and Health Care Act (TRHCA) authorized a physician quality reporting system, including an incentive payment for eligible professionals 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.

The PQRI was further modified as a result of The Medicare, Medicaid, and SCHIP Extension Act (MMSEA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). MMSEA authorized CMS to establish two alternative reporting periods, the reporting of measures groups, and to allow submission of data on PQRI quality measures through clinical data registries. For each program year, CMS implements PQRI through an annual rulemaking process published in the *Federal Register*. The program has expanded the number of measures and reporting options over time to facilitate quality reporting by a broad array of eligible professionals.

The 2009 PQRI continued as a pay-for-reporting program that included claims- and registry-based reporting of data on 153 individual quality measures as well as the addition of seven measures groups. The two alternative reporting periods for this program year were: January 1, 2009 – December 31, 2009 and July 1, 2009 – December 31, 2009. There were nine options for satisfactorily reporting quality measures data for the 2009 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 eligible professional selected.

For more information on the 2009 PQRI, please visit the PQRI section of the CMS website at http://www.cms.gov/PQRI.

Report Overview

The 2009 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 eligible professional 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 also include information on the measure-applicability validation (MAV) process and any impact it may have had on the eligible professional's incentive eligibility.

The 2009 PQRI included four claims-based reporting methods, five 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, 2009 – December 31, 2009 (for the 12-month reporting period) and for services furnished from July 1, 2009 – December 31, 2009 (for the 6-month reporting period) were analyzed to determine whether the eligible professional 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 submitting at least one valid QDC via claims or submitting data via a qualified registry. Valid submissions are where a QDC was submitted and all measure-eligibility

criteria was met (i.e., correct age, gender, diagnosis, and CPT). For those NPIs satisfactorily reporting using multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive.

CMS aims to distribute feedback reports as closely as possible to the incentive payment timeframe. 2009 PQRI feedback reports will be distributed in approximately November 2010. eligible professionals who are considered solo practitioners may access their feedback reports through the Physician and Other Health Care Professionals Quality Reporting Portal at https://www.qualitynet.org/portal/server.pt. TIN-level reports on the Portal require an Individuals Authorized Access to CMS Computer Services (IACS) account. Eligible professionals who submitted under multiple TINs may have earned an incentive either under one or more than one TIN. Participants may also contact their Carrier/MAC to request individual NPI-level reports via the alternate feedback report fulfillment process.

Note: *These reports 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 these reports to protect the privacy of the individual practitioner with whom the SSN is potentially associated. 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
- Recommend 166 MHZ Pentium processor with a minimum of 125 MB free space and 32 MB RAM

Software

- Microsoft® Internet Explorer 6.0 and above, Mozilla® Firefox 2.0 and above, or Apple® Safari 2.0 and above
- Sun® Java Runtime Environment (JRE) 1.6x or higher
- Adobe® Acrobat® Reader 5.0 and above

Internet Connection and Download Time

- Reports will be accessible via any Internet connection running on a minimum of 33.6k modem or high-speed 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 2009 PQRI feedback reports. PQRI feedback reports will be generated for each TIN with at least one eligible professional 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 for NPIs:** The total incentive amount earned by the Tax ID. The actual incentive payment may vary slightly from this amount due to rounding.
- **NPI Total Earned Incentive Amount:** The 2.0% incentive amount earned for each TIN/NPI.

For definition of terms related to 2009 PQRI feedback reports, see **Appendix A**. Also refer to the footnotes within each table for additional content detail.

Example 1.1

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 are 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.

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 incentive amount earned for all NPIs reporting under one TIN.

Total Tax ID Earned Incentive Amount for NPIs (listed below): $16,226.67	Distribution of Total Incentive Earned Among Carriers/MACs That Processed Payments		
	Carrier/MAC Identification #	Proportion of Incentive per Carrier/MAC¤	Tax ID Earned Incentive Amount Under Carrier/MAC
	12345	90.0%	$14,604.00
	67890	10.0%	$1,622.67

NPIs that did not earn an incentive will still appear in the report along with the reason they were not incentive eligible.

Estimated total amount of Medicare Part B PFS charges per individual NPI.

Total 2% incentive amount earned by each individual NPI.

NPI	NPI Name«	Incentive Eligible•				Total # Measures Submitted^	Total # Measures Denominator Eligible~	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	$2,000.00
1000000003	Not Available	Individual measure(s) reporting via registry	12 months	Yes	Sufficient # of measures reported at 80%	6	4	3	$133,333.33	$2,666.67
1000000004	Not Available	Measures Groups - 80% beneficiaries via claims	6 months	Yes	Sufficient # of beneficiaries reported at 80% and a minimum of 15 eligible beneficiaries	N/A	N/A	N/A	$93,000.00	$1,860.00
1000000006	Not Available	Measures Groups - 80% beneficiaries via registry	12 months	Yes	Sufficient # of beneficiaries reported at 80% and a minimum of 30 eligible beneficiaries	N/A	N/A	N/A	$125,000.00	$2,500.00
1000000008	Beans, John	Measures Groups - 80% beneficiaries via claims	12 months	Yes	Sufficient # of beneficiaries reported at 80% and a minimum of 30 eligible beneficiaries	N/A	N/A	N/A	$40,000.00	$800.00
1000000009	Smithson, Steve	Measures Groups - 30 consecutive patients via registry	12 months	Yes	Sufficient # of consecutive patients reported	N/A	N/A	N/A	$125,000.00	$2,500.00
1000000011	Jones, Josie	Measures Groups - 80% beneficiaries via registry	6 months	Yes	Sufficient # of beneficiaries reported at 80% and a minimum of 15 eligible beneficiaries	N/A	N/A	N/A	$70,000.00	$1,400.00
1000000012	Doe, John	Individual measure(s) reporting via claims	12 months	Yes	Sufficient # of measures reported at 80%	6	4	3	$60,000.00	$1,200.00

Example 1.1 continued

NPI	NPI Name«	Incentive Eligible•				Total # Measures Submitted^	Total # Measures Denominator Eligible~	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					
1000000013	Not Available	Measures Groups - 30 consecutive beneficiaries via claims	12 months	Yes	Sufficient # of consecutive beneficiaries reported	N/A	N/A	N/A	$65,000.00	$1,300.00
1000000001	Not Available	Measures Groups - 80% beneficiaries via registry	6 months	No	Insufficient % of beneficiaries reported	N/A	N/A	N/A	$20,000.00	N/A
1000000005	Not Available	Individual measure(s) reporting via claims	12 months	No	Insufficient # of measures reported at 80%	6	3	2	$68,000.00	N/A
1000000007	Not Available	Individual measure(s) reporting via claims	12 months	No	Did not pass MAV	8	4	1	$580,000.00	N/A
1000000010	Johnson, John	Measures Groups - 30 consecutive patients via registry	12 months	No	Insufficient # of consecutive patients reported	N/A	N/A	N/A	$120,000.00	N/A
1000000014	Not Available	Measures Groups - 80% beneficiaries via registry	12 months	No	Insufficient # of minimum eligible beneficiaries	N/A	N/A	N/A	$109,000.00	N/A
									Total:	$16,226.67

«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/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 2009 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 Carrier/MACs based on the proportionate split of the Tax ID's total estimated allowed Medicare Part B Physician Fee Sc
(PFS) charges billed across the Carrier/MACs. (100% of incentive will be distributed by a single Carrier/MAC if a single Carrier/MAC 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 measures where quality-data codes (QDCs) or quality actions data are submitted, but are not necessarily valid. Only valid submissions count towards reporting success. If the reporting method is throu measures groups, this field will be populated with 'N/A'.
~The number of measures for which the TIN/NPI reported at least one valid quality-data code (QDC) or quality action data. If the reporting method is through measures groups, this field will be populated with 'N/A'.
‡The total number of measures the TIN/NPI reported at a satisfactory rate; satisfactory rate is for ≥ 80% of instances. If the reporting method is through measures groups, this field will be populated with 'N/A'.
□The total estimated amount of Medicare Part B 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 m by which the NPI was incentive eligible.
*The amount of the incentive is based on the total estimated allowed Medicare Part B 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.

Total 2% incentive amount earned by the TIN for all participating NPIs.

Note: The registry information is based on data calculated and supplied by the 2009 PQRI participating registries.
Note: The PQRI incentive payments are subject to offsets. Payments are made to the first NPI associated with the TIN. If the first NPI associated with the TIN has an offset, Carrier/MACs will apply the lump sum and/or sanction.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

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/registry for Medicare Part B Physician Fee Schedule (PFS) covered professional services for which one or more PQRI quality measure applied will receive Table 2. This report reflects 1) the Participation Summary, 2) PQRI Incentive Detail listing the NPI's total earned incentive amount, and 3) a PQRI Reporting Detail listing the individual NPI's reporting rate for each measure.

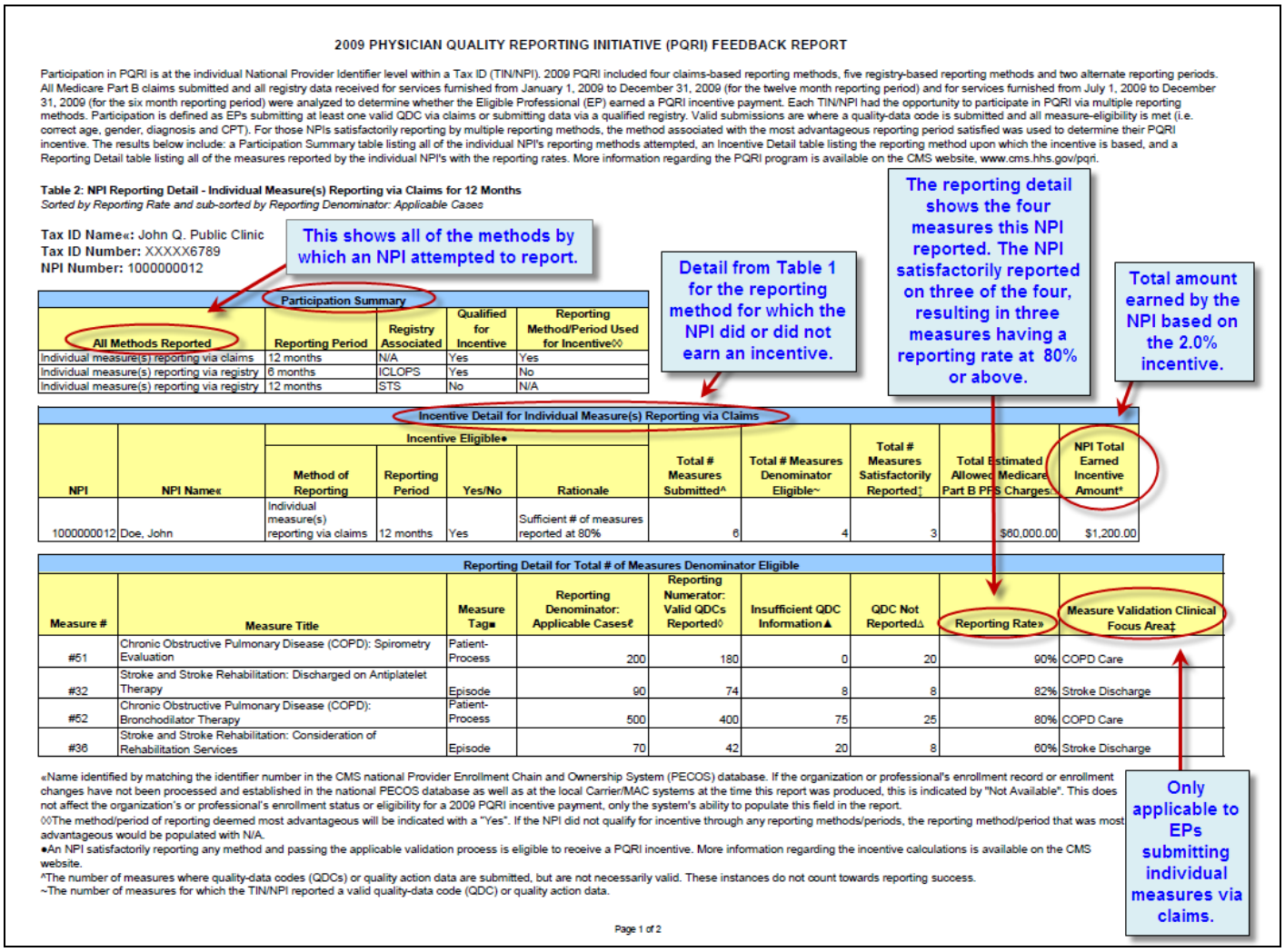
- **Total # Measures Denominator Eligible:** The number of measures for which a TIN/NPI reported a valid quality-data code (QDC).
- **Total # Measures Satisfactorily Reported:** The total number of measures the TIN/NPI reported at a satisfactory rate; satisfactory rate is reporting on 80% or more of eligible instances.
- **Reporting Rate:** 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.
- **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 reporting period for the method by which the NPI was incentive eligible.
- **NPI Total Earned Incentive Amount:** The 2.0% incentive for each incentive-eligible professional's TIN/NPI.

Examples of Table 2: NPI Reporting Detail in this *Guide* include:

- *Figure 2.1 Screenshot of Table 2 for Individual Measure(s) via Claims for 12 Months: NPI Reporting Detail*
- *Figure 2.2 Screenshot of Table 2 for Individual Measure(s) Reporting via Registry for 12 Months: NPI Reporting Detail*
- *Figure 2.3 Screenshot of Table 2 for Measures Groups: 80% Beneficiaries via Claims for 6 Months: NPI Reporting Detail*
- *Figure 2.4 Screenshot of Table 2 for Measures Groups: 80% Beneficiaries via Registry for 12 Months: NPI Reporting Detail*
- *Figure 2.5 Screenshot of Table 2 for Measures Groups: 80% Beneficiaries via Claims for 12 Months: NPI Reporting Detail*
- *Figure 2.6 Screenshot of Table 2 for Measures Groups: 30 Consecutive Patients via Registry for 12 Months: NPI Reporting Detail*
- *Figure 2.7 Screenshot of Table 2 for Measures Groups: 80% Beneficiaries via Registry for 6 Months: NPI Reporting Detail*
- *Figure 2.8 Screenshot of Table 2 for Measures Groups: 30 Consecutive Beneficiaries via Claims for 12 Months: NPI Reporting Detail*
- *Figure 2.9 Screenshot of Table 2 for Individual Measure(s) Reporting via Registry for 6 Months: NPI Reporting Detail*

For definition of terms related to 2009 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



2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Individual Measure(s) Reporting via Claims for 12 Months
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 by which an NPI attempted to report.

Detail from Table 1 for the reporting method for which the NPI did or did not earn an incentive.

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

Total amount earned by the NPI based on the 2.0% incentive.

Participation Summary

All Methods Reported	Reporting Period	Registry Associated	Qualified for Incentive	Reporting Method/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«	Incentive Eligible• Method of Reporting	Reporting Period	Yes/No	Rationale	Total # Measures Submitted^	Total # Measures Denominator Eligible~	Total # Measures Satisfactorily Reported‡	Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
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 for Total # of Measures Denominator Eligible

Measure #	Measure Title	Measure Tag■	Reporting Denominator: Applicable Cases£	Reporting Numerator: Valid QDCs Reported◊	Insufficient QDC Information▲	QDC Not Reported∆	Reporting Rate»	Measure Validation Clinical Focus Area‡
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	Patient-Process	200	180	0	20	90%	COPD Care
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	Episode	90	74	8	8	82%	Stroke Discharge
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	Patient-Process	500	400	75	25	80%	COPD Care
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	Episode	70	42	20	8	60%	Stroke Discharge

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.
◊◊The method/period of reporting deemed most advantageous will be indicated with a "Yes". If the NPI did not qualify for incentive through any reporting methods/periods, the reporting method/period that was most advantageous would be populated with N/A.
•An NPI satisfactorily reporting any 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 measures where quality-data codes (QDCs) or quality action data are 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) or quality action data.

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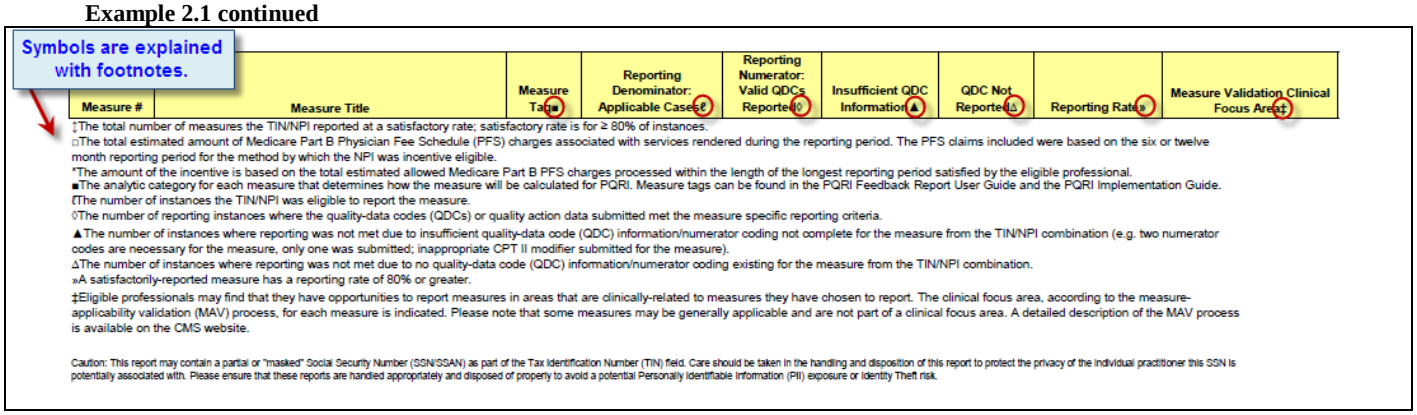
Only applicable to EPs submitting individual measures via claims.

Example 2.1 continued



Symbols are explained with footnotes.

Measure #	Measure Title	Measure Tag■	Reporting Denominator: Applicable Cases£	Reporting Numerator: Valid QDCs Reported◊	Insufficient QDC Information▲	QDC Not Reported∆	Reporting Rate»	Measure Validation Clinical Focus Area‡

‡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 PFS charges processed within the length of the longest reporting period satisfied by the eligible professional.
■The analytic category for each measure that determines how the measure will be calculated for PQRI. Measure tags can be found in the PQRI Feedback Report User Guide and the PQRI Implementation Guide.
£The number of instances the TIN/NPI was eligible to report the measure.
◊The number of reporting instances where the quality-data codes (QDCs) or quality action data submitted met the measure specific reporting criteria.
▲The number of instances where reporting 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 number of instances where reporting was not met due to no quality-data code (QDC) information/numerator coding existing for the measure from the TIN/NPI combination.
»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.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 2.1 Screenshot of Table 2 for Individual Measure(s) via Claims Reporting for 12 Months: NPI Reporting Detail

Example 2.2

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Individual Measure(s) Reporting via Registry for 12 Months
Sorted by Reporting Rate

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

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

If the reporting method is through a registry, the registry name 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 Method/Period Used for Incentive◊◊
Individual measure(s) reporting by registry	12 months	ACC	Yes	Yes
Measures Groups - 80% beneficiaries via registry	12 months	SVS	Yes	No

Incentive Detail for Individual Measure(s) Reporting via Registry

NPI	NPI Name«	Incentive Eligible•					Total # Measures Submitted^	Total # Measures Denominator Eligible~	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	$2,666.67

Reporting Detail for Total # of Measures Denominator Eligible

Measure #	Measure Title	Measure Tag■	Reporting Denominator: Applicable Cases£	Reporting Numerator◊	Reporting Rate»
#31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	Episode	520	451	87%
#35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	Episode	450	382	85%
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	Episode	410	336	82%
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	Episode	375	270	72%

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.
◊◊The method/period of reporting deemed most advantageous will be indicated with a "Yes". If the NPI did not qualify for incentive through any reporting methods/periods, the reporting method/period that was most advantageous would be populated with N/A.
•An NPI satisfactorily reporting any 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 measures where quality-data codes (QDCs) or quality action data are 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) or quality action data.
‡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 PFS charges processed within the length of the longest reporting period satisfied by the eligible professional.
■The analytic category for each measure that determines how the measure will be calculated for PQRI. Measure tags can be found in the PQRI Feedback Report User Guide and the PQRI Implementation Guide.
£The number of instances the TIN/NPI was eligible to report the measure.

Figure 2.2 Screenshot of Table 2 for Individual Measure(s) Reporting via Registry for 12 Months: NPI Reporting Detail

Example 2.3

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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.gov/pqri.

There were nine different reporting methods for 2009 - four through claims and five through registries. These are listed in Appendix A.

This NPI reported Rheumatoid Arthritis and Chronic Kidney Disease measures groups. The reporting detail shows all of the measures within that measures group and the breakdown of QDCs submitted for the measures. The reporting rate is also shown.

Table 2: NPI Reporting Detail - Measures Groups: 80% Beneficiaries via Claims for 6 Months
Sorted by Reporting Rate of Measures Group and Sub-Sorted by Measure #

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

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

Incentive Detail for Measures Groups - 80% Beneficiaries via Claims							
		Incentive Eligible•					
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	Measures Groups - 80% beneficiaries via claims	6 months	Yes	Sufficient # of beneficiaries reported at 80% and a minimum of 15 eligible beneficiaries	$93,000.00	$1,860.00

Reporting Detail						
Measure #	Measures Groups (with Measures Titles)▶	Reporting Denominator: Applicable Cases♦	Reporting Numerator••	Insufficient QDC Information▲	QDC Not Reported△	Reporting Rate**
N/A	**Rheumatoid Arthritis Measures Group▶▶**	250	215	N/A	N/A	86%
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	250	220	30	0	88%
#176	Tuberculosis Screening	250	225	25	0	90%
#177	Periodic Assessment of Disease Activity	250	215	35	0	86%
#178	Functional Status Assessment	250	215	32	3	86%
#179	Assessment and Classification of Disease Prognosis	250	215	35	0	86%
#180	Glucocorticoid Management	250	215	35	0	86%
N/A	**Chronic Kidney Disease Measures Group▶▶**	250	215	N/A	N/A	86%
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH)	250	220	30	0	88%
#122	Blood Pressure Management	250	225	25	0	90%
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-	250	215	35	0	86%
#135	Influenza Immunization	250	215	30	5	86%
#153	Referral for Arteriovenous (AV) Fistula	250	215	35	0	86%

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.

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Figure 2.3 Screenshot of Table 2 for Measures Groups: 80% Beneficiaries via Claims for 6 Months: NPI Reporting Detail

Example 2.4

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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,

Table 2: NPI Reporting Detail - Measures Groups: 80% Beneficiaries via Registry for 12 Months
Sorted by Reporting Rate of Measures Group and Sub-Sorted by Measure #

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

Rheumatoid Arthritis is one of seven measures groups used in 2009 PQRI. The measures within this particular measures group are also listed.

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

Incentive Detail for Measures Groups - 80% Beneficiaries via Registry								
		Incentive Eligible•						
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*
1000000006	Not Available	Measures Groups - 80% beneficiaries via registry	12 months	Cedaron	Yes	Sufficient # of beneficiaries reported at 80% and a minimum of 30 eligible beneficiaries	$125,000.00	$2,500.00

Reporting Detail				
Measure #	Measures Groups (with Measures Titles)►	Reporting Denominator: Applicable Cases♦	Reporting Numerator••	Reporting Rate**
N/A	**Rheumatoid Arthritis Measures Group►►**	462	397	86%
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	462	407	88%
#176	Tuberculosis Screening	462	416	90%
#177	Periodic Assessment of Disease Activity	462	397	86%
#178	Functional Status Assessment	462	397	86%
#179	Assessment and Classification of Disease Prognosis	462	397	86%
#180	Glucocorticoid Management	462	420	91%
N/A	**Chronic Kidney Disease Measures Group►►**	250	233	93%
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH)	250	213	85%
#122	Blood Pressure Management	250	200	80%
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-	250	205	82%
#135	Influenza Immunization	250	225	90%
#153	Referral for Arteriovenous (AV) Fistula	250	233	93%

Total earned incentive amount for this particular NPI.

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Example 2.4 continued

Tables may be longer than one page. Footnotes are included with each table.

«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 enroll have not been processed and established in the national PECOS database as well as at the local Carrier/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.

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

•An NPI satisfactorily reporting any 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 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 specified in the 2009 PQRI Measures Groups Specifications Manual located on the CMS PQRI website.

►►This count is for all measures reported within the measures group.

♦The # of reporting instances meeting the common denominator inclusion criteria for the measures group.

••The # of reporting instances for which this TIN/NPI submitted all quality-data code(s) (QDCs) or quality action data corresponding with all applicable measures within the measures group or submitted the composite G-code for the measures group. For each measure within the measures group, this indicates the # of reporting instances for which this TIN/NPI submitted one or more QDCs or quality actions corresponding with the applicable measure within the measures group.

**The reporting rate for the measures group where all applicable QDCs or quality action data for all applicable measures within the measures group is reported for an eligible reporting instance which is used to determine incentive eligibility. The reporting rate for the measure where a QDC or quality action for the measure is reported for applicable cases.

Note: Due to measures group calculations, the overall measures groups reporting rate will not be an average of the individual measure's reporting rates.

Because of measures groups calculations, the overall measures groups reporting rate will not be an average of the individual measure's reporting rates.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report t 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.

Figure 2.4 Screenshot of Table 2 for Measures Groups: 80% Beneficiaries via Registry for 12 Months: NPI Reporting Detail

Example 2.5

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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

Table 2: NPI Reporting Detail - Measures Groups: 80% Beneficiaries via Claims for 12 Months
Sorted by Reporting Rate of Measures Group and Sub-Sorted by Measure #

Tax ID Name«: John Q. Public Clinic
Tax ID Number: XXXXX6789
NPI Number: 1000000008

The NPI reported using two different methods, and qualified for the incentive through each of the two methods. If the NPI achieved satisfactory reporting under more than one 2009 PQRI reporting method, he/she will receive the incentive payment for the most advantageous reporting period for which he/she qualified (in this case, 12 months).

Participation Summary

All Methods Reported	Reporting Period	Registry Associated	Qualified for Incentive	Reporting Method/Period Used for Incentive◊◊
Measures Groups - 80% beneficiaries via claims	12 months	N/A	Yes	Yes
Measures Groups - 80% beneficiaries via registry	6 months	SVS	Yes	No

Incentive Detail for Measures Groups - 80% Beneficiaries via Claims

NPI	NPI Name«	Incentive Eligible•				Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
		Method of Reporting	Reporting Period	Yes/No	Rationale		
1000000008	Beans, John	Measures Groups - 80% beneficiaries via claims	12 months	Yes	Sufficient # of beneficiaries reported at 80% and a minimum of 30 eligible beneficiaries	$40,000.00	$800.00

Reporting Detail

Measure #	Measures Groups (with Measures Titles)►	Reporting Denominator: Applicable Cases♦	Reporting Numerator••	Insufficient QDC Information▲	QDC Not Reported△	Reporting Rate**
N/A	**Rheumatoid Arthritis Measures Group►►**	250	215	N/A	N/A	86%
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	250	220	30	0	88%
#176	Tuberculosis Screening	250	225	19	6	90%
#177	Periodic Assessment of Disease Activity	250	215	35	0	86%
#178	Functional Status Assessment	250	215	35	0	86%
#179	Assessment and Classification of Disease Prognosis	250	215	35	0	86%
#180	Glucocorticoid Management	250	215	34	1	86%
N/A	**Chronic Kidney Disease Measures Group►►**	250	215	N/A	N/A	86%

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Example 2.5 continued

Measure #	Measures Groups (with Measures Titles)►	Reporting Denominator: Applicable Cases♦	Reporting Numerator••	Insufficient QDC Information▲	QDC Not Reported△	Reporting Rate**
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and	250	220	30	0	88%
#122	Blood Pressure Management	250	225	25	0	90%
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating	250	215	35	0	86%
#135	Influenza Immunization	250	215	33	2	86%
#153	Referral for Arteriovenous (AV) Fistula	250	215	35	0	86%

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the

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

•An NPI satisfactorily reporting any method and passing the applicable validation process is eligible to receive a PQRI incentive. More information regarding the incentive
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 in
six or twelve month reporting period for the method by which the NPI was incentive eligible.

Information on insufficient quality-data codes

*The amount of the incentive is based on the total estimated allowed Medicare Part B 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 specified in the 2009 PQRI Measures Groups Specifications Manual located on the CMS PQRI website.

►►This count is for all measures reported within the measures group.

♦The # of reporting instances meeting the common denominator inclusion criteria for the measures group.

••The # of reporting instances for which this TIN/NPI submitted all quality-data code(s) (QDCs) or quality action data corresponding with all applicable measures within the measures group or submitted the composite G-code for the measures group. For each measure within the measures group, this indicates the # of reporting instances for which this TIN/NPI submitted one or more QDCs or quality actions corresponding with the applicable measure within the measures group.

▲The number of instances where reporting 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). This column will be populated with N/A for the Measures Group Title line.

△The number of instances where reporting was not met due to no quality-data code (QDC) information/numerator coding existing for the measure from the TIN/NPI combination. This column will be populated with N/A for the Measures Group Title line.

**The reporting rate for the measures group where all applicable QDCs or quality action data for all applicable measures within the measures group is reported for an eligible reporting instance which is used to determine incentive eligibility. The reporting rate for the measure where a QDC or quality action for the measure is reported for applicable cases.

Note: Due to measures group calculations, the overall measures groups reporting rate will not be an average of the individual measure's reporting rates.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 2.5 Screenshot of Table 2 for Measures Groups: 80% Beneficiaries via Claims for 12 Months: NPI Reporting Detail

Example 2.6

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 in the measures groups reported by the individual NPI's with the reporting denominator and reporting numerator. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 2: NPI Reporting Detail - Measures Groups: 30 Consecutive Patients via Registry for 12 Months
Sorted by Reporting Numerator of Measures Group and Sub-Sorted by Measure #

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 Method/Period Used for Incentive◊◊
Measures Groups - 30 consecutive patients via registry	12 months	ICLOPS	Yes	Yes

Incentive Detail for Measures Groups - 30 Consecutive Patients via Registry								
		Incentive Eligible●					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		
1000000009	Smithson, Steve	Measures Groups - 30 consecutive patients via registry	12 months	ICLOPS	Yes	Sufficient # of consecutive patients reported	$125,000.00	$2,500.00

Reporting Detail			
Measure #	Measures Groups (with Measures Titles)►►	Reporting Denominator: Applicable Cases°°°	Reporting Numerator□□
N/A	**Preventive Care Measures Group►►**	30	30
#39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	30	30
#48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	30	30
#110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	30	30
#111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older	30	30
#112	Preventive Care and Screening: Screening Mammography	30	30
#113	Preventive Care and Screening: Colorectal Cancer Screening	30	30

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

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Example 2.6 continued

Measure #	Measures Groups (with Measures Titles)►►	Reporting Denominator: Applicable Cases°°°	Reporting Numerator□□
#114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	30	30
#115	Preventive Care and Screening: Advising Smokers to Quit	30	30
#128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	30	30
N/A	**Diabetes Mellitus Measures Group►►**	30	30
#1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus	30	30
#2	Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus	30	30
#3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus	30	30
#117	Dilated Eye Exam in Diabetic Patient	30	30
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	30	30
#163	Foot Exam	30	30

Symbols are explained with footnotes.

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.

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

●An NPI satisfactorily reporting any 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 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 specified in the 2009 PQRI Measures Groups Specifications Manual located on the CMS PQRI website.

►►This count is for all measures reported within the measures group.

°°°The # of consecutive reporting instances meeting the common denominator inclusion criteria for the measures group.

□□The # of consecutive reporting instances for which this TIN/NPI submitted all quality-data code(s) (QDCs) or quality action data corresponding with all applicable measures within the measures group or submitted the composite G-code for the measures group. For each measure within the measures group, this indicates the # of consecutive reporting instances for which this TIN/NPI submitted one or more QDCs or quality actions corresponding with the applicable measure within the measures group. A satisfactorily-reported measures group for 30 consecutive patients has a reporting numerator of at least 30.

Note: Due to measures group calculations, the overall measures groups reporting rate will not be an average of the individual measure's reporting rates.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 2.6 Screenshot of Table 2 for Measures Groups: 30 Consecutive Patients via Registry for 12 Months: NPI Reporting Detail

Example 2.7

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Measures Groups: 80% Beneficiaries via Registry for 6 Months
Sorted by Reporting Rate of Measures Group and Sub-Sorted by Measure #

This table is sorted by reporting rate of measures groups, then sub-sorted by PQRI measure number.

Tax ID Name«: John Q. Public Clinic
Tax ID Number: XXXXX6789
NPI Number: 1000000011

Participation Summary				
All Methods Reported	Reporting Period	Registry Associated	Qualified for Incentive	Reporting Method/Period Used for Incentive◊◊
Measures Groups - 80% beneficiaries via registry	6 months	ICLOPS	Yes	Yes
Individual measure(s) reporting via claims	12 months	N/A	No	N/A
Individual measure(s) reporting via registry	6 months	ICLOPS	No	N/A

Incentive Detail for Measures Groups - 80% Beneficiaries via Registry								
		Incentive Eligible•					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		
1000000011	Jones, Josie	Measures Groups - 80% beneficiaries via registry	6 months	ICLOPS	Yes	Sufficient # of beneficiaries reported at 80% and a minimum of 15 eligible beneficiaries	$70,000.00	$1,400.00

Reporting Detail				
Measure #	Measures Groups (with Measures Titles)►	Reporting Denominator: Applicable Cases♦	Reporting Numerator••	Reporting Rate**
N/A	**Rheumatoid Arthritis Measures Group►►**	320	282	88%
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	320	262	82%

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Example 2.7 continued

Measure #	Measures Groups (with Measures Titles)►	Reporting Denominator: Applicable Cases♦	Reporting Numerator••	Reporting Rate**
#176	Tuberculosis Screening	320	272	85%
#177	Periodic Assessment of Disease Activity	320	256	80%
#178	Functional Status Assessment	320	282	88%
#179	Assessment and Classification of Disease Prognosis	320	282	88%
#180	Glucocorticoid Management	320	282	88%
N/A	**Chronic Kidney Disease Measures Group►►**	250	223	89%
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH)	250	220	88%
#122	Blood Pressure Management	250	225	90%
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-	250	215	86%
#135	Influenza Immunization	250	215	86%
#153	Referral for Arteriovenous (AV) Fistula	250	215	86%

All measures groups submitted under the reporting method will be displayed.

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.

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

•An NPI satisfactorily reporting any 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 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 specified in the 2009 PQRI Measures Groups Specifications Manual located on the CMS PQRI website.

►►This count is for all measures reported within the measures group.

♦The # of reporting instances meeting the common denominator inclusion criteria for the measures group.

••The # of reporting instances for which this TIN/NPI submitted all quality-data code(s) (QDCs) or quality action data corresponding with all applicable measures within the measures group or submitted the composite G-code for the measures group. For each measure within the measures group, this indicates the # of reporting instances for which this TIN/NPI submitted one or more QDCs or quality actions corresponding with the applicable measure within the measures group.

**The reporting rate for the measures group where all applicable QDCs or quality action data for all applicable measures within the measures group is reported for an eligible reporting instance which is used to determine incentive eligibility. The reporting rate for the measure where a QDC or quality action for the measure is reported for applicable cases.

Note: Due to measures group calculations, the overall measures groups reporting rate will not be an average of the individual measure's reporting rates.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 2.7 Screenshot of Table 2 for Measures Groups: 80% Beneficiaries via Registry for 6 Months: NPI Reporting Detail

Example 2.8

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 in the measures groups reported by the individual NPI's with the reporting denominator and reporting numerator. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 2: NPI Reporting Detail - Measures Groups: 30 Consecutive Beneficiaries via Claims for 12 Months
Sorted by Reporting Numerator of Measures Group and Sub-Sorted by Measure #

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

Participation Summary

All Methods Reported	Reporting Period	Registry Associated	Qualified for Incentive	Reporting Method/Period Used for Incentive◊◊
Measures Groups - 30 consecutive beneficiaries via claims	12 months	N/A	Yes	Yes
Individual measure(s) reporting via registry	6 months	Cedaron	No	N/A

Eligible professional's name is identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database.

Incentive Detail for Measures Groups - 30 Consecutive Beneficiaries via Claims

NPI	NPI Name«	Incentive Eligible•			Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
		Method of Reporting	Reporting Period	Yes/No	Rationale		
1000000013	Not Available	Measures Groups - 30 consecutive beneficiaries via claims	12 months	Yes	Sufficient # of consecutive beneficiaries reported	$65,000.00	$1,300.00

Reporting Detail

Measure #	Measures Groups (with Measures Titles)►	Reporting Denominator: Applicable Cases***	Reporting Numerator□□	Insufficient QDC Information▲	QDC Not Reported△
N/A	**Preventive Care Measures Group►►**	35	30	N/A	N/A
#39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	30	30	0	0
#48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	30	30	0	0
#110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	32	30	2	0
#111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older	30	30	0	0
#112	Preventive Care and Screening: Screening Mammography	38	30	0	8

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Example 2.8 continued

Measure #	Measures Groups (with Measures Titles)►	Reporting Denominator: Applicable Cases***	Reporting Numerator□□	Insufficient QDC Information▲	QDC Not Reported△
#113	Preventive Care and Screening: Colorectal Cancer Screening	30	30	0	0
#114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	30	30	0	0
#115	Preventive Care and Screening: Advising Smokers to Quit	30	30	0	0
#128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	30	30	0	0
N/A	**Diabetes Mellitus Measures Group►►**	30	30	N/A	N/A
#1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus	30	30	0	0
#2	Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus	33	30	3	0
#3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus	30	30	0	0
#117	Dilated Eye Exam in Diabetic Patient	30	30	0	0
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	30	30	0	0
#163	Foot Exam	31	30	0	1

The number of instances where reporting was not met due to insufficient QDC information/ numerator coding not complete for the measure from the TIN/NPI combination. This column will be populated with N/A for the measures group title line.

«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 re changes have not been processed and established in the national PECOS database as well as at the local Carrier/MAC systems at the time this report was produced, this is indicated by "Not A does not affect the organization's or professional's enrollment status or eligibility for a 2009 PQRI incentive payment, only the system's ability to populate this field in the report.
◊◊The method/period of reporting deemed most advantageous will be indicated with a "Yes". If the NPI did not qualify for incentive through any reporting methods/periods, the reporting method/ most advantageous would be populated with N/A.
•An NPI satisfactorily reporting any 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 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 specified in the 2009 PQRI Measures Groups Specifications Manual located on the CMS PQRI website.
►►This count is for all measures reported within the measures group.
***The # of consecutive reporting instances meeting the common denominator inclusion criteria for the measures group.

□□The # of consecutive reporting instances for which this TIN/NPI submitted all quality-data code(s) (QDCs) or quality action data corresponding with all applicable measures within the measures group or submitted the composite G-code for the measures group. For each measure within the measures group, this indicates the # of consecutive reporting instances for which this TIN/NPI submitted one or more QDCs or quality actions corresponding with the applicable measure within the measures group. A satisfactorily-reported measures group for 30 consecutive beneficiaries has a reporting numerator of at least 30.
▲The number of instances where reporting 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). This column will be populated with N/A for the Measures Group Title line.
△The number of instances where reporting was not met due to no quality-data code (QDC) information/numerator coding existing for the measure from the TIN/NPI combination. Due to measures groups calculations, these instances will not reflect whether the measures group is satisfactorily reported. This column will be populated with N/A for the Measures Group Title line.

Note: Due to measures group calculations, the overall measures groups reporting rate will not be an average of the individual measure's reporting rates.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 2.8 Screenshot of Table 2 for Measures Groups: 30 Consecutive Beneficiaries via Claims for 12 Months: NPI Reporting Detail

Example 2.9

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Individual Measure(s) Reporting via Registry for 6 Months
Sorted by Reporting Rate

Tax ID Name«: John Q. Public Clinic
Tax ID Number: XXXXX6789
NPI Number: 1000000002

The analytic category for each measure that determines how the measure will be calculated for PQRI.

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

Incentive Detail for Individual Measure(s) Reporting via Registry											
		Incentive Eligible•									
NPI	NPI Name«	Method of Reporting	Reporting Period	Registry Associated	Yes/No	Rationale	Total # Measures Submitted^	Total # Measures Denominator Eligible~	Total # Measures Satisfactorily Reported‡	Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
1000000002	Smith, Susie	Individual measure(s) reporting via registry	6 months	ACC	Yes	Sufficient # of measures reported at 80%	10	8	5	$100,000.00	$2,000.00

Reporting Detail for Total # of Measures Denominator Eligible					
Measure #	Measure Title	Measure Tag■	Reporting Denominator: Applicable Cases€	Reporting Numerator◊	Reporting Rate»
#31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	Episode	520	451	87%
#35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	Episode	450	382	85%
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	Episode	410	336	82%
#33	Stroke and Stroke Rehabilitation: Anticoagulent Therapy Prescribed for Atrial Fibrillation at Discharge	Episode	406	330	81%
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	Episode	400	320	80%
#34	Stroke and Stroke Rehabilitation: Tissue Pasminogen Activator (t-PA) Considered	Episode	370	274	74%
#47	Advance Care Plan	Patient-Process	358	261	73%
#124	HIT: Adoption/Use of Health Information Technology (Electronic Health Records)	Visit	321	201	63%

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Example 2.9 continued

Measure #	Measure Title	Measure Tag■	Reporting Denominator: Applicable Cases€	Reporting Numerator◊	Reporting Rate»

Reports may be longer than one page. Footnotes are included with each table.

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.
◊◊The method/period of reporting deemed most advantageous will be indicated with a "Yes". If the NPI did not qualify for incentive through any reporting methods/periods, the reporting method/period that was most advantageous would be populated with N/A.
•An NPI satisfactorily reporting any 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 measures where quality-data codes (QDCs) or quality action data are 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) or quality action data.
‡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 PFS charges processed within the length of the longest reporting period satisfied by the eligible professional.
■The analytic category for each measure that determines how the measure will be calculated for PQRI. Measure tags can be found in the PQRI Feedback Report User Guide and the PQRI Implementation Guide.
€The number of instances the TIN/NPI was eligible to report the measure.
◊The number of reporting instances where the quality-data codes (QDCs) or quality action data submitted met the measure specific reporting criteria.
»A satisfactorily-reported measure has a reporting rate of 80% or greater.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 2.9 Screenshot of Table 2 for Individual Measure(s) Reporting via Registry for 6 Months: NPI Reporting Detail

Table 3: NPI QDC Submission Error Detail

For the 2009 PQRI, only NPIs who participated through claims-based measure reporting with QDC submission errors will receive Table 3. This will only apply to eligible professionals who submitted at least one insufficient QDC. There is one NPI detail report for each TIN/NPI participating in PQRI.

- **QDC Exceptions (Denominator Mismatches):**
  - **Only Incorrect CPT:** Number of invalid QDC submissions resulting from an incorrect CPT code.
  - **Only QDC on Claim (no CPT/HCPCS):** Number of invalid QDC submissions due to a missing qualifying denominator code since all lines were QDCs.

For definition of terms related to 2009 PQRI feedback reports, see **Appendix A**. Also refer to the footnotes within each table for additional content detail.

Example 3.1

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five 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 for individual measures via claims 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.

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.

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

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

Denominator mismatches are shown in the QDC Exceptions column.

QDC Submission Error Detail

			QDC Occurrences			QDC Exceptions (Denominator Mismatches)						
Measure #	Measure Title	Measure Tag■	Actual # ReportedΩ	Reporting Numerator: Valid QDCs Reported◊	% of Valid QDCs Acceptedʊ	Gender	Age	Only Incorrect CPT	Only Incorrect DX	Both Incorrect CPT and DX┌	Only QDC on Claim (no CPT/HCPCS)△	Only QDC and Incorrect DX§
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	Episode	99	74	74.7%	0	0	13	5	4	1	2
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	Episode	54	42	77.8%	0	0	8	2	0	2	0
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	Patient-Process	210	180	85.7%	0	0	21	2	7	0	0
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	Patient-Process	410	400	97.6%	0	0	3	7	0	0	0
#53	Asthma: Pharmacologic Therapy	Patient-Process	50	0	0.0%	0	25	12	32	4	2	0
#64	Asthma Assessment	Patient-Process	25	0	0.0%	0	15	14	2	8	0	1

NPIs will only receive this table if they had QDC submission errors when reporting the PQRI measure (or a percent of valid QDCs accepted that was less than 100%).

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.

■The analytic category for each measure that determines how the measure will be calculated for PQRI. Measure tags can be found in the PQRI Feedback Report User Guide and the PQRI Implementation Guide.
ΩNumber of quality-data code (QDC) submissions for a measure whether or not the QDC submission was valid and appropriate.
◊Number of valid and appropriate quality-data code (QDC) submissions for a measure.
ʊThe percentage of reported quality-data codes (QDCs) that were valid.
┌Number 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.
§Number 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/HCPCS), and Only QDC and Incorrect DX (i.e. a submission attempt may be counted for age, gender, and incorrect DX).

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

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 participated in the 2009 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 2009 PQRI.***

- **Clinical Performance Rate:** The Clinical Performance Rate is calculated by dividing the Clinical Performance Numerator by the Clinical Performance Denominator. If 'NULL', all of the measure's performance eligible instances were performance exclusions.
- **Clinical Performance Not Met:**
  - 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.
- **Clinical Performance Denominator:** The performance denominator is determined by subtracting the number of eligible instances excluded from the numerator eligible reporting instances (Clinical Performance Denominator = Clinical Performance Numerator Met + Clinical Performance Not Met). Valid reasons for exclusions may apply and are specific to each measure. The 2009 PQRI Quality Measures Specifications document is available on the CMS PQRI website.
- **Clinical Performance Numerator Met:** The number of instances the TIN/NPI submitted the appropriate QDCs or quality action data satisfactorily meeting the performance requirements for the measure.
- **Reporting Numerator:** The number of reporting instances where the QDCs or quality action data submitted met the measure specific reporting criteria. (Reporting Numerator = 1P + 2P + 3P + Other + Clinical Performance Denominator).

Examples of Table 4: NPI Performance Detail in this *Guide* include:

- *Figure 4.1 Screenshot of Table 4 for Individual Measure(s) via Claims for 12 Months: NPI Reporting Detail*
- *Figure 4.2 Screenshot of Table 4 for Individual Measure(s) Reporting via Registry for 12 Months: NPI Reporting Detail*
- *Figure 4.3 Screenshot of Table 4 for Measures Groups: 80% Beneficiaries via Claims for 6 Months: NPI Reporting Detail*
- *Figure 4.4 Screenshot of Table 4 for Measures Groups: 80% Beneficiaries via Registry for 12 Months: NPI Reporting Detail*
- *Figure 4.5 Screenshot of Table 4 for Measures Groups: 80% Beneficiaries via Claims for 12 Months: NPI Reporting Detail*
- *Figure 4.6 Screenshot of Table 4 for Measures Groups: 30 Consecutive Patients via Registry for 12 Months: NPI Reporting Detail*
- *Figure 4.7 Screenshot of Table 4 for Measures Groups: 80% Beneficiaries via Registry for 6 Months: NPI Reporting Detail*
- *Figure 4.8 Screenshot of Table 4 for Measures Groups: 30 Consecutive Beneficiaries via Claims for 12 Months: NPI Reporting Detail*
- *Figure 4.9 Screenshot of Table 4 for Individual Measure(s) Reporting via Registry for 6 Months: NPI Reporting Detail*

For definition of terms related to 2009 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

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Individual Measure(s) Reporting via Claims for 12 Months
Sorted by Clinical Performance Rate and Sub-Sorted by Reporting Numerator

Reporting Numerator = 1P + 2P + 3P + Other + Clinical Performance Denominator
Clinical Performance Denominator = Clinical Performance Numerator Met + Clinical Performa

The peformance denominator is determined by subtracting the number of eligible instances excluded from the numerator-eligible reporting instances.

The National Comparison for Performance includes performance information for all TIN/NPI combinations submitting at least one QDC for the measure.

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								National Comparison for Performance◊◊◊			
Measure #	Measure Title	Reporting Numerator: Valid QDCs Reported◊	Medical (1P)	Patient (2P)	System (3P)	Other««	Clinical Performance Denominator ¤¤	Clinical Performance Numerator Met‖	Clinical Performance Not Met¤	Clinical Performance Rate□□□	National Mean Performance Rate***	25th Percentile	50th Percentile	75th Percentile
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	180	53	15	12	0	100	80	20	80%	50%	23%	51%	84%
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	42	6	4	0	0	32	18	14	56%	82%	74%	81%	91%
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	400	7	3	1	14	375	175	190	47%	33%	0%	34%	72%
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	74	70	4	0	0	0	0	0	NULL	52%	34%	53%	95%

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.
◊The number of reporting instances where the quality-data codes (QDCs) or quality action data 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 2009 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) or quality action data satisfactorily meeting the performance requirements for the measure.
¤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.
□□□The Clinical Performance Rate is calculated by dividing the Clinical Performance Numerator by the Clinical Performance Denominator. If 'NULL', all of the measure's performance eligible instances were performance exclusions.
◊◊◊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.
***The mean performance rate for all TIN/NPI combinations submitting at least one QDC for the measure.

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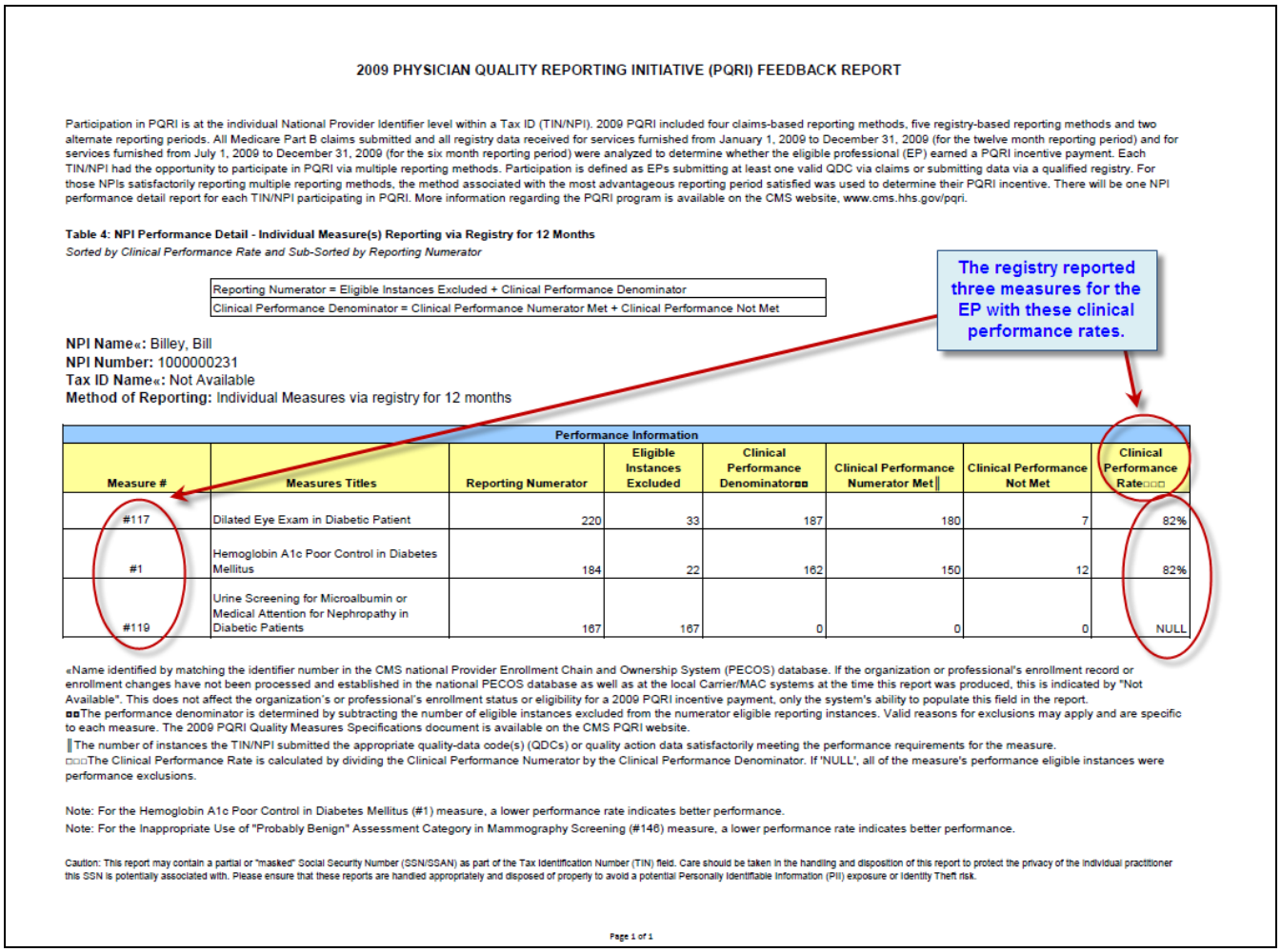
Figure 4.1. Screenshot of Table 4 for Individual Measure(s) Reporting via Claims for 12 Months: NPI Performance Detail

Example 4.2



2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Individual Measure(s) Reporting via Registry for 12 Months

Sorted by Clinical Performance Rate and Sub-Sorted by Reporting Numerator

Reporting Numerator = Eligible Instances Excluded + Clinical Performance Denominator
Clinical Performance Denominator = Clinical Performance Numerator Met + Clinical Performance Not Met

The registry reported three measures for the EP 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	Reporting Numerator	Eligible Instances Excluded	Clinical Performance Denominator▫▫	Clinical Performance Numerator Met‖	Clinical Performance Not Met	Clinical Performance Rate▫▫▫
#117	Dilated Eye Exam in Diabetic Patient	220	33	187	180	7	82%
#1	Hemoglobin A1c Poor Control in Diabetes Mellitus	184	22	162	150	12	82%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	167	167	0	0	0	NULL

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.
▫▫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 2009 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) or quality action data 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. If 'NULL', all of the measure's performance eligible instances were performance exclusions.

Note: For the Hemoglobin A1c Poor Control in Diabetes Mellitus (#1) measure, a lower performance rate indicates better performance.
Note: For the Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening (#146) measure, a lower performance rate indicates better performance.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

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Figure 4.2. Screenshot of Table 4 for Individual Measure(s) Reporting via Registry for 12 Months: NPI Performance Detail

Example 4.3

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Measures Groups: 80% Beneficiaries via Claims for 6 Months
Sorted by Measure Group and Sub-Sorted by Clinical Performance Rate

Reporting Numerator = 1P + 2P + 3P + Other + Clinical Performance Denominator
Clinical Performance Denominator = Clinical Performance Numerator Met + Clinical Performance Not Met

The clinical performance rate is a result of the clinical performance numerator met divided by the clinical performance denominator. For measure #119, it's 27 divided by 30 for 97%.

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

Performance Information										
			Eligible Instances Excluded							
Measure #	Measures Groups (with Measures Titles)►	Reporting Numerator	Medical (1P)	Patient (2P)	System (3P)	Other««	Clinical Performance Denominator¤¤	Clinical Performance Numerator Met‖	Clinical Performance Not Met¤	Clinical Performance Rate□□□
N/A	**Diabetes Mellitus Measures Group**									
#117	Dilated Eye Exam in Diabetic Patient	30	0	0	0	0	30	30	0	100%
#1	Hemoglobin A1c Poor Control in Diabetes Mellitus	30	0	0	0	0	30	28	2	93%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	30	0	0	0	0	30	27	3	97%
#3	High Blood Pressure Control in Diabetes Mellitus	30	0	0	0	2	28	20	8	71%
#2	Low Density Lipoprotein Control in Diabetes Mellitus	30	0	0	0	0	30	20	10	67%
#163	Foot Exam	30	30	0	0	0	0	0	0	NULL
N/A	**Rheumatiod Arthritis Measures Group**									
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	250	27	0	0	0	223	203	20	91%
#176	Tuberculosis Screening	250	39	0	0	13	198	173	25	87%
#177	Periodic Assessment of Disease Activity	250	0	0	0	0	250	192	58	77%

Example 4.3 continued

#178	Functional Status Assessment	250	0	0	0	0	250	190	60	76%
#179	Assessment and Classification of Disease Prognosis	250	0	0	0	0	250	180	70	72%
#180	Glucocorticoid Management	250	20	0	0	0	230	159	71	69%

«Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or prof enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier/MAC systems at the time this report was pr Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2009 PQRI incentive payment, only the system's ability to populate

Tables can be longer than one page.

►Each measure within the measures group is analyzed as specified in the 2009 PQRI Measures Groups Specifications Manual located on the CMS PQRI website.

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

¤¤The performan acting the number of eligible instances excluded from the number of eligible beneficiaries. Valid reasons for exclusions may apply, these are specific to each measure. ecifications Manual containing measure specific information is available on the CMS website.

Symbols are explained with footnotes.

¤Includes instanc PT II code is used to indicate the quality action was not provided for a reason not otherwise specified.

‖The number of i ppropriate quality-data code(s) (QDCs) or quality action data 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. If 'NULL', all of the measure's performance eligible instances were performance exclusions.

Note: For the Hemoglobin A1c Poor Control in Diabetes Mellitus (#1) measure, a lower performance rate indicates better performance.

Note: For the Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening (#146) measure, a lower performance rate indicates better performance.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 4.3. Screenshot of Table 4 for Measures Groups: 80% Beneficiaries via Claims for 6 Months: NPI Performance Detail

Example 4.4

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Measures Groups: 80% Beneficiaries via Registry for 12 Months
Sorted by Measure Group and Sub-Sorted by Clinical Performance Rate

Reporting Numerator = Eligible Instances Excluded + Clinical Performance Denominator
Clinical Performance Denominator = Clinical Performance Numerator Met + Clinical Performance Not Met

The number of reporting instances where QDCs or quality action data submitted met the measure-specific reporting criteria.

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

Performance Information							
Measure #	Measures Groups (with Measures Titles)►	Reporting Numerator	Eligible Instances Excluded	Clinical Performance Denominator▫▫	Clinical Performance Numerator Met‖	Clinical Performance Not Met	Clinical Performance Rate▫▫▫
N/A	**Chronic Kidney Disease Measures Group**						
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	462	32	430	385	45	90%
#122	Blood Pressure Management	462	0	462	373	89	81%
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	462	15	447	352	95	79%
#135	Influenza Immunization	462	22	440	365	75	74%
#153	Referral for Arteriovenous (AV) Fistula	462	25	437	300	137	69%
N/A	**Rheumatiod Arthritis Measures Group**						
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	320	32	288	245	43	85%
#176	Tuberculosis Screening	320	18	302	233	69	77%
#177	Periodic Assessment of Disease Activity	320	26	294	213	81	72%
#178	Functional Status Assessment	320	23	297	193	104	65%
#179	Assessment and Classification of Disease Prognosis	320	33	287	181	106	63%
#180	Glucocorticoid Management	320	320	0	0	0	NULL

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.
►Each measure within the measures group is analyzed as specified in the 2009 PQRI Measures Groups Specifications Manual located on the CMS PQRI website.
▫▫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 2009 PQRI Measures Groups Specifications Manual 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) or quality action data 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. If 'NULL', all of the measure's performance eligible instances were performance exclusions.

Note: For the Hemoglobin A1c Poor Control in Diabetes Mellitus (#1) measure, a lower performance rate indicates better performance.
Note: For the Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening (#146) measure, a lower performance rate indicates better performance.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 4.4. Screenshot of Table 4 for Measures Groups: 80% Beneficiaries via Registry for 12 Months: NPI Performance Detail

Example 4.5

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Measures Groups: 80% Beneficiaries via Claims for 12 Months
Sorted by Measure Group and Sub-Sorted by Clinical Performance Rate

Reporting Numerator = 1P + 2P + 3P + Other + Clinical Perform
Clinical Performance Denominator = Clinical Performance Num

The number of instances the TIN/NPI submitted the appropriate QDCs or quality action data 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.

NPI Name«: Billey, Bill
NPI Number: 1000000231
Tax ID Name«: West Clinic
Method of Reporting: Measures Groups - 80% beneficiaries via claims for 12 months

Performance Information										
			Eligible Instances Excluded							
Measure #	Measures Groups (with Measures Titles)►	Reporting Numerator	Medical (1P)	Patient (2P)	System (3P)	Other««	Clinical Performance Denominator▫▫	Clinical Performance Numerator Met‖	Clinical Performance Not Met▫	Clinical Performance Rate□□□
N/A	**Diabetes Mellitus Measures Group**									
#117	Dilated Eye Exam in Diabetic Patient	30	0	0	0	0	30	30	0	100%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	30	0	0	0	0	30	28	2	97%
#1	Hemoglobin A1c Poor Control in Diabetes Mellitus	30	0	0	0	0	30	27	3	93%
#3	High Blood Pressure Control in Diabetes Mellitus	30	0	0	0	2	28	20	8	71%
#2	Low Density Lipoprotein Control in Diabetes Mellitus	30	0	0	0	0	30	20	10	67%
#163	Foot Exam	30	4	0	0	0	26	15	11	58%
N/A	**Rheumatiod Arthritis Measures Group**									
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	250	27	0	0	0	223	203	20	91%
#176	Tuberculosis Screening	250	39	0	0	13	198	173	25	87%

Example 4.5 continued

#177	Periodic Assessment of Disease Activity	250	0	0	0	0	250	192	58	77%
#178	Functional Status Assessment	250	0	0	0	0	250	190	60	76%
#179	Assessment and Classification of Disease Prognosis	250	0	0	0	0	250	180	70	72%
#180	Glucocorticoid Management	250	250	0	0	0	0	0	0	NULL

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.

►Each measure within the measures group is analyzed as specified in the 2009 PQRI Measures Groups Specifications Manual located on the CMS PQRI website.

««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 2009 PQRI Measures Groups Specifications Manual 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 the TIN/NPI submitted the appropriate quality-data code(s) (QDCs) or quality action data 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. If 'NULL', all of the measure's performance eligible instances were performance exclusions.

Note: For the Hemoglobin A1c Poor Control in Diabetes Mellitus (#1) measure, a lower performance rate indicates better performance.

Note: For the Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening (#146) measure, a lower performance rate indicates better performance.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 4.5. Screenshot of Table 4 for Measures Groups: 80% Beneficiaries via Claims for 12 Months: NPI Performance Detail

Example 4.6

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Measures Groups: 30 Consecutive Patients via Registry for 12 Months
Sorted by Measure Group and Sub-Sorted by Clinical Performance Rate

Reporting Numerator = Eligible Instances Excluded + Clinical Performance Denominator
Clinical Performance Denominator = Clinical Performance Numerator Met + Clinical Performance Not Met

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: Measures Groups - 30 consecutive patients via registry for 12 months

Performance Information							
Measure #	Measures Groups (with Measures Titles)►	Reporting Numerator	Eligible Instances Excluded	Clinical Performance Denominator▫▫	Clinical Performance Numerator Met‖	Clinical Performance Not Met	Clinical Performance Rate▫▫▫
N/A	**Diabetes Mellitus Measures Group**						
#117	Dilated Eye Exam in Diabetic Patient	30	0	30	25	5	83%
#1	Hemoglobin A1c Poor Control in Diabetes Mellitus	30	2	28	23	5	82%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	30	0	30	24	6	80%
#3	High Blood Pressure Control in Diabetes Mellitus	30	3	24	21	3	78%
#2	Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	30	0	30	23	7	77%
#163	Foot Exam	30	30	0	0	0	NULL
N/A	**Rheumatiod Arthritis Measures Group**						
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	320	32	288	245	43	85%
#176	Tuberculosis Screening	320	18	302	233	69	77%
#177	Periodic Assessment of Disease Activity	320	26	294	213	81	72%
#178	Functional Status Assessment	320	23	297	193	104	65%

Example 4.6 continued

Measure #	Measures Groups (with Measures Titles)►	Reporting Numerator	Eligible Instances Excluded	Clinical Performance Denominator▫▫	Clinical Performance Numerator Met‖	Clinical Performance Not Met	Clinical Performance Rate▫▫▫
#179	Assessment and Classification of Disease Prognosis	320	33	287	181	106	63%
#180	Glucocorticoid Management	320	20	300	180	120	60%

«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/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 stat… …nt, only the system's ability to populate this field in the report.

►Each measure within the measures group is analyzed as specified in the 2009 PQRI Measures Gr… …PQRI website.

▫▫The performance denominator is determined by subtracting the number of eligible instances exclu… …alid reasons for exclusions may apply, these are specific to each measure. The 2009 PQRI Measures Groups Specifications Manual containing m… …CMS website.

‖The number of instances the TIN/NPI submitted the appropriate quality-data code(s) (QDCs) or qu… …mance requirements for the measure.

▫▫▫The Clinical Performance Rate is calculated by dividing the Clinical Performance Numerator by t… …, all of the measure's performance eligible instances were performance exclusions.

The performance denominator is determined by subtracting the number of eligible instances excluded from the number of eligible beneficiaries.

Note: For the Hemoglobin A1c Poor Control in Diabetes Mellitus (#1) measure, a lower performance rate indicates better performance.
Note: For the Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening (#146) measure, a lower performance rate indicates better performance.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 4.6. Screenshot of Table 4 for Measures Groups: 30 Consecutive Patients via Registry for 12 Months: NPI Performance Detail

Example 4.7

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Measures Groups: 80% Beneficiaries via Registry for 6 Months
Sorted by Measure Group and Sub-Sorted by Clinical Performance Rate

Reporting Numerator = Eligible Instances Excluded + Clinical Performance Denominator
Clinical Performance Denominator = Clinical Performance Numerator Met + Clinical Performance Not Met

The number of instances the TIN/NPI submitted a modifier or QDC as performance exclusion for the measure.

NPI Name«: Jones, Joe
NPI Number: 1000000222
Tax ID Name«: Not Available
Method of Reporting: Measures Groups - 80% beneficiaries via registry for 6 months

Performance Information							
Measure #	Measures Groups (with Measures Titles)►	Reporting Numerator	Eligible Instances Excluded	Clinical Performance Denominator▫▫	Clinical Performance Numerator Met‖	Clinical Performance Not Met	Clinical Performance Rate▫▫▫
N/A	**Chronic Kidney Disease Measures Group**						
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	462	32	430	385	45	90%
#122	Blood Pressure Management	462	0	462	373	89	81%
#123	Plan of Care - Elevated Hemoglobin for Patients	462	15	447	352	95	79%
#135	Influenza Immunization	462	22	440	365	75	74%
#153	Referral for Arteriovenous (AV) Fistula	462	25	437	300	137	69%
N/A	**Rheumatiod Arthritis Measures Group**						
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	320	32	288	245	43	85%
#176	Tuberculosis Screening	320	18	302	233	69	77%
#177	Periodic Assessment of Disease Activity	320	26	294	213	81	72%
#178	Functional Status Assessment	320	23	297	193	104	65%
#179	Assessment and Classification of Disease Prognosis	320	33	287	181	106	63%
#180	Glucocorticoid Management	320	320	0	0	0	NULL

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.

►Each measure within the measures group is analyzed as specified in the 2009 PQRI Measures Groups Specifications Manual located on the CMS PQRI website.

▫▫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 2009 PQRI Measures Groups Specifications Manual 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) or quality action data 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. If 'NULL', all of the measure's performance eligible instances were performance exclusions.

Note: For the Hemoglobin A1c Poor Control in Diabetes Mellitus (#1) measure, a lower performance rate indicates better performance.

Note: For the Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening (#146) measure, a lower performance rate indicates better performance.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 4.7. Screenshot of Table 4 for Measures Groups: 80% Beneficiaries via Registry for 6 Months: NPI Performance Detail

Example 4.8

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Measures Groups: 30 Consecutive Beneficiaries via Claims for 12 Months
Sorted by Measure Group and Sub-Sorted by Clinical Performance Rate

Reporting Numerator = 1P + 2P + 3P + Other + Clinical Performance Denominator
Clinical Performance Denominator = Clinical Performance Numerator Met + Clinical Performance Not Met

NPI Name«: Billey, Bill
NPI Number: 1000000231
Tax ID Name«: South Public Clinic
Method of Reporting: Measures Groups - 30 consecutive beneficiaries via claims for 12 months

The EP reported two measures groups via claims with these clinical performance rates. If "NULL" is listed, then all of the measure's performance-eligible instances were performance exclusions.

Performance Information										
			Eligible Instances Excluded							
Measure #	Measures Groups (with Measures Titles)►	Reporting Numerator	Medical (1P)	Patient (2P)	System (3P)	Other««	Clinical Performance Denominator¤ ¤	Clinical Performance Numerator Met‖	Clinical Performance Not Met¤	Clinical Performance Rate□□□
N/A	**Diabetes Mellitus Measures Group**									
#117	Dilated Eye Exam in Diabetic Patient	30	0	0	0	0	30	30	0	100%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	30	0	0	0	0	30	28	2	97%
#1	Hemoglobin A1c Poor Control in Diabetes Mellitus	30	0	0	0	0	30	27	3	93%
#3	High Blood Pressure Control in Diabetes Mellitus	30	0	0	0	2	28	20	8	71%
#2	Low Density Lipoprotein Control in Diabetes Mellitus	30	0	0	0	0	30	20	10	67%
#163	Foot Exam	30	30	0	0	0	0	0	0	NULL
N/A	**Rheumatiod Arthritis Measures Group**									
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	250	27	0	0	0	223	203	20	91%
#176	Tuberculosis Screening	250	39	0	0	13	198	173	25	87%
#177	Periodic Assessment of Disease Activity	250	0	0	0	0	250	192	58	77%
#178	Functional Status Assessment	250	0	0	0	0	250	190	60	76%
#179	Assessment and Classification of Disease Prognosis	250	0	0	0	0	250	180	70	72%
#180	Glucocorticoid Management	250	20	0	0	0	230	159	71	69%

Example 4.8 continued

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.
►Each measure within the measures group is analyzed as specified in the 2009 PQRI Measures Groups Specifications Manual located on the CMS PQRI website.
««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 2009 PQRI Measures Groups Specifications Manual 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) or quality action data 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 Clinical Performance Denominator. If 'NULL', all of the measure's performance eligible instances were performance exclusions.

Note: For the Hemoglobin A1c Poor Control in Diabetes Mellitus (#1) measure, a lower performance rate indicates better performance.
Note: For the Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening (#146) measure, a lower performance rate indicates better performance.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 4.8. Screenshot of Table 4 for Measures Groups: 30 Consecutive Beneficiaries via Claims for 12 Months: NPI Performance Detail

Example 4.9

2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2009 PQRI included four claims-based reporting methods, five registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 to December 31, 2009 (for the twelve month reporting period) and for services furnished from July 1, 2009 to December 31, 2009 (for the six 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 - Individual Measure(s) Reporting via Registry for 6 Months

Sorted by Clinical Performance Rate and Sub-Sorted by Reporting Numerator

Reporting Numerator = Eligible Instances Excluded + Clinical Performance Denominator
Clinical Performance Denominator = Clinical Performance Numerator Met + Clinical Performance Not Met

The 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 6 months

Performance Information							
Measure #	Measures Titles	Reporting Numerator	Eligible Instances Excluded	Clinical Performance Denominator▫▫	Clinical Performance Numerator Met‖	Clinical Performance Not Met	Clinical Performance Rate▫▫▫
#117	Dilated Eye Exam in Diabetic Patient	89	4	85	80	5	90%
#1	Hemoglobin A1c Poor Control in Diabetes Mellitus	78	10	68	58	10	74%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	92	92	0	0	0	NULL

«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/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 2009 PQRI incentive payment, only the system's ability to populate this field in the report.
▫▫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 2009 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) or quality action data 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. If 'NULL', all of the measure's performance eligible instances were performance exclusions.

Note: For the Hemoglobin A1c Poor Control in Diabetes Mellitus (#1) measure, a lower performance rate indicates better performance.
Note: For the Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening (#146) measure, a lower performance rate indicates better performance.

Caution: This report may contain a partial or "masked" Social Security Number (SSN/SSAN) as part of the Tax Identification Number (TIN) field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner this 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.

Figure 4.9. Screenshot of Table 4 for Individual Measures: 80% via Registry for 6 Months: NPI Performance Detail

Accessing Feedback Reports from the Physician and Other Health Care Professionals Quality Reporting Portal

2009 PQRI feedback reports will be available through the Physician and Other Health Care Professionals Quality Reporting Portal on a secured website, My QualityNet (https://www.qualitynet.org/portal/server.pt), downloadable as an Adobe® Acrobat® PDF in the fall of 2010. The report may also be available as a Microsoft® Excel or .csv file. To access TIN-level feedback reports, you will need to create 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.gov/IACS/). MLN articles with additional IACS information can be found on the CMS website at:

- http://www.cms.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.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.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 Portal via QualityNet is the secured entry point to access the reports. Your report is safely stored online and accessible only to you (and those you specifically authorize) through the IACS web application.

Please see the *2010 Portal User Guide* (https://www.qualitynet.org/portal/server.pt) for detailed instructions on logging into the Portal.

Figure 5.1 Screenshot of Physician and Other Health Care Professionals Quality Reporting Portal

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 2009 PQRI included a validation process to ensure that each eligible professional satisfactorily reported the minimum number of measures. Eligible professional s who satisfactorily submitted QDCs via claims-based reporting for fewer than three PQRI measures for at least 80% of their patients eligible for each measure reported were subject to MAV to determine whether they should have submitted QDCs for additional measure(s). This validation process is only applicable to claims-based reporting and does not apply to registry-based submission. For more information, refer to PQRI FAQs and the 2009 MAV documents on the CMS PQRI website at http://www.cms.gov/PQRI/2009/list.asp#TopOfPage.

Lump-Sum Incentive Payment

Payment Calculations

- The 2.0% incentive will be based on CMS' estimate of all Medicare Part B PFS allowed charges for covered professional services: (1) furnished during the applicable 2009 reporting period, (2) processed by the Carrier or 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 eligible professional 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 eligible professional's services and quality data.
    - Incentive payments earned by individual eligible professionals 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 eligible professionals' incentives to the TIN level.
    - For eligible professionals 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.
    - Eligible professionals 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 2009 PQRI program pages on the CMS PQRI website (http://www.cms.gov/pqri).

Distribution

- 2009 PQRI Incentive payments will be issued to the TIN by the Carrier or MAC in October/November of 2010 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 2009 PQRI and the 2009 Electronic Prescribing (eRx) Incentive Program will be distributed separately.
- If a TIN submits claims to multiple Medicare claims-processing contractors (Carriers or 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 2009 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 MAC.
- If your incentive payment amount does not match what is reflected in your PQRI feedback report, contact your Carrier or MAC. The incentive amount may differ by a penny or two from what is reflected in the feedback report due to rounding. The proportion of incentive amount by Carrier/MAC may not equal 100 percent 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 MAC and identified as a lump-sum PQRI incentive payment. CMS will provide the 2009 PQRI feedback reports through a separate process.
- The Electronic Remittance Advice sends a 2-character code (LE) to indicate incentive payments plus a 4-digit code for the type of incentive and reporting year (PQ09) to accompany the incentive payment.

- The Paper Remittance Advice states: “This is a PQRI incentive payment.”
- PQRI participants will not receive claim-level detail in the feedback reports.
- 2009 PQRI feedback reports will be available November 2010.
- 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 eligible professional (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 for multiple years will now be accessible via the Portal and will not be archived.
- An individual NPI within a TIN will be included in all tables of the feedback report when **all** of their QDCs are submitted on claims that are not denominator eligible for the measure. Since all of the QDCs are invalid submissions, Tables 1, 2, and 4 will be populated with zeroes in most or all of the numeric fields of the tables, but Table 3 will give detailed information in regards to these invalid submissions.
- In some cases, an individual NPI will be indicated in the feedback report as incentive eligible, but the incentive payment is determined to be zero dollars. This is due to when the incentive payment calculation for the individual NPI indicates they do not have any total estimated Medicare Part B PFS allowed charges for covered professional services billed under that individual's TIN/NPI combination.

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 QualityNet Help Desk at 866-288-8912 or qnetsupport@sdps.org (Monday-Friday 7:00 a.m.-7:00 p.m. CT). You may also contact them for **PQRI assistance including accessing the Portal**.
- Contact your Carrier or 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.gov/MLNGenInfo/01_Overview.asp.

Copyright, Trademark, and Code-Set Maintenance Information

Appendix A: 2009 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). 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 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 2009 PQRI incentive payment; only the system's ability to populate this field in the report.
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 MAC Identification #	Carrier and/or MAC number to which the TIN bills their claims.
Proportion of Incentive per Carrier/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/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.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 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 2009 PQRI incentive payment; only the system's ability to populate this field in the report.

Term	Definition
Incentive Eligible	• **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 12 months – 80% measures groups via claims o 12 months – consecutive measures groups via claims o 6 months – individual measures via registry o 6 months – 80% measures groups via registry o 6 months – 80% measures groups via claims • **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% and a minimum of 15 eligible beneficiaries o Sufficient # of beneficiaries reported at 80% and a minimum of 30 eligible beneficiaries o Sufficient # of consecutive patients reported o Sufficient # of consecutive beneficiaries reported o Insufficient # of consecutive patients reported o Insufficient % of beneficiaries reported o Insufficient # of measures reported at 80% o Did not pass MAV o Insufficient number of minimum eligible beneficiaries More information regarding incentive calculations can be found on the CMS website, http://www.cms.gov/pqri.
Total # Measures Submitted	The number of measures where quality-data codes (QDCs) or quality actions data are submitted, but are not necessarily valid. Only valid submissions count toward reporting success. If the reporting method is through measures groups, this field will be populated with 'N/A'.
Total # Measures Denominator Eligible	The number of measures for which the TIN/NPI reported at least one valid quality-data code (QDC) or quality action data. If the reporting method is through measures groups, this field will be populated with 'N/A'. 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 2009 PQRI program page on the CMS website at http://www.cms.gov/pqri.
Total # Measures Satisfactorily Reported	The total number of measures the TIN/NPI reported at a satisfactory rate; satisfactory rate is for ≥ 80% of instances. If the reporting method is through measures groups, this field will be populated with 'N/A'.
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 amount of the incentive is based on the total estimated allowed Medicare Part B 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.

Table 2: NPI Participation Detail

Term	Definition
Tax ID Name	Legal business name associated with a TIN. 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 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 2009 PQRI incentive payment; only the system's ability to populate this field in the report.
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.
Qualified for Incentive	"Yes" if satisfactorily met reporting criteria and "No" if did not satisfactorily meet reporting criteria.
Reporting Method/Period Used for Incentive	The method/period of reporting deemed most advantageous will be indicated with a "Yes". If the NPI did not qualify for incentive through any reporting methods/periods, the reporting method/period 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 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 2009 PQRI incentive payment; only the system's ability to populate this field in the report.

Term	Definition
Incentive Eligible	• **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 12 months – 80% measures groups via claims o 12 months – consecutive measures groups via claims o 6 months – individual measures via registry o 6 months – 80% measures groups via registry o 6 months – 80% measures groups via claims • **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% and a minimum of 15 eligible beneficiaries o Sufficient # of beneficiaries reported at 80% and a minimum of 30 eligible beneficiaries o Sufficient # of consecutive patients reported o Sufficient # of consecutive beneficiaries reported o Insufficient # of consecutive patients reported o Insufficient % of beneficiaries reported o Insufficient # of measures reported at 80% o Did not pass MAV o Insufficient number of minimum eligible beneficiaries More information regarding incentive calculations can be found on the CMS website, http://www.cms.gov/pqri.
Total # Measures Submitted	The number of measures where QDCs or quality action data are submitted, but not necessarily valid. Only valid submissions count toward reporting success.
Total # Measures Denominator Eligible	The number of measures for which the TIN/NPI reported at least one valid quality-data code (QDC) or quality action data. If the reporting method is through measures groups, this field will be populated with 'N/A'. • **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 2009 PQRI program page on the CMS website at http://www.cms.gov/pqri.
Total # Measures Satisfactorily Reported	The total number of measures the TIN/NPI reported at a satisfactory rate; satisfactory rate is for ≥ 80% of instances. If the reporting method is through measures groups, this field will be populated with 'N/A'.
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 amount of the incentive is based on the total estimated allowed Medicare Part B 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.
Measure #/Measure Title	2009 PQRI measure number and title.

<table>
<tr><th>Term</th><th>Definition</th></tr>
<tr><td>Measure Tag</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.
<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>5, 6, 7, 8, 12, 14, 18, 19, 39, 41, 47, 48, 49, 50, 51, 52, 53, 64, 67, 68, 69, 70, 71, 72, 79, 83, 84, 85, 86, 87, 89, 90, 106, 108, 110, 111, 112, 113, 114, 115, 117, 118, 119, 121, 126, 127, 134, 135, 136, 137, 140, 141, 152, 153, 154, 155, 156, 160, 161, 162, 163, 173, 176, 177, 178, 179, 180, 183, 184, 186</td></tr>
<tr><td>Patient-Periodic</td><td>81, 82, 123, 148, 149, 150, 151, 159, 174, 175</td></tr>
<tr><td>Episode</td><td>9, 24, 26, 31, 32, 33, 34, 35, 36, 40, 46, 54, 55, 56, 57, 58, 59, 65, 66, 91, 93, 102, 104, 105, 116</td></tr>
<tr><td>Procedure</td><td>10, 11, 20, 21, 22, 23, 30, 43, 44, 45, 76, 95, 99, 100, 139, 145, 146, 147, 157, 158, 164, 165, 166, 167, 168, 169, 170, 171, 171, 185</td></tr>
<tr><td>Visit</td><td>92, 94, 107, 109, 122, 124, 130, 131, 138, 142, 143, 144, 181, 182</td></tr>
</table></td></tr>
<tr><td>Reporting Denominator: Applicable Cases</td><td>The number of instances the TIN/NPI was eligible to report the measure or the number of reporting instances meeting the common denominator inclusion criteria for the measures group.</td></tr>
<tr><td>Reporting Numerator: Valid QDCs Reported</td><td>The number of reporting instances where the quality-data codes (QDCs) or quality action data submitted met the measure-specific reporting criteria.

The number of reporting instances for which this TIN/NPI submitted all quality-data code(s) (QDCs) or quality action data corresponding with all applicable measures within the measures group or submitted the composite G-code for the measures group. For each measure within the measures group, this indicates the number of reporting instances for which this TIN/NPI submitted one or more QDCs or quality actions corresponding with the applicable measure within the measures group.</td></tr>
<tr><td>Insufficient QDC Information</td><td>The number of instances where reporting 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). This column will be populated with N/A for the measures group title line.</td></tr>
<tr><td>QDC Not Reported</td><td>The number of instances where reporting was not met due to no quality-data code (QDC) information/numerator coding existing for the measure from the TIN/NPI combination. This column will be populated with N/A for the measures group title line.</td></tr>
</table>

Term	Definition
Reporting Rate	A satisfactorily-reported measure has a reporting rate of 80% or greater. The reporting rate for the measures group where all applicable QDCs or quality action data for all applicable measures within the measures group is reported for an eligible reporting instance which is used to determine incentive eligibility. The reporting rate for the measure where a QDC or quality action for the measure is reported for applicable cases.
Measure Validation Clinical Focus Area	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. • **Measure-Applicability Validation (MAV):** o If an eligible professional submits QDCs for only one or two PQRI measures for the 2009 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.gov/pqri.
Measures Groups	2009 PQRI Measures Groups submitted by the NPI. Each measure within the measures group is analyzed as specified in the *2009 PQRI Measures Groups Specifications Manual* located on the CMS PQRI website.

Table 3: NPI QDC Submission Error Detail

<table>
<tr><th>Term</th><th>Definition</th></tr>
<tr><td>Tax ID Name</td><td>Legal business name associated with a TIN. 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 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 2009 PQRI incentive payment; only the system's ability to populate this field in the report.</td></tr>
<tr><td>NPI Name</td><td>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 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 2009 PQRI incentive payment; only the system's ability to populate this field in the report.</td></tr>
<tr><td>NPI Number</td><td>Individual National Provider Identifier of the eligible professional billing under the TIN.</td></tr>
<tr><td>Method of Reporting</td><td>The method of reporting attempted by the NPI. For those NPIs participating in PQRI by multiple reporting methods, the most advantageous method is displayed.</td></tr>
<tr><td>Measure #/Measure Title</td><td>2009 PQRI measure number and title.</td></tr>
<tr><td>Measure Tag</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.

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<tr><td>Patient-Periodic</td><td>81, 82, 123, 148, 149, 150, 151, 159, 174, 175</td></tr>
<tr><td>Episode</td><td>9, 24, 26, 31, 32, 33, 34, 35, 36, 40, 46, 54, 55, 56, 57, 58, 59, 65, 66, 91, 93, 102, 104, 105, 116</td></tr>
<tr><td>Procedure</td><td>10, 11, 20, 21, 22, 23, 30, 43, 44, 45, 76, 95, 99, 100, 139, 145, 146, 147, 157, 158, 164, 165, 166, 167, 168, 169, 170, 171, 171, 185</td></tr>
<tr><td>Visit</td><td>92, 94, 107, 109, 122, 124, 130, 131, 138, 142, 143, 144, 181, 182</td></tr>
</table></td></tr>
</table>

Term	Definition
QDC Occurrences	• **Actual # Reported:** Number of QDC submissions for a measure, whether or not the QDC submission was valid and appropriate • **Reporting 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
Gender	Number of QDC submissions that were not accepted due to not meeting the gender requirements for the measure.
Age	Number of QDC submissions that were not accepted due to not meeting the age requirements for the measure.
Only Incorrect CPT	Number of invalid QDC submissions resulting from an incorrect CPT code.
Only Incorrect DX	Number of invalid QDC submissions resulting from an incorrect diagnosis code.
Both Incorrect CPT and DX	Number of invalid QDC submissions resulting from a combination of incorrect CPT code and incorrect diagnosis code.
Only QDC on Claim (no CPT/HCPCS)	Number of invalid QDC submissions due to a missing qualifying denominator code since all lines were QDCs.
Only QDC and Incorrect DX	Number of invalid QDC submissions due to a missing qualifying denominator code since all lines were QDCs and the diagnosis code was incorrect.

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. 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 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 2009 PQRI incentive payment; only the system's ability to populate this field in the report.
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 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 2009 PQRI incentive payment; only the system's ability to populate this field in the report.
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 #/Measure Title	2009 PQRI measure number and title.
Reporting Numerator: Valid QDCs Reported	The number of reporting instances where the quality-data codes (QDCs) or quality action data submitted met the measure-specific reporting criteria.

Term	Definition
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:** Includes instances where a CPT II code, G-code, or 8P modifier is used 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 numerator eligible reporting instances. Valid reasons for exclusions may apply and are specific to each measure. The *2009 PQRI Quality Measures Specifications* document is available on the CMS PQRI website.
Clinical Performance Numerator Met	Number of instances the TIN/NPI submitted the appropriate QDC(s) or quality action data 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.
Clinical Performance Not Met	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. • **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).
Clinical Performance Rate	For “poor control” or “inappropriate care” measures, it is desirable to have a lower rate. The Clinical Performance Rate is calculated by dividing the Clinical Performance Numerator by the Clinical Performance Denominator. If 'NULL', all of the measure's performance eligible instances were performance exclusions. 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.
National Comparison for Performance	The National Comparison for Performance includes performance information for all 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.
National Mean Performance Rate	The mean performance rate for all TIN/NPI combinations submitting at least one QDC for the measure.
Measures Groups - Title	Name of 2009 PQRI measures group.