User Guide

2012 Physician Quality Reporting System (PQRS) Feedback Reports

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User Guide 2012 Physician Quality Reporting System (PQRS) Feedback Reports

Purpose

The Physician Quality Reporting System (PQRS) Feedback Report User Guide is designed to assist eligible professionals and their authorized users with accessing and interpreting the 2012 PQRS feedback reports. The 2012 PQRS incentive payments are scheduled to be made in the fall of 2013. Feedback reports reflect data from the Medicare Part B Physician Fee Schedule (PFS) claims received with dates of service between January 1, 2012 – December 31, 2012 that were processed into the National Claims History (NCH) by February 22, 2013.

PQRS 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 Physician Quality Reporting Initiative (PQRI). Note: In 2011 the PQRI program name changed to Physician Quality Reporting System (PQRS).

PQRS 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 PQRS measures through clinical data registries. CMS implements PQRS program requirements 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.

2012 PQRS continued as a pay-for-reporting program that included claims-, registry-, electronic health record (EHR)-, and Group Practice Reporting Option (GPRO) Web Interface-based reporting of data on 269 individual quality measures as well as 22 measures groups. The two reporting periods for this program year were: January 1, 2012 – December 31, 2012 and July 1, 2012 – December 31, 2012. There were 13 options for satisfactorily reporting quality measures data for 2012 PQRS that differed based on the reporting period, the reporting option (individual measures or measures groups), and the selected data collection method (claims, qualified registry, qualified EHR, or CMS-selected GPRO Web Interface).

CMS-selected group practices participating in 2012 PQRS GPRO will receive an incentive payment at the Tax Identification Number (TIN)-level. A CMS-selected group practice is defined as a single TIN with 25 or more individual eligible professionals or individual National Provider Identifiers (NPIs). Group practices must have gone through a self-nomination process, have been selected for participation by CMS and met the requirements for participating in 2012 PQRS GPRO.

Physicians who are incentive eligible for PQRS can receive an additional 0.5% incentive payment when Maintenance of Certification Program Incentive requirements have been met. This physician-only incentive will be paid at the same time as the 2012 PQRS incentive for those physicians who qualify. Physicians cannot receive more than one additional 0.5% Maintenance of Certification Program Incentive, even if they complete a Maintenance of Certification Program in more than one specialty.

For more information on 2012 PQRS, please visit the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Report Overview

The 2012 PQRS feedback reports, not including GPRO feedback reports, are packaged at the TIN-level, with individual-level reporting (by NPI) and performance information for each eligible professional who reported at least one PQRS 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 for individual measures via claims also include information on the measure-applicability validation (MAV) process and any impact it may have had on the eligible professional's incentive eligibility. For more information about MAV, go to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

2012 PQRS included claims-based reporting, four registry-based reporting, CMS-selected GPRO Web Interface, and EHR reporting. All Medicare Part B claims submitted with PQRS QDCs, all registry data, all EHR data, and all GPRO Web Interface data received for services furnished from January 1, 2012 – December 31, 2012 (for the 12-month reporting period) and for services furnished from July 1, 2012 – December 31, 2012 (for the 6-month reporting period, only available to those reporting measures groups via registry) were analyzed to determine whether the eligible professional or group practice met satisfactory reporting criteria and earned a PQRS incentive payment. Each TIN/NPI had the opportunity to participate in PQRS via multiple reporting methods. Participation is defined as eligible professionals submitting at least one QDC via claims or submitting data via a qualified registry, qualified EHR, or GPRO Web Interface. For claims reporting, a valid submission was counted when a QDC was submitted and all measure-eligibility criteria were met (i.e., correct age, gender, diagnosis, and CPT). For registry, EHR, and GPRO Web Interface reporting, a valid submission was counted when PQRS quality data was correctly submitted. For those NPIs satisfactorily reporting using multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRS incentive.

CMS aims to distribute feedback reports as closely as possible to the PQRS incentive payment timeframe. 2012 PQRS feedback reports are scheduled to be available in the fall of 2013. For more information on that process, see http://www.cms.gov/MLNMattersArticles/downloads/SE0922.pdf.
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 PQRS feedback reports are listed below.

Hardware

- 233 MH_Z Pentium processor with a minimum of 150 MB free disk space
- 64 MB Ram (128 MB is recommended)

Software

- Microsoft® Internet Explorer version 8.0
- Adobe® Acrobat® Reader version 5.0 and above, or Microsoft® 2007 Excel
- JRE 1.6.0_21 (software available for download on the Portal)
- Windows XP operating system

Internet Connection

- The Portal will be accessible via any Internet connection running on a minimum of 33.6k or high-speed Internet.

Participant Feedback Report Content and Appearance

Four tables may be included in the 2012 PQRS feedback reports. Feedback reports will be generated for each TIN with at least one eligible professional reporting *any* QDC. Participants reporting as individuals will receive Tables 1-4. 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 PQRS. For TIN/NPIs reporting via multiple reporting methods, the feedback report will display each reporting method. 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. Those individuals who participated in the Maintenance of Certification Program Incentive will receive that data on Table 1 and will see additional detail on Table 2. For more information on accessing 2012 PQRS feedback reports, CMS-selected group practices should go to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html.

TIN-Level Feedback Report Including NPI Data (non-GPRO)

Each TIN will receive only one report. A TIN-level feedback report with NPI detail will include the following tables:

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

Key Terms:

- **Total Tax ID Incentive Amount for NPIs:** 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 Tax ID was eligible. If N/A, the Tax ID was not eligible to receive an incentive. If applicable, the total incentive amount will include an additional incentive based upon eligible professionals within the Tax ID meeting the requirements for the Maintenance of Certification Program.
- **Physician Quality Reporting 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 Reporting Detail
Figure 1.2: NPI Reporting Detail: Incentive and Participation Summary

Figure 1.3: Reporting Detail Summary

Figure 1.4: Claims Reporting Detail for Individual Measures – 12-months

Figure 1.5: EHR Direct Data Submission Reporting Detail – 12-months

Figure 1.6: EHR Data Submission Vendor Submission Reporting Detail – 12-months

Figure 1.7: Reporting Detail of Information Submitted by Registries for Individual Measures – 12-months and 6-monthsFigure 1.8: Claims Reporting Detail for Measures Groups 30 Beneficiary Method – 12-months

Figure 1.9: Reporting Detail of Information Submitted by Registries for the 30 Beneficiaries Measures Groups Method – 12-months

Figure 1.10: Claims Reporting Detail for Measures Groups 50% Method – 12-months

Figure 1.11: Reporting Detail of Information Submitted by Registries for the 80% Eligible Instances Measures Groups Method – 12-months and 6-months

Key Terms:

- **Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period:** 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.
- **Total # Measures Reported:** The number of measures where QDCs or quality action data are submitted, but are not necessarily valid. These instances do not count towards reporting success.
- **Total # Measures Reported on Denominator-Eligible Instances:** The number of measures for which the TIN/NPI reported a valid QDC or quality action data.
- **Total # Measures Satisfactorily Reported:** The total number of measures the TIN/NPI reported at a satisfactory rate.
    - Satisfactorily reported measures are those measures that meet certain analytical requirements such as reporting frequency, performance timeframes and timeliness of data submission. Requirements for each measure and measures group are outlined in the *2012 Physician Quality Reporting (PQRS) Claims/Registry Measures Specifications* and *2012 Physician Quality Reporting (PQRS) Measures Groups Specifications*. Performance detail can be found in Table 4 of the feedback report.

Table 3: NPI QDC Submission Error Detail (only applies to those who submitted via claims)
Figure 1.12: QDC Submission Error Detail – 12-months

Key Terms:

- **Number of Times Quality Data was Reported:** Number of QDC submissions for a measure whether or not the QDC submission was valid and appropriate.
- **% of Correctly Reported Quality Data:** The percentage of reported QDCs that were valid.

Table 4: NPI Performance Detail
Figure 1.13: Claims Performance Information for Individual Measures – 12-months

Figure 1.14: EHR Direct Data Submission Performance Information – 12-months

Figure 1.15: EHR Data Submission Vendor Submission Performance Information – 12-months

Figure 1.16: Registry Performance Information for Individual Measures – 12-months

Figure 1.17: Claims Performance Information for Measures Groups 30 Beneficiary Method – 12-months

Figure 1.18: Registry Performance Information for Measures Groups 30 Beneficiary Method – 12-months

Figure 1.19: Claims Performance Information for Measures Groups 50% Method – 12-months

Figure 1.20: Registry Performance Information for the 80% Eligible Instances Measures Groups Method – 12-months and 6-months

Key Terms:

- **Performance Met:** The number of instances the TIN/NPI submitted the appropriate QDCs or quality action data satisfactorily meeting the performance requirements for the measure.
- **Performance Not Met:** 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.
- **Performance Rate:** The Performance Rate is calculated by dividing the Performance Met by the Performance Denominator.
    - If "NULL", all of the measure's performance eligible instances were performance exclusions.
    - Measures with a 0% performance rate and measures groups containing a measure with a 0% performance rate will not be counted. *The recommended clinical quality action must be performed on at least one patient for each individual measure reported by the eligible professional. A 0% performance rate could be due to the fact that none of the provider's eligible patients were in compliance for the measure or that the provider did not provide the correct quality action to the patient. Exceptions for the 0% performance rate are those measures where a lower rate indicate better performance (i.e., #1, #123 and #146)*

NOTE: Performance information is provided for eligible professional's use to assess and improve their clinical performance.

For definition of terms related to the *2012 Physician Quality Reporting System Feedback Report*, see Appendix A. Also refer to the footnotes within each table for additional content detail.

The screenshots are provided for examples only and are subject to change. Minor changes in language and/or format should be expected.

Example - TIN-Level Feedback Report: Table 1

2012 PHYSICIAN QUALITY REPORTING SYSTEM FEEDBACK REPORT

(TIN-LEVEL REPORT WITH INDIVIDUAL NPIs)

Eligible professionals may participate in the Physician Quality Reporting System (Physician Quality Reporting) either at the individual level using their unique TIN/NPI or as a member of a selected group practice under the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2012 Physician Quality Reporting included three Medicare Part B claims-based reporting methods, four qualified registry-based reporting methods, and two qualified electronic health record (EHR) methods. The twelve month reporting period will be utilized for all reporting methods with the exception of registry-based reporting, which will also have one six month reporting option available. Tax IDs reporting under the GPRO (Group Practice Reporting Option) for Physician Quality Reporting will submit data using the GPRO web interface. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2012 to December 31, 2012 (for the twelve month reporting period) and for services furnished from July 1, 2012 to December 31, 2012 (for the six month registry Measures Group reporting period) were reviewed to evaluate whether an eligible professional or group successfully reported for the Physician Quality Reporting incentive. Participation by an eligible professional or group practice is defined as submitting quality data via one of the aforementioned methods. A submission is considered valid if quality data is submitted and all measure-eligibility criteria is met (i.e., correct age, gender, diagnosis and CPT). For eligible professionals participating at the TIN/NPI level via multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their Physician Quality Reporting incentive. Additionally, in 2012 NPIs had the opportunity to qualify for a Maintenance of Certification Program incentive by submitting data via a Maintenance of Certification Program qualified entity. Please note that the Maintenance of Certification Program incentive is only available if satisfactorily reporting data via any of the reporting methods for the twelve-month reporting period. The methods reported and amounts earned for each TIN/NPI are summarized below. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/.

Table 1: Earned Incentive Summary ID)

Sorted by NPI Number and Sub-Sorted *od of Reporting*

Tax ID Name*: John Q. Public Clinic

Tax ID Number: XXXXX6789

Total incentive amount earned for all NPIs reporting under one TIN

Total incentive amount earned for TIN under each Carrier or A/B MAC (includes Maintenance of Certification Program Incentive)

Total Tax ID Earned Incentive Amount for NPIs (listed below): $4591.67	Distribution of Total Incentive Earned Among A/B MACs and Carriers That Processed Payments	
	A/B MAC and Carrier Identification #	Tax ID Earned Incentive Amount Under A/B MAC and Carrier
	12345	$2,389.17
	67890	$2,202.50

This column lists the reason why an eligible professional was or wasn't incentive eligible

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

NPI	NPI Name*	Method of Reporting[2]	Reporting Period	Incentive Eligibility Rationale	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period[3]	Physician Quality Reporting NPI Total Earned Incentive Amount[4]
1000000001	Not Available	Measures Groups - 80% eligible instances via registry	6 months	Insufficient # of eligible instances reported	$20,000.00	N/A
1000000002	Susie Smith	Individual measure(s) reporting via claims	12 months	Did not pass MAV	$100,000.00	N/A
1000000002	Susie Smith	Measures Groups - 30 beneficiaries via registry	12 months	Insufficient # of beneficiaries reported	$100,000.00	N/A
1000000003	Not Available	Individual measure(s) reporting via registry	12 months	Sufficient # of measures reported	$133,333.33	$666.67
1000000005	Not Available	Individual measure(s) reporting via claims	12 months	Insufficient # of measures reported	$68,000.00	N/A
1000000005	Not Available	Measures Groups - 80% eligible instances via registry	12 months	Insufficient # of eligible instances reported	$68,000.00	N/A

Figure 1.1: Earned Incentive Summary for Taxpayer Identification Number (Tax ID)

Example TIN-Level Feedback Report: Table 1 (continued)

NPI	NPI Name*	Method of Reporting[2]	Reporting Period	Incentive Eligibility Rationale	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period[3]	Physician Quality Reporting NPI Total Earned Incentive Amount[4]
1000000006	Not Available	Measures Groups - 80% eligible instances via registry	12 months	Sufficient # of eligible instances reported	$125,000.00	$625.00
1000000007	Not Available	Individual measure(s) reporting via registry	12 months	Insufficient # of measures reported	$580,000.00	N/A
1000000008	John Beans	Measures Groups - 50% eligible instances via claims	12 months	Sufficient # of eligible instances reported	$40,000.00	$200.00
1000000009	Steve Smithson	Measures Groups - 30 beneficiaries via registry	12 months	Sufficient # of beneficiaries reported	$125,000.00	$625.00
1000000010	John Johnson	Measures Groups - 30 beneficiaries via claims	12 months	Insufficient # of beneficiaries reported	$120,000.00	N/A
1000000011	Josie Jones	Measures Groups - 80% eligible instances via registry	6 months	Sufficient # of eligible instances reported	$70,000.00	$350.00
1000000012	John Beans	Individual measure(s) reporting via claims	12 months	Sufficient # of measures reported	$60,000.00	$300.00
1000000013	Not Available	Measures Groups - 30 beneficiaries via claims	12 months	Sufficient # of beneficiaries reported	$65,000.00	$325.00
1000000014	Not Available	Measures Groups - 50% eligible instances via claims	12 months	Insufficient # of eligible instances reported	$168,000.00	N/A
1000000016	Melissa Smith	Individual measure(s) reporting via electronic health records (Data Submission Vendor)	12 months	Sufficient # of measures reported	$150,000.00	$750.00
1000000018	Not Available	Individual measure(s) reporting via electronic health records (Direct EHR)	12 months	Insufficient # of measures reported	$250,000.00	N/A
1000000019	Not Available	Individual measure(s) reporting via electronic health records (Direct EHR)	12 months	Sufficient # of measures reported	$150,000.00	$750.00
1000000021	Not Available	Individual measure(s) reporting via electronic health records (Data Submission Vendor)	12 months	Insufficient # of measures reported	$200,000.00	N/A
					Total:	$4,591.67

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

Total 0.5% incentive amount earned by each individual NPI for PQRS (does not include Maintenance of Certification Program incentive)

Figure 1.1: Earned Incentive Summary for Taxpayer Identification Number (Tax ID)

Example TIN-Level Feedback Report: Table 1 (continued)

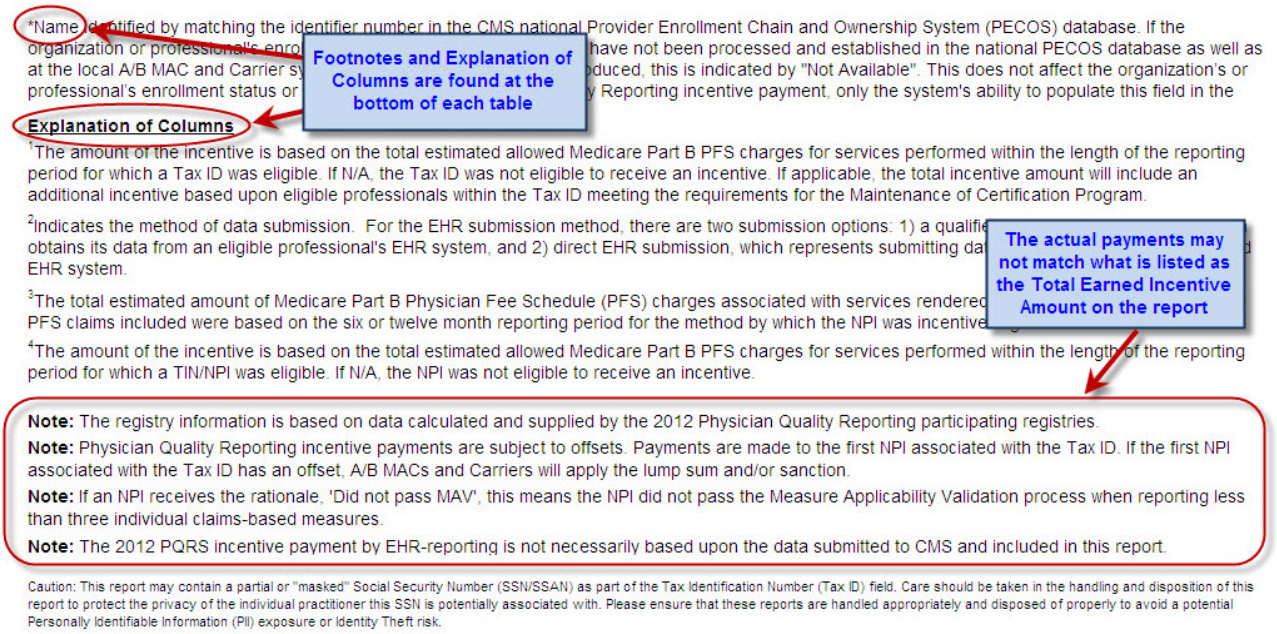


Figure 1.1: Earned Incentive Summary for Taxpayer Identification Number (Tax ID)

Example - TIN-Level Feedback Report: Table 2

2012 PHYSICIAN QUALITY REPORTING SYSTEM FEEDBACK REPORT

(INDIVIDUAL NPI REPORT)

Eligible professionals may participate in the Physician Quality Reporting System (Physician Quality Reporting) either at the individual level using their unique TIN/NPI or as a member of a selected group practice under the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2012 Physician Quality Reporting included three Medicare Part B claims-based reporting methods, four qualified registry-based reporting methods, and two qualified electronic health record (EHR) methods. The twelve month reporting period will be utilized for all reporting methods with the exception of registry-based reporting, which will also have one six month reporting option available. Tax IDs reporting under the GPRO (Group Practice Reporting Option) for Physician Quality Reporting will submit data using the GPRO web interface. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2012 to December 31, 2012 (for the twelve month reporting period) and for services furnished from July 1, 2012 to December 31, 2012 (for the six month registry Measures Group reporting period) were reviewed to evaluate whether an eligible professional or group successfully reported for the Physician Quality Reporting incentive. Participation by an eligible professional or group practice is defined as submitting quality data via one of the aforementioned methods. A submission is considered valid if quality data is submitted and all measure-eligibility criteria is met (i.e., correct age, gender, diagnosis and CPT). For eligible professionals participating at the TIN/NPI level via multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their Physician Quality Reporting incentive. Additionally, in 2012 NPIs had the opportunity to qualify for a Maintenance of Certification Program incentive by submitting data via a Maintenance of Certification Program qualified entity. Please note that the Maintenance of Certification Program incentive is only available if satisfactorily reporting data via any of the reporting methods for the twelve-month reporting period. The methods reported and amounts earned for each TIN/NPI are summarized below. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/.

Table 2: NPI Reporting Detail

Participation and Reporting Detail Summary Tables Sorted by Method Reported and Reporting Period

Reporting Detail Tables Sorted by Measure # for Indivi... ...sures Groups and Sub-Sorted by Measure # for Measures Groups Methods

Tax ID Name*: John Q. Publ
Tax ID Number: XXXXX6789
NPI Number: 1000000012
NPI Name*: John Beans

Total incentive amount earned by the NPI for 2012

Total 0.5% incentive earned by the NPI for 2012 Physician Quality Reporting

Total 0.5% incentive earned by the NPI for 2011 Maintenance of Certification Program

Incentive Summary

Total NPI Incentive Amount Earned for the Reporting Period	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period	Physician Quality Reporting Incentive Amount	Maintenance of Certification Total Earned Incentive Amount (0.5%)
$600.00	$60,000.00	$300.00	$300.00

Detail from Table 1 for the reporting method(s)/period for which the NPI did or did not earn an incentive
Note: Actual reports will be specific to the NPIs reporting method(s)/period

Participation Summary

Method Reported[1]	Reporting Period	Registry/EHR Name (If Applicable)	Incentive Eligible for Method Reported	Reporting Method/Period Selected for Incentive Payment[2]
Individual measure(s) reporting via claims	12 months	N/A	Yes	Yes
Individual measure(s) reporting via electronic health records (Data Submission Vendor)	12 months	Epic	Yes	N/A
Individual measure(s) reporting via electronic health records (Direct EHR)	12 months	Epic	Yes	N/A
Individual measure(s) reporting via registry	12 months	ICLOPS	Yes	N/A
Measures Groups - 30 beneficiaries via claims	12 months	N/A	Yes	N/A
Measures Groups - 30 beneficiaries via registry	12 months	ICLOPS	Yes	N/A
Measures Groups - 50% eligible instances via claims	12 months	N/A	Yes	N/A
Measures Groups - 80% eligible instances via registry	12 months	Cedaron	Yes	N/A
Measures Groups - 80% eligible instances via registry	6 months	SVS	Yes	N/A

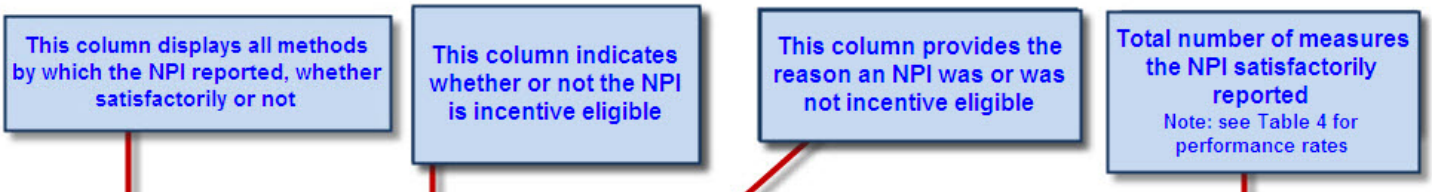
Maintenance of Certification Program Summary

Maintenance of Certification Program Requirements Satisfactorily Reported	Maintenance of Certification Program Incentive Eligible
Yes	Yes

Indicates whether the Maintenance of Certification Program requirements were met and if the NPI is eligible for the additional 0.5% incentive
Note: Table will only appear if applicable

Figure 1.2: NPI Reporting Detail: Incentive and Participation Summary

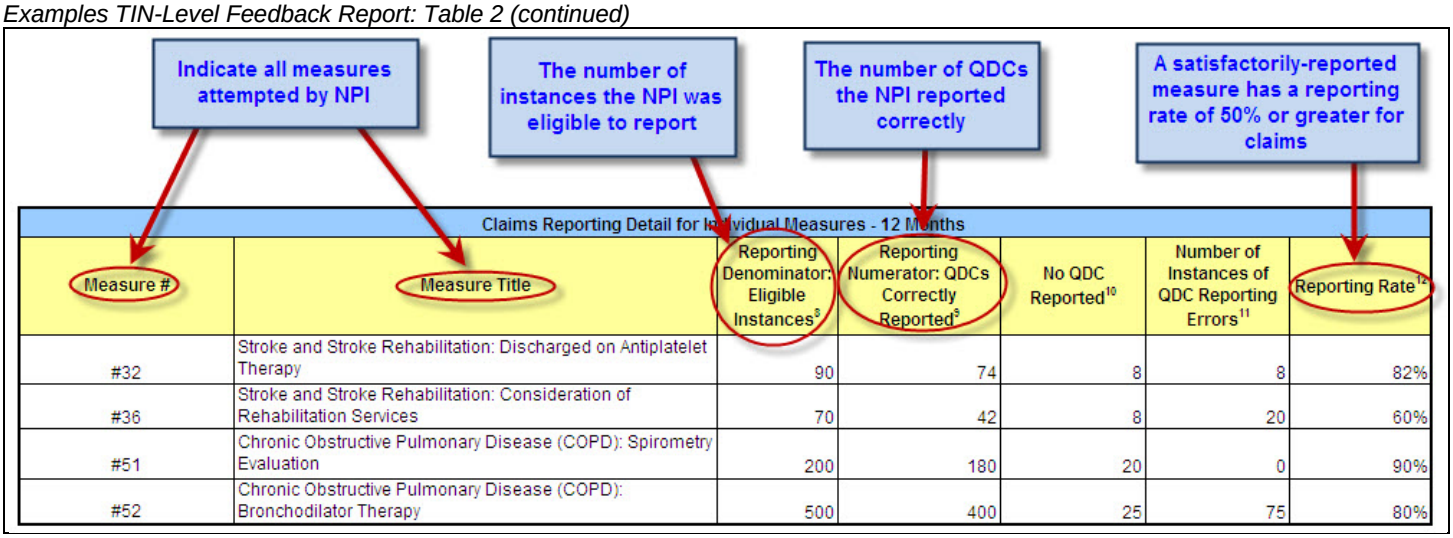
Example TIN-Level Feedback Report: Table 2 (continued)



Reporting Detail Summary							
Method of Reporting[1]	Reporting Period	Incentive Eligible (Yes/No)[3]	Incentive Eligibility Rationale	Total # Measures Groups Reported	Total # Measures Reported[4]	Total # Measures Reported on Denominator Eligible Instances[5]	Total # Measures Satisfactorily Reported[6]
Individual measure(s) reporting via claims	12 months	Yes	Sufficient # of measures reported	N/A	4	4	3
Individual measure(s) reporting via claims	12 months	No	Did not pass MAV	N/A	2	2	1
Individual measure(s) reporting via claims	12 months	No	Insufficient # of measures reported	N/A	2	2	1
reporting via electronic health records (Data Submission Vendor)	12 months	Yes	Sufficient # of measures reported	N/A	4	4	3
reporting via electronic health records (Data Submission Vendor)	12 months	No	Insufficient # of measures reported	N/A	2	2	1
Individual measure(s) reporting via registry	12 months	Yes	Sufficient # of measures reported	N/A	8	8	5
Individual measure(s) reporting via registry	12 months	No	Insufficient # of measures reported	N/A	2	2	1
Measures Groups - 30 beneficiaries via claims	12 months	Yes	Sufficient # of beneficiaries reported	2	15	15	15
Measures Groups - 30 beneficiaries via claims	12 months	No	Insufficient # of beneficiaries reported	1	12	9	5
Measures Groups - 30 beneficiaries via registry	12 months	Yes	Sufficient # of beneficiaries reported	2	15	15	15
Measures Groups - 30 beneficiaries via registry	12 months	No	Insufficient # of beneficiaries reported	1	12	9	5
Measures Groups - 50% eligible instances via claims	12 months	Yes	Sufficient # of eligible instances reported	2	10	10	10
Measures Groups - 50% eligible instances via claims	12 months	No	Insufficient # of eligible instances reported	1	12	9	5
Measures Groups - 80% eligible instances via registry	12 months	Yes	Sufficient # of eligible instances reported	2	10	10	10
Measures Groups - 80% eligible instances via registry	12 months	No	Insufficient # of eligible instances reported	1	12	9	5
Measures Groups - 80% eligible instances via registry	6 months	Yes	Sufficient # of eligible instances reported	2	10	10	10
Measures Groups - 80% eligible instances via registry	6 months	No	Insufficient # of eligible instances reported	1	12	9	5
Individual measure(s) reporting via EHR (Direct EHR)	12 months	No	Insufficient # of measures reported	N/A	2	2	1
Individual measure(s) reporting via EHR (Direct EHR)	12 months	Yes	Sufficient # of measures reported	N/A	9	9	9

Figure 1.3: Reporting Detail Summary

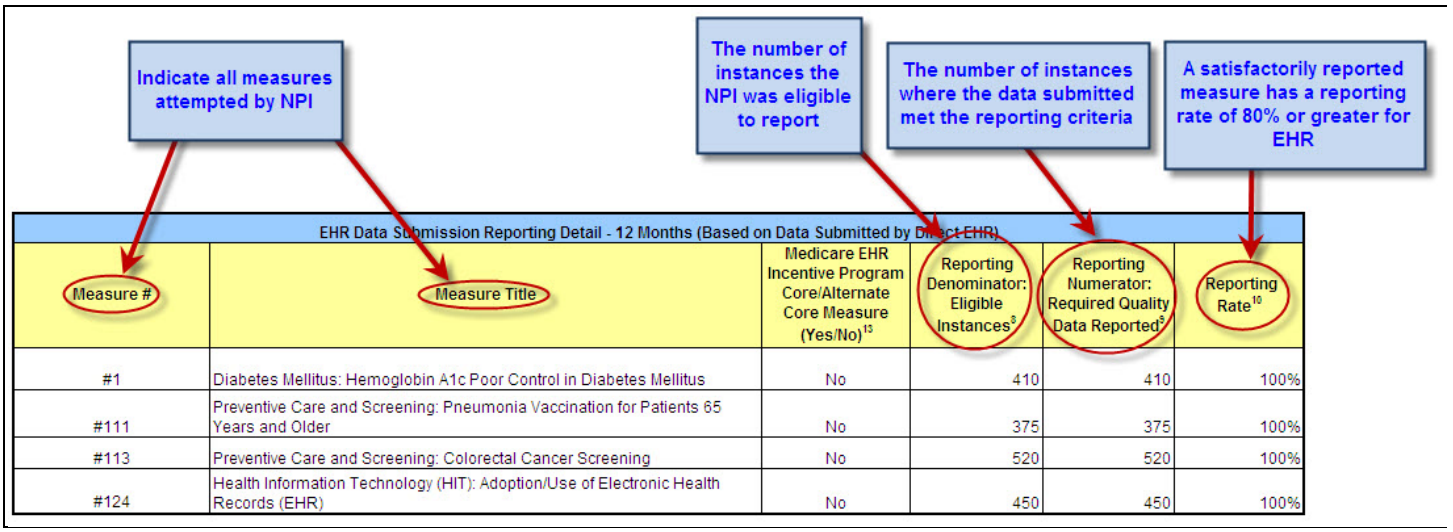
Examples TIN-Level Feedback Report: Table 2 (continued)



Claims Reporting Detail for Individual Measures - 12 Months

Measure #	Measure Title	Reporting Denominator: Eligible Instances[8]	Reporting Numerator: QDCs Correctly Reported[8]	No QDC Reported[10]	Number of Instances of QDC Reporting Errors[11]	Reporting Rate[12]
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	90	74	8	8	82%
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	70	42	8	20	60%
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	200	180	20	0	90%
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	500	400	25	75	80%

Figure 1.4: Claims Reporting Detail for Individual Measures – 12-months

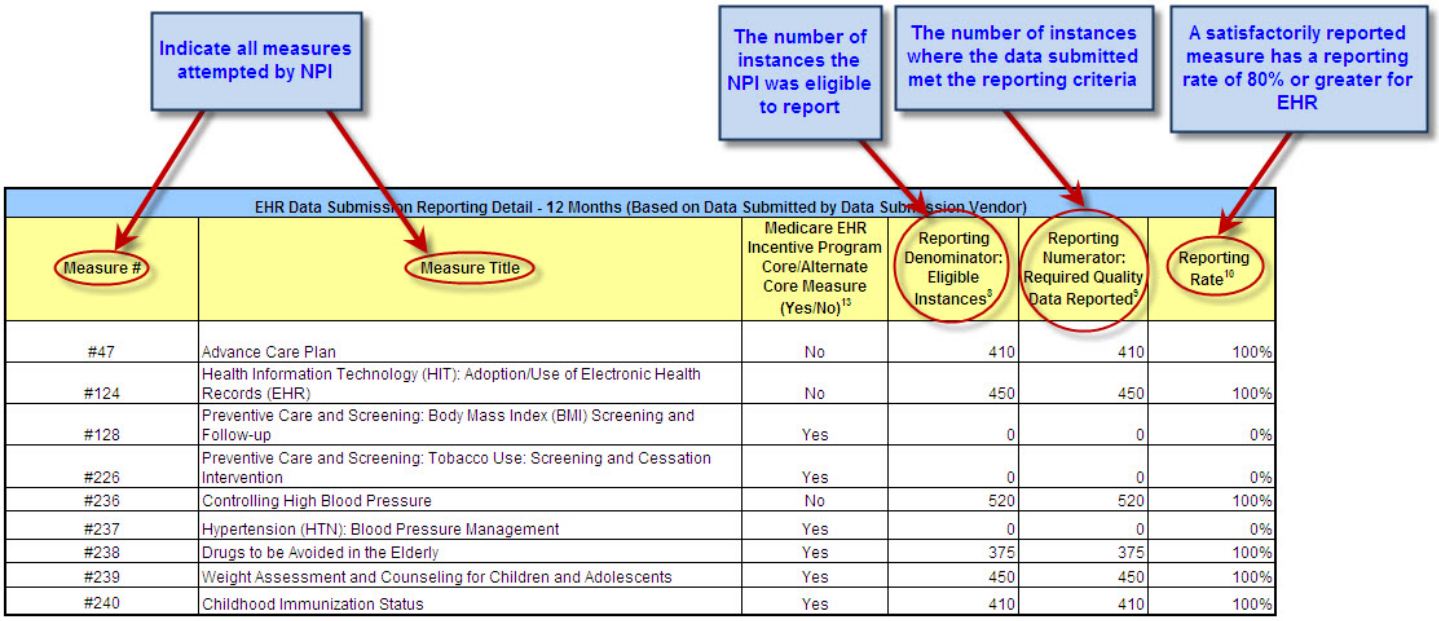


EHR Data Submission Reporting Detail - 12 Months (Based on Data Submitted by Direct EHR)

Measure #	Measure Title	Medicare EHR Incentive Program Core/Alternate Core Measure (Yes/No)[13]	Reporting Denominator: Eligible Instances[8]	Reporting Numerator: Required Quality Data Reported[8]	Reporting Rate[10]
#1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	No	410	410	100%
#111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	No	375	375	100%
#113	Preventive Care and Screening: Colorectal Cancer Screening	No	520	520	100%
#124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	No	450	450	100%

Figure 1.5: EHR Direct Submission Reporting Detail – 12-months

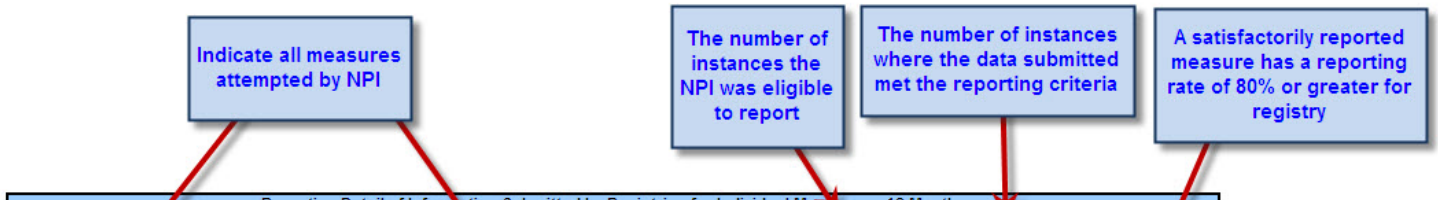
Examples TIN-Level Feedback Report: Table 2 (continued)



EHR Data Submission Reporting Detail - 12 Months (Based on Data Submitted by Data Submission Vendor)

Measure #	Measure Title	Medicare EHR Incentive Program Core/Alternate Core Measure (Yes/No)[13]	Reporting Denominator: Eligible Instances[9]	Reporting Numerator: Required Quality Data Reported[9]	Reporting Rate[10]
#47	Advance Care Plan	No	410	410	100%
#124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	No	450	450	100%
#128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up	Yes	0	0	0%
#226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Yes	0	0	0%
#236	Controlling High Blood Pressure	No	520	520	100%
#237	Hypertension (HTN): Blood Pressure Management	Yes	0	0	0%
#238	Drugs to be Avoided in the Elderly	Yes	375	375	100%
#239	Weight Assessment and Counseling for Children and Adolescents	Yes	450	450	100%
#240	Childhood Immunization Status	Yes	410	410	100%

Figure 1.6: EHR Data Submission Vendor Submission Reporting Detail – 12-months

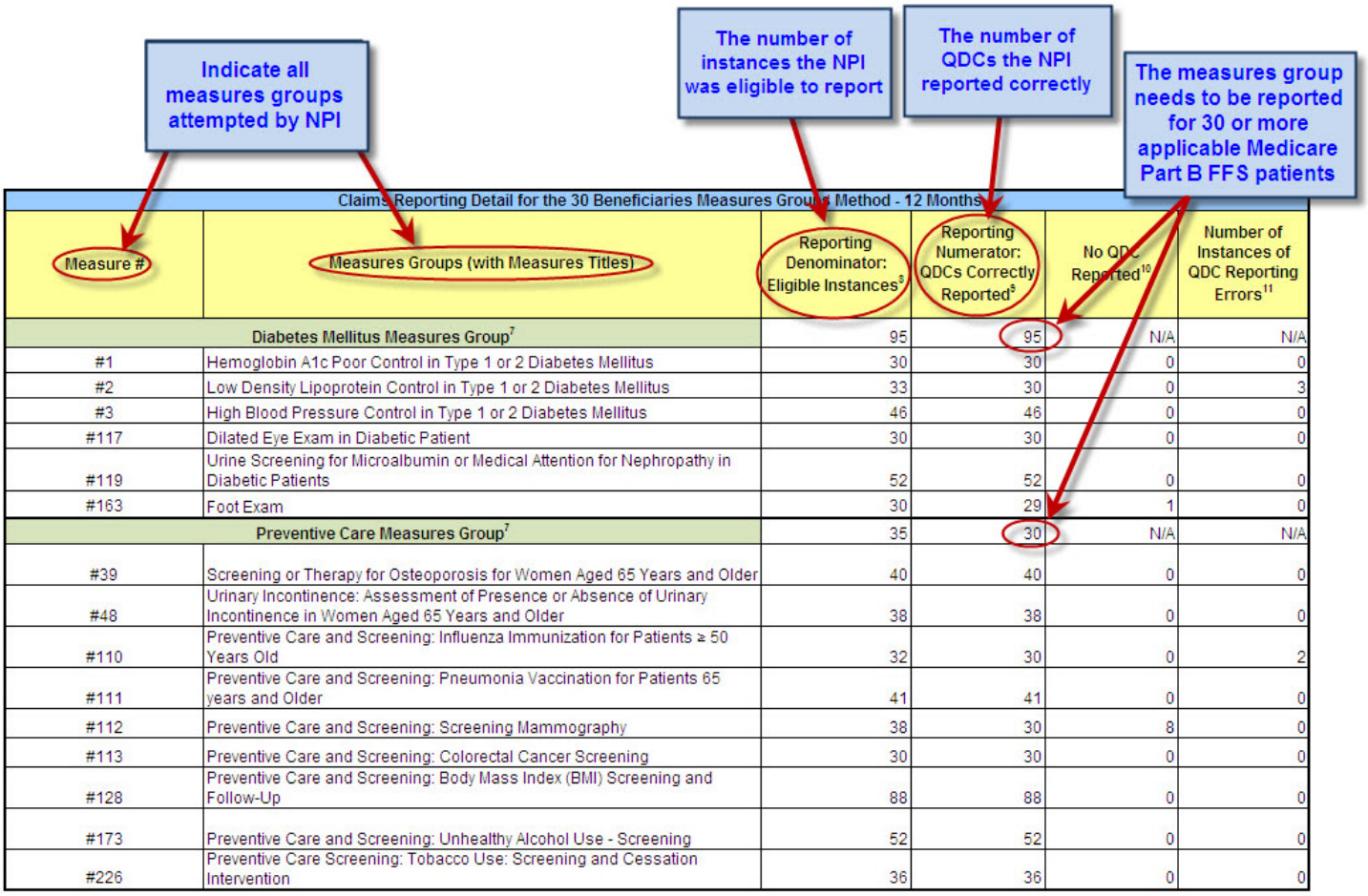


Reporting Detail of Information Submitted by Registries for Individual Measures - 12 Months

Measure #	Measure Title	Reporting Denominator: Eligible Instances[9]	Reporting Numerator: Required Quality Data Reported[9]	Reporting Rate[10]
#31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	520	451	87%
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	400	320	80%
#33	Stroke and Stroke Rehabilitation: Anticoagulent Therapy Prescribed for Atrial Fibrillation at Discharge	406	330	81%
#34	Stroke and Stroke Rehabilitation: Tissue Pasminogen Activator (t-PA) Considered	370	274	74%
#35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	450	382	85%
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	410	336	82%
#47	Advance Care Plan	358	261	73%
#124	HIT: Adoption/Use of Health Information Technology (Electronic Health Records)	321	201	63%

Figure 1.7: Reporting Detail of Information Submitted by Registries for Individual Measures – 12-months

Example TIN-Level Feedback Report: Table 2 (continued):

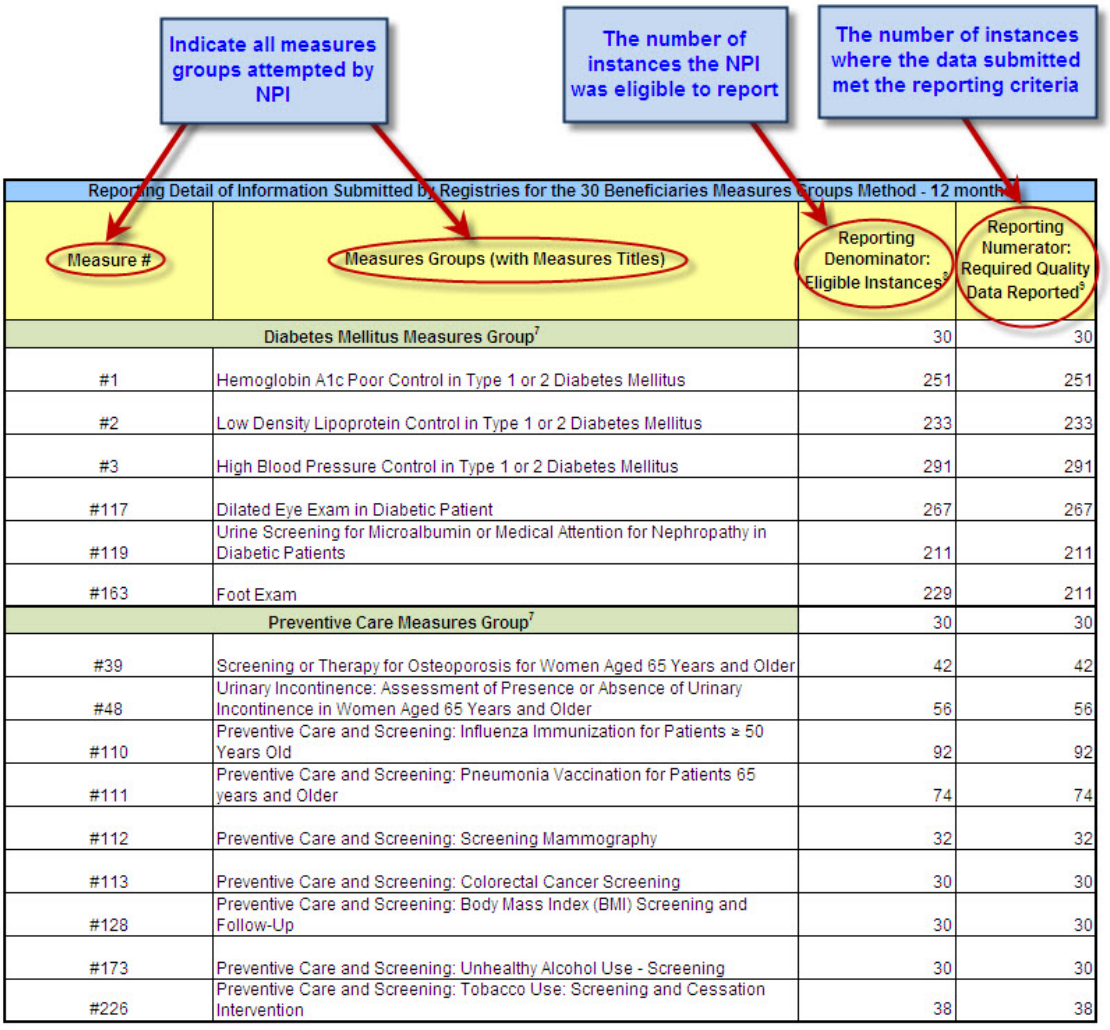


Claims Reporting Detail for the 30 Beneficiaries Measures Groups Method - 12 Months

Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[8]	Reporting Numerator: QDCs Correctly Reported[9]	No QDCs Reported[10]	Number of Instances of QDC Reporting Errors[11]
Diabetes Mellitus Measures Group[7]		95	95	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	0	3
#3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus	46	46	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	52	52	0	0
#163	Foot Exam	30	29	1	0
Preventive Care Measures Group[7]		35	30	N/A	N/A
#39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	40	40	0	0
#48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	38	38	0	0
#110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	32	30	0	2
#111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older	41	41	0	0
#112	Preventive Care and Screening: Screening Mammography	38	30	8	0
#113	Preventive Care and Screening: Colorectal Cancer Screening	30	30	0	0
#128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	88	88	0	0
#173	Preventive Care and Screening: Unhealthy Alcohol Use - Screening	52	52	0	0
#226	Preventive Care Screening: Tobacco Use: Screening and Cessation Intervention	36	36	0	0

Figure 1.8: Claims Reporting Detail for Measures Groups 30 Beneficiary Method – 12-months

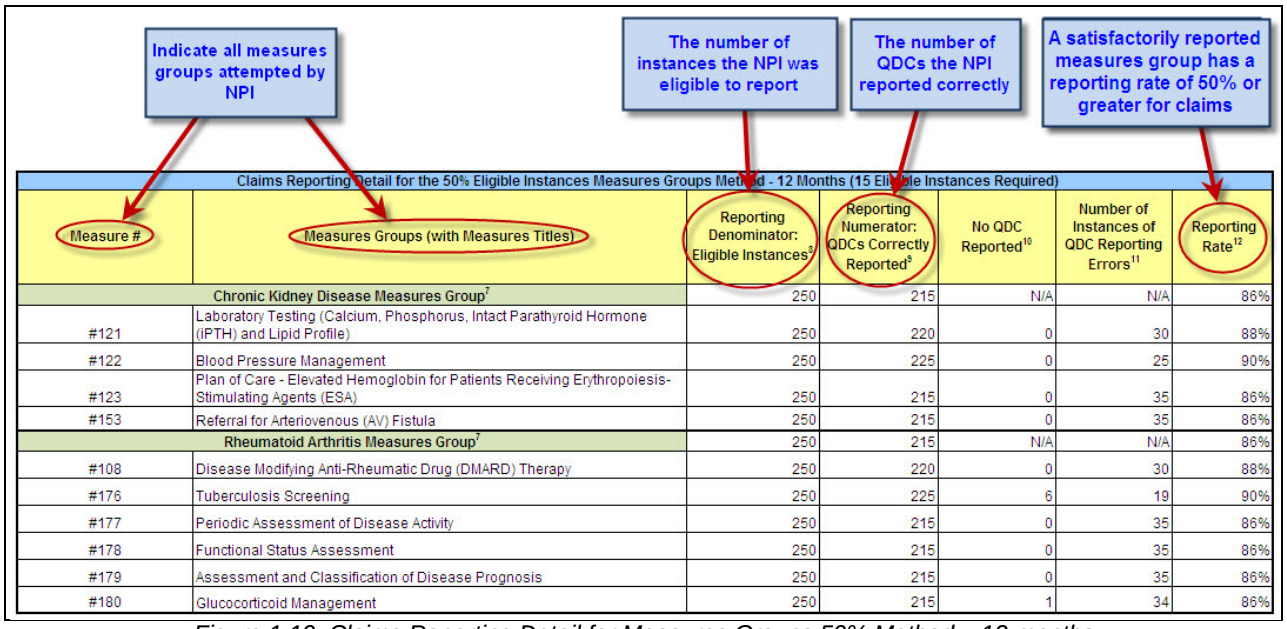
Example TIN-Level Feedback Report: Table 2 (continued)



Reporting Detail of Information Submitted by Registries for the 30 Beneficiaries Measures Groups Method - 12 months			
Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[5]	Reporting Numerator: Required Quality Data Reported[5]
Diabetes Mellitus Measures Group[7]		30	30
#1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus	251	251
#2	Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus	233	233
#3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus	291	291
#117	Dilated Eye Exam in Diabetic Patient	267	267
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	211	211
#163	Foot Exam	229	211
Preventive Care Measures Group[7]		30	30
#39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	42	42
#48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	56	56
#110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	92	92
#111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older	74	74
#112	Preventive Care and Screening: Screening Mammography	32	32
#113	Preventive Care and Screening: Colorectal Cancer Screening	30	30
#128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	30	30
#173	Preventive Care and Screening: Unhealthy Alcohol Use - Screening	30	30
#226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	38	38

Figure 1.9: Reporting Detail of Information Submitted by Registries for the 30 Beneficiaries Measures Groups Method – 12-months

Example TIN-Level Feedback Report: Table 2 (continued)

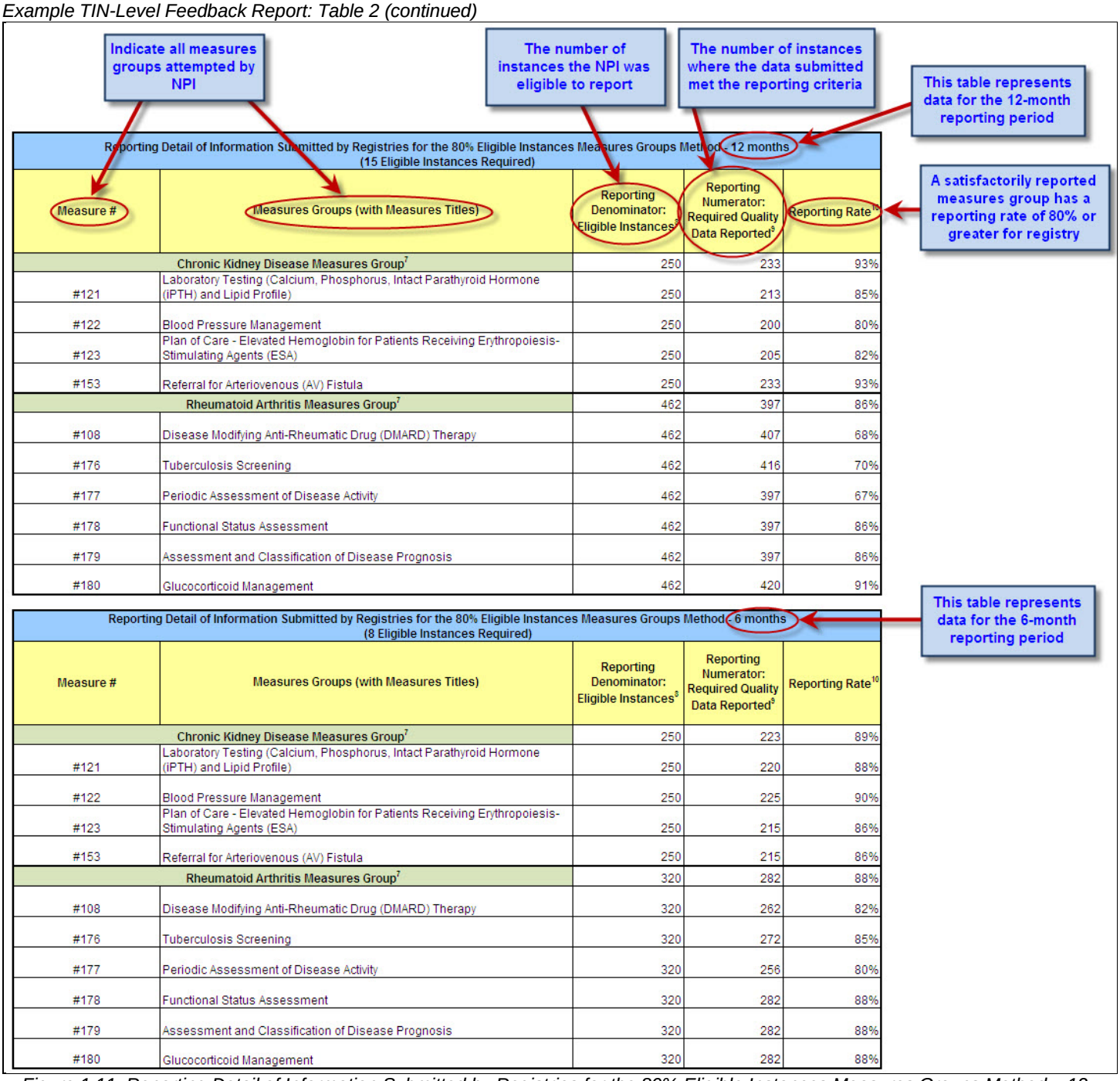


Claims Reporting Detail for the 50% Eligible Instances Measures Groups Method - 12 Months (15 Eligible Instances Required)

Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[8]	Reporting Numerator: QDCs Correctly Reported[9]	No QDC Reported[10]	Number of Instances of QDC Reporting Errors[11]	Reporting Rate[12]
	Chronic Kidney Disease Measures Group[7]	250	215	N/A	N/A	86%
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	250	220	0	30	88%
#122	Blood Pressure Management	250	225	0	25	90%
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	250	215	0	35	86%
#153	Referral for Arteriovenous (AV) Fistula	250	215	0	35	86%
	Rheumatoid Arthritis Measures Group[7]	250	215	N/A	N/A	86%
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	250	220	0	30	88%
#176	Tuberculosis Screening	250	225	6	19	90%
#177	Periodic Assessment of Disease Activity	250	215	0	35	86%
#178	Functional Status Assessment	250	215	0	35	86%
#179	Assessment and Classification of Disease Prognosis	250	215	0	35	86%
#180	Glucocorticoid Management	250	215	1	34	86%

Figure 1.10: Claims Reporting Detail for Measures Groups 50% Method – 12-months

Example TIN-Level Feedback Report: Table 2 (continued)



Reporting Detail of Information Submitted by Registries for the 80% Eligible Instances Measures Groups Method - 12 months
(15 Eligible Instances Required)

Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[8]	Reporting Numerator: Required Quality Data Reported[9]	Reporting Rate[10]
	Chronic Kidney Disease Measures Group[7]	250	233	93%
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	250	213	85%
#122	Blood Pressure Management	250	200	80%
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	250	205	82%
#153	Referral for Arteriovenous (AV) Fistula	250	233	93%
	Rheumatoid Arthritis Measures Group[7]	462	397	86%
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	462	407	68%
#176	Tuberculosis Screening	462	416	70%
#177	Periodic Assessment of Disease Activity	462	397	67%
#178	Functional Status Assessment	462	397	86%
#179	Assessment and Classification of Disease Prognosis	462	397	86%
#180	Glucocorticoid Management	462	420	91%

Reporting Detail of Information Submitted by Registries for the 80% Eligible Instances Measures Groups Method - 6 months
(8 Eligible Instances Required)

Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[8]	Reporting Numerator: Required Quality Data Reported[9]	Reporting Rate[10]
	Chronic Kidney Disease Measures Group[7]	250	223	89%
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	250	220	88%
#122	Blood Pressure Management	250	225	90%
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	250	215	86%
#153	Referral for Arteriovenous (AV) Fistula	250	215	86%
	Rheumatoid Arthritis Measures Group[7]	320	282	88%
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	320	262	82%
#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%

Figure 1.11: Reporting Detail of Information Submitted by Registries for the 80% Eligible Instances Measures Groups Method – 12-months and 6-months

Example - TIN-Level Feedback Report: Table 3

2012 PHYSICIAN QUALITY REPORTING SYSTEM FEEDBACK REPORT

(INDIVIDUAL NPI SUBMISSION ERROR REPORT)

Eligible professionals may participate in the Physician Quality Reporting System (Physician Quality Reporting) either at the individual level using their unique TIN/NPI or as a member of a selected group practice under the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2012 Physician Quality Reporting included three Medicare Part B claims-based reporting methods, four qualified registry-based reporting methods, and two qualified electronic health record (EHR) methods. The twelve month reporting period will be utilized for all reporting methods with the exception of registry-based reporting, which will also have one six month reporting option available. Tax IDs reporting under the GPRO (Group Practice Reporting Option) for Physician Quality Reporting will submit data using the GPRO web interface. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2012 to December 31, 2012 (for the twelve month reporting period) and for services furnished from July 1, 2012 to December 31, 2012 (for the six month registry Measures Group reporting period) were reviewed to evaluate whether an eligible professional or group successfully reported for the Physician Quality Reporting incentive. Participation by an eligible professional or group practice is defined as submitting quality data via one of the aforementioned methods. A submission is considered valid if quality data is submitted and all measure-eligibility criteria is met (i.e., correct age, gender, diagnosis and CPT). For eligible professionals participating at the TIN/NPI level via multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their Physician Quality Reporting incentive. Additionally, in 2012 NPIs had the opportunity to qualify for a Maintenance of Certification Program incentive by submitting data via a Maintenance of Certification Program qualified entity. Please note that the Maintenance of Certification Program incentive is only available if satisfactorily reporting data via any of the reporting methods for the twelve-month reporting period. The individual NPI's quality-data code (QDC) submission error results for individual measures via claims are below. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/Medi...Instruments/PQRS/.

Table 3: NPI QDC Subm
Sorted by Measure

Tax ID Name*: John Q. F
Tax ID Number: XXXXX6
NPI Name*: John Beans
NPI Number: 1000000012

Indicates the number of times numerator QDCs were reported, regardless of denominator-eligibility

The number of valid and appropriate QDC submissions for a measure
Note: This column should match the 'Reporting Numerator: QDCs Correctly Reported' column on Table 2

The percentage of QDCs that were reported correctly

These columns outline the number of QDC errors associated with a specific reason

QDC Submission Error Detail							
		QDC Occurrences			Quality Data Reporting Errors (With Reasons for the Errors)		
Measure #	Measure Title	Number of Times Quality Data Was Reported[1]	Number of Times Quality Data Was Reported Correctly[2]	% of Correctly Reported Quality Data[3]	Measure Reported on an Instance with an Incorrect Age and/or Gender[4]	Measure Reported on an Instance with an Incorrect DX and/or CPT Code[5]	Measure Reported on an Instance with a Missing CPT Code (Denominator Code)[6]
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	99	74	74.7%	12	12	1
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	54	42	77.8%	0	7	5
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	210	180	85.7%	30	0	0
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	410	400	97.6%	9	1	0

Figure 1.12: NPI QDC Submission Error Detail – 12-months

Note: This table does not determine incentive eligibility.

Example - TIN-Level Feedback Report: Table 4

2012 PHYSICIAN QUALITY REPORTING SYSTEM FEEDBACK REPORT

(INDIVIDUAL NPI REPORT)

Eligible professionals may participate in the Physician Quality Reporting System (Physician Quality Reporting) either at the individual level using their unique TIN/NPI or as a member of a selected group practice under the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2012 Physician Quality Reporting included three Medicare Part B claims-based reporting methods, four qualified registry-based reporting methods, and two qualified electronic health record (EHR) methods. The twelve month reporting period will be utilized for all reporting methods with the exception of registry-based reporting, which will also have one six month reporting option available. Tax IDs reporting under the GPRO (Group Practice Reporting Option) for Physician Quality Reporting will submit data using the GPRO web interface. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2012 to December 31, 2012 (for the twelve month reporting period) and for services furnished from July 1, 2012 to December 31, 2012 (for the six month registry Measures Group reporting period) were reviewed to evaluate whether an eligible professional or group successfully reported for the Physician Quality Reporting incentive. Participation by an eligible professional or group practice is defined as submitting quality data via one of the aforementioned methods. A submission is considered valid if quality data is submitted and all measure-eligibility criteria is met (i.e., correct age, gender, diagnosis and CPT). For eligible professionals participating at the TIN/NPI level via multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their Physician Quality Reporting incentive. Additionally, in 2012 NPIs had the opportunity to qualify for a Maintenance of Certification Program incentive by submitting data via a Maintenance of Certification Program qualified entity. Please note that the Maintenance of Certification Program incentive is only available if satisfactorily reporting data via any of the reporting methods for the twelve-month reporting period. The results below include a Performance Detail table listing all of the measures and measures groups reported by the individual NPIs with the performance rates. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/Medic- atient-Assessment-Instruments/PQRS/.

Table 4: NPI Performance Detail

Measures Groups Table(s) - Sorted by Measures Group and Sub-Sorted by Measure #

Individual Measures Table(s) - Sorted by Measure #

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

The number of instances the appropriate QDC was submitted to satisfactorily meet performance requirements for the measure

Performance Rate is calculated by dividing the Performance Met by the Performance Denominator

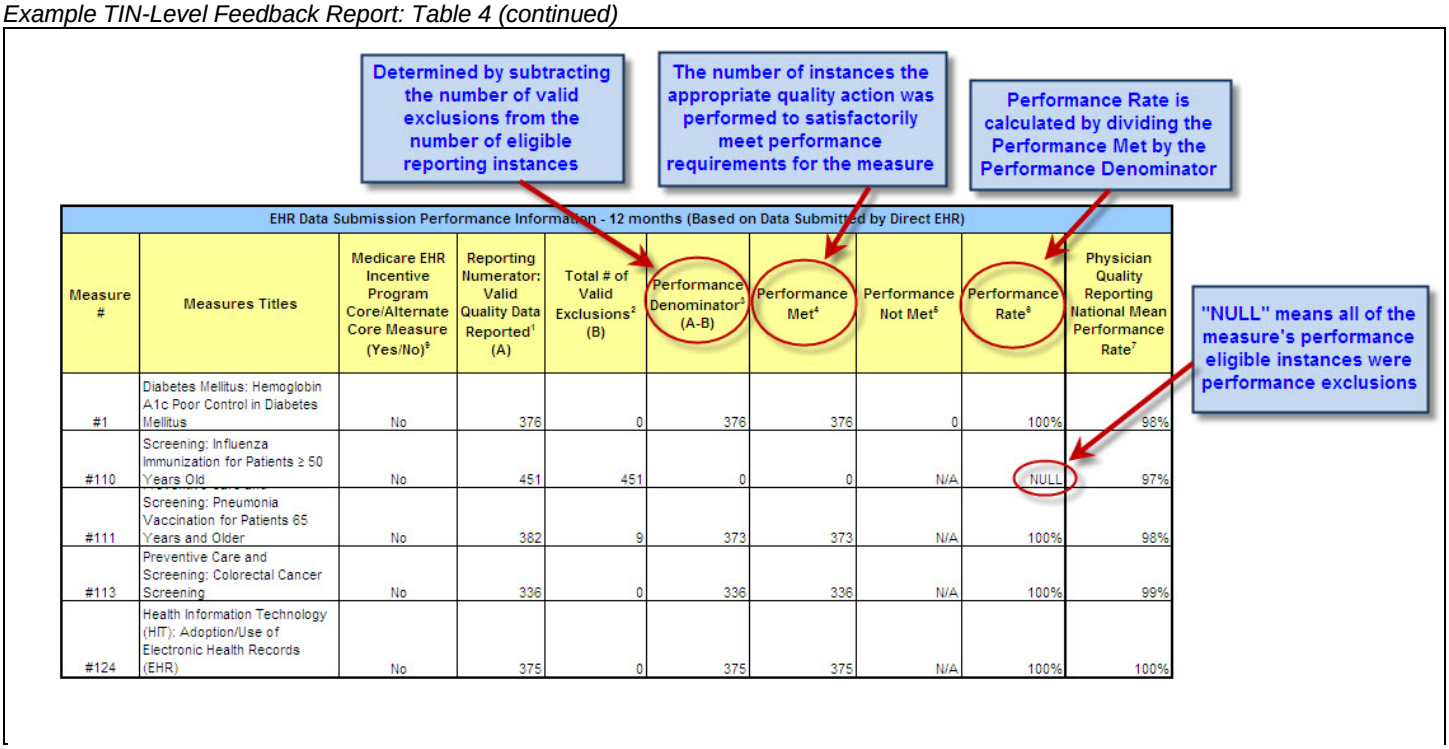
Includes performance information for all TIN/NPI combinations submitting at least one QDC for the measure

0% measures do not count toward the incentive payment

Claims Performance Information for Individual Measures - 12 months								
Measure #	Measure Title	Reporting Numerator: Valid QDCs Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]	Physician Quality Reporting National Mean Performance Rate[7]
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	74	74	0	0	0	0%	52%
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	42	10	32	18	14	56%	82%
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	180	80	100	80	20	80%	50%
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	400	25	375	175	200	47%	33%

Figure 1.13: Claims Performance Information for Individual Measures – 12-months

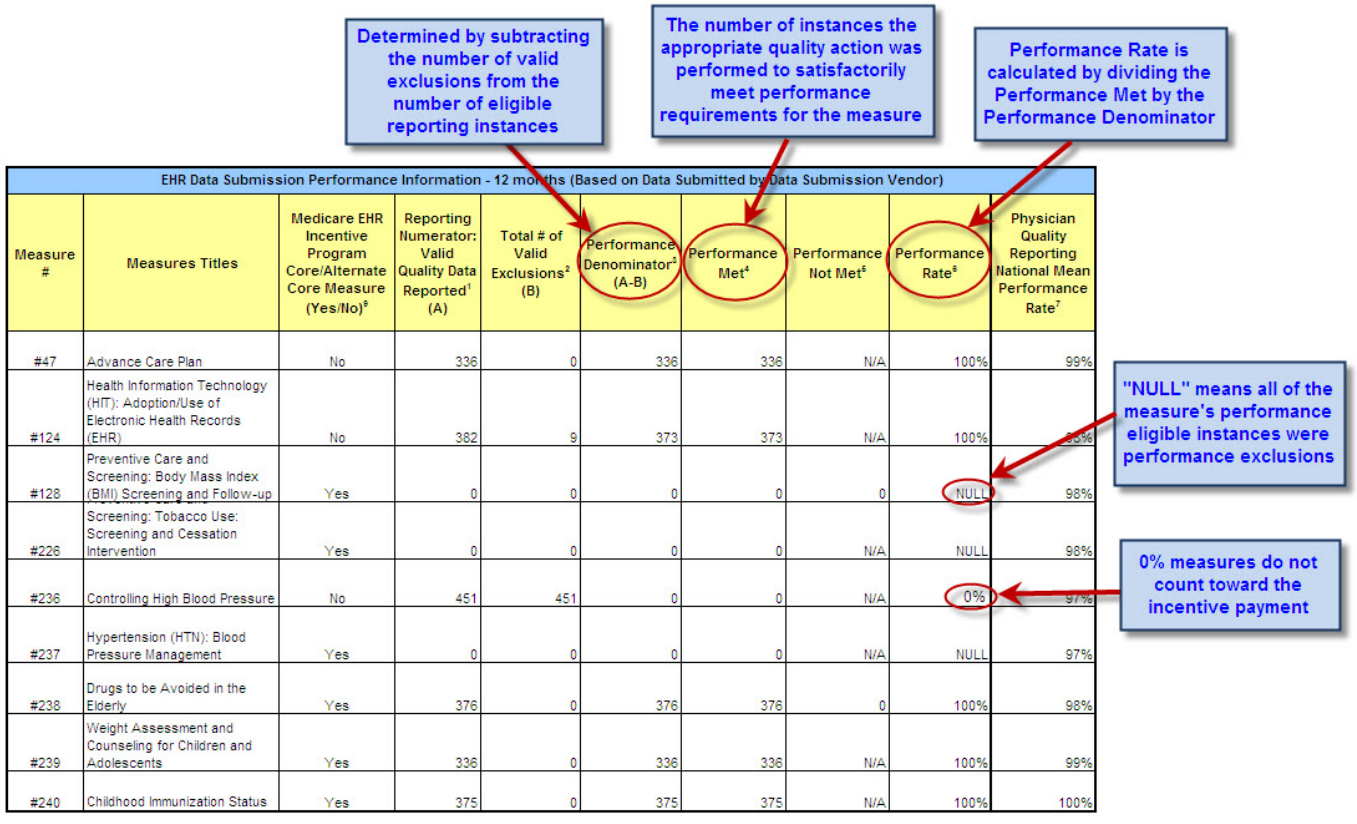
Example TIN-Level Feedback Report: Table 4 (continued)



EHR Data Submission Performance Information - 12 months (Based on Data Submitted by Direct EHR)

Measure #	Measures Titles	Medicare EHR Incentive Program Core/Alternate Core Measure (Yes/No)[8]	Reporting Numerator: Valid Quality Data Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]	Physician Quality Reporting National Mean Performance Rate[7]
#1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	No	376	0	376	376	0	100%	98%
#110	Screening: Influenza Immunization for Patients ≥ 50 Years Old	No	451	451	0	0	N/A	NULL	97%
#111	Screening: Pneumonia Vaccination for Patients 65 Years and Older	No	382	9	373	373	N/A	100%	98%
#113	Preventive Care and Screening: Colorectal Cancer Screening	No	336	0	336	336	N/A	100%	99%
#124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	No	375	0	375	375	N/A	100%	100%

Figure 1.14: EHR Direct Data Submission Performance Information – 12-months

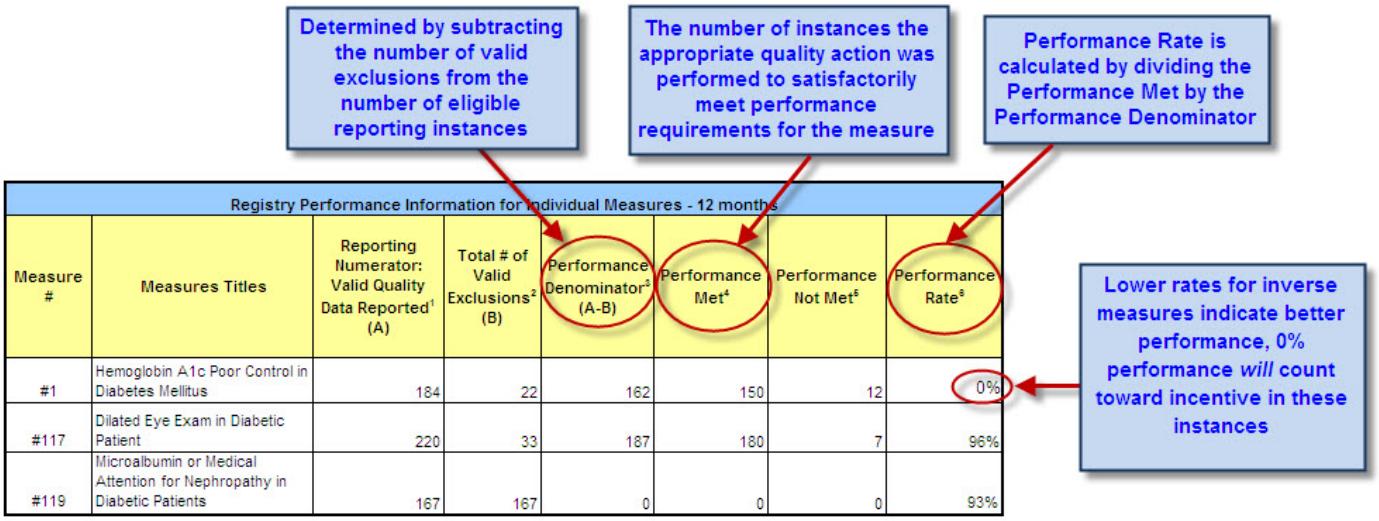


EHR Data Submission Performance Information - 12 months (Based on Data Submitted by Data Submission Vendor)

Measure #	Measures Titles	Medicare EHR Incentive Program Core/Alternate Core Measure (Yes/No)[8]	Reporting Numerator: Valid Quality Data Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]	Physician Quality Reporting National Mean Performance Rate[7]
#47	Advance Care Plan	No	336	0	336	336	N/A	100%	99%
#124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	No	382	9	373	373	N/A	100%	98%
#128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up	Yes	0	0	0	0	0	NULL	98%
#226	Screening: Tobacco Use: Screening and Cessation Intervention	Yes	0	0	0	0	N/A	NULL	98%
#236	Controlling High Blood Pressure	No	451	451	0	0	N/A	0%	97%
#237	Hypertension (HTN): Blood Pressure Management	Yes	0	0	0	0	N/A	NULL	97%
#238	Drugs to be Avoided in the Elderly	Yes	376	0	376	376	0	100%	98%
#239	Weight Assessment and Counseling for Children and Adolescents	Yes	336	0	336	336	N/A	100%	99%
#240	Childhood Immunization Status	Yes	375	0	375	375	N/A	100%	100%

Figure 1.15: EHR Data Submission Vendor Submission Performance Information – 12-months

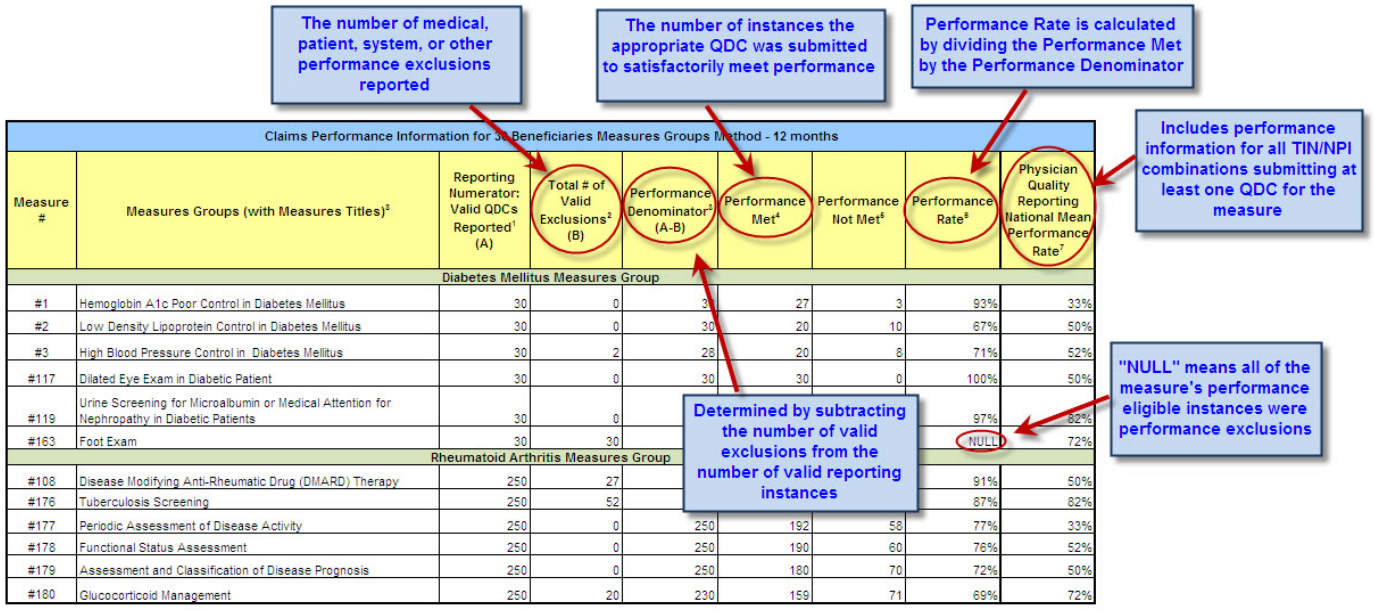
Example TIN-Level Feedback Report: Table 4 (continued)



Registry Performance Information for Individual Measures - 12 months

Measure #	Measures Titles	Reporting Numerator: Valid Quality Data Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]
#1	Hemoglobin A1c Poor Control in Diabetes Mellitus	184	22	162	150	12	0%
#117	Dilated Eye Exam in Diabetic Patient	220	33	187	180	7	96%
#119	Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	167	167	0	0	0	93%

Figure 1.16: Registry Performance Information for Individual Measures – 12-months and 6-months

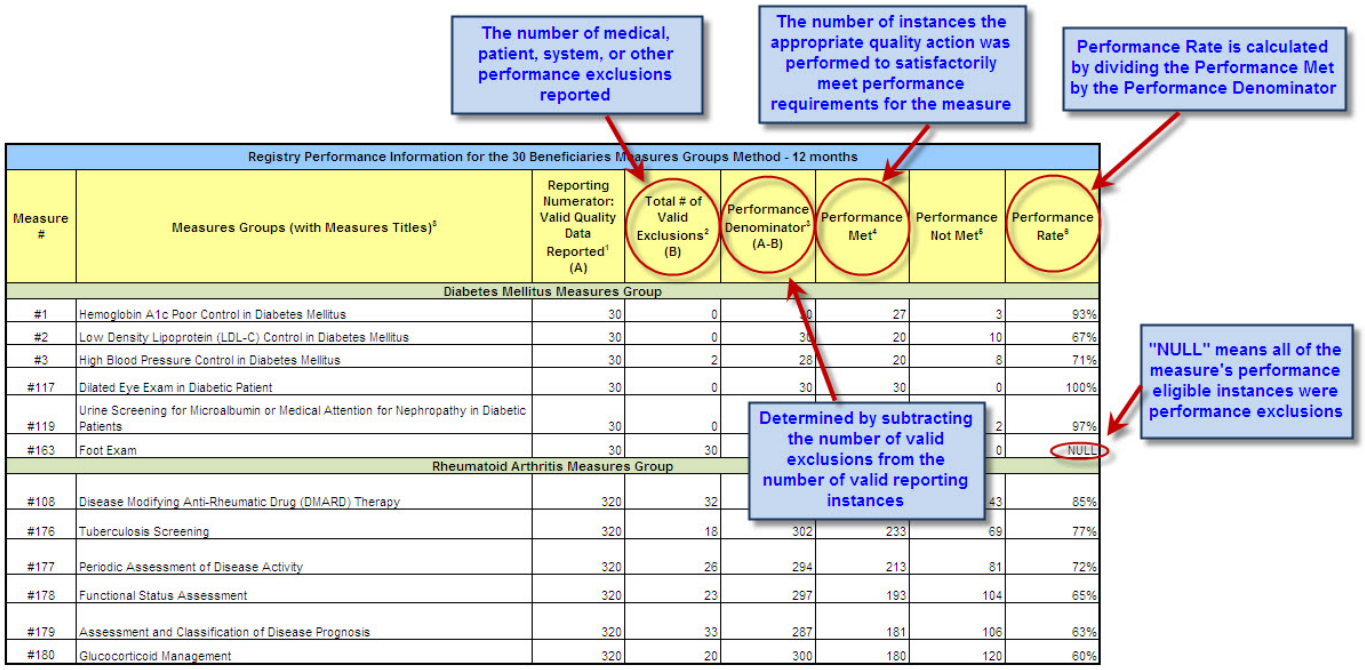


Claims Performance Information for 30 Beneficiaries Measures Groups Method - 12 months

Measure #	Measures Groups (with Measures Titles)[8]	Reporting Numerator: Valid QDCs Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]	Physician Quality Reporting National Mean Performance Rate[7]
	Diabetes Mellitus Measures Group							
#1	Hemoglobin A1c Poor Control in Diabetes Mellitus	30	0	30	27	3	93%	33%
#2	Low Density Lipoprotein Control in Diabetes Mellitus	30	0	30	20	10	67%	50%
#3	High Blood Pressure Control in Diabetes Mellitus	30	2	28	20	8	71%	52%
#117	Dilated Eye Exam in Diabetic Patient	30	0	30	30	0	100%	50%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	30	0				97%	82%
#163	Foot Exam	30	30				NULL	72%
	Rheumatoid Arthritis Measures Group							
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	250	27				91%	50%
#176	Tuberculosis Screening	250	52				87%	82%
#177	Periodic Assessment of Disease Activity	250	0	250	192	58	77%	33%
#178	Functional Status Assessment	250	0	250	190	60	76%	52%
#179	Assessment and Classification of Disease Prognosis	250	0	250	180	70	72%	50%
#180	Glucocorticoid Management	250	20	230	159	71	69%	72%

Figure 1.17: Claims Performance Information for Measures Groups 30 Beneficiary Method – 12-months

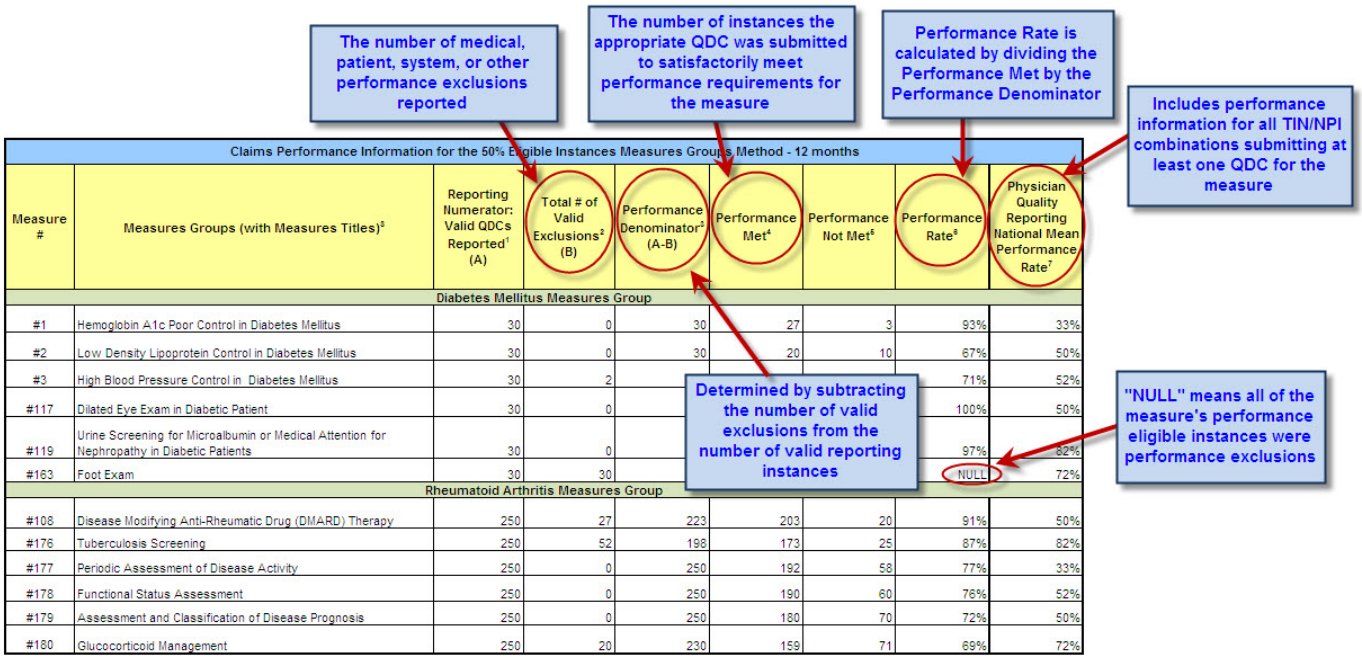
Example TIN-Level Feedback Report: Table 4 (continued)



Registry Performance Information for the 30 Beneficiaries Measures Groups Method - 12 months

Measure #	Measures Groups (with Measures Titles)[5]	Reporting Numerator: Valid Quality Data Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]
Diabetes Mellitus Measures Group							
#1	Hemoglobin A1c Poor Control in Diabetes Mellitus	30	0	30	27	3	93%
#2	Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	30	0	30	20	10	67%
#3	High Blood Pressure Control in Diabetes Mellitus	30	2	28	20	8	71%
#117	Dilated Eye Exam in Diabetic Patient	30	0	30	30	0	100%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	30	0	30	28	2	97%
#163	Foot Exam	30	30	0	0	0	NULL
Rheumatoid 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	20	300	180	120	60%

Figure 1.18: Registry Performance Information for Measures Groups 30 Beneficiary Method – 12-months

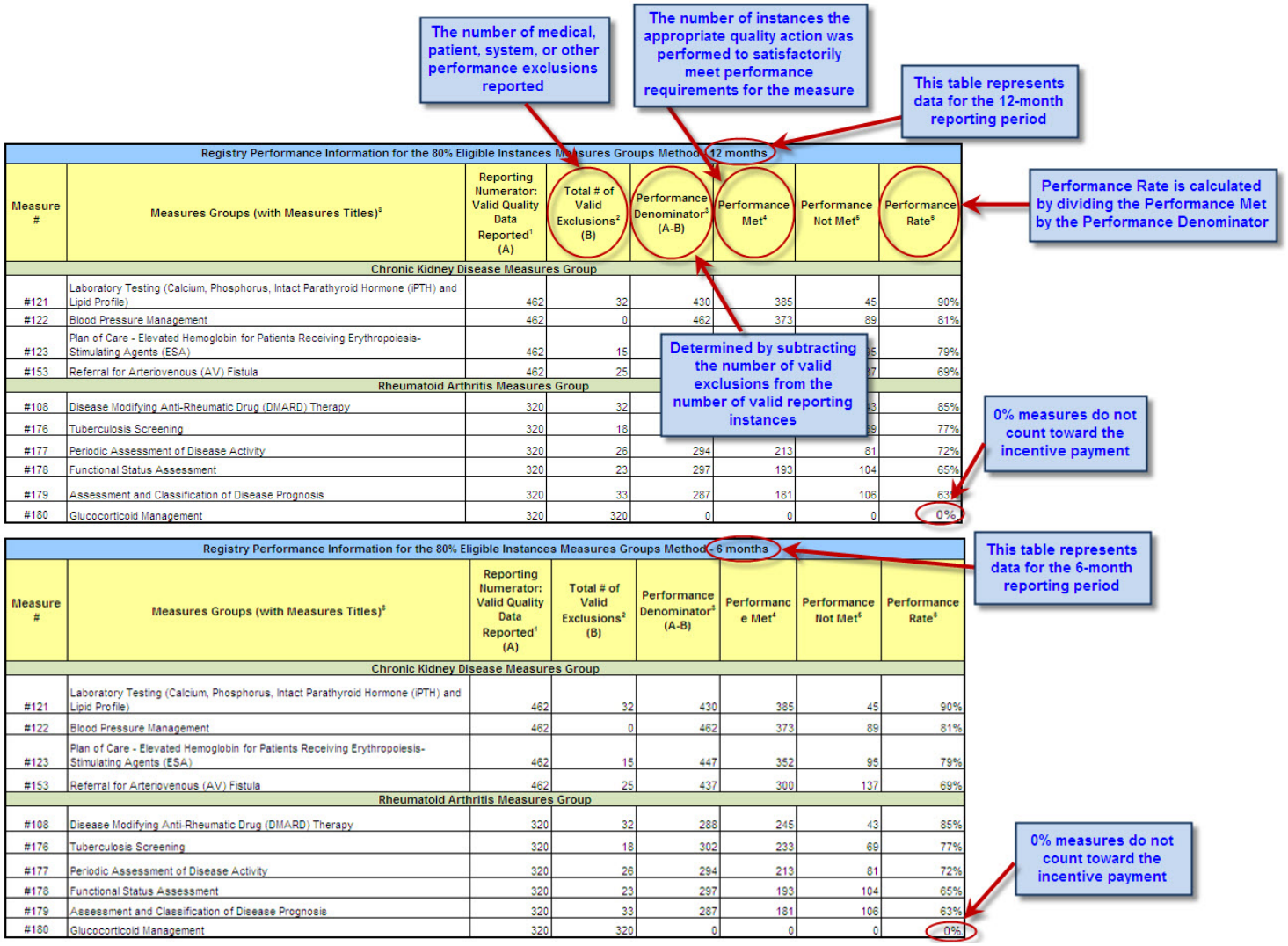


Claims Performance Information for the 50% Eligible Instances Measures Groups Method - 12 months

Measure #	Measures Groups (with Measures Titles)[5]	Reporting Numerator: Valid QDCs Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]	Physician Quality Reporting National Mean Performance Rate[7]
Diabetes Mellitus Measures Group								
#1	Hemoglobin A1c Poor Control in Diabetes Mellitus	30	0	30	27	3	93%	33%
#2	Low Density Lipoprotein Control in Diabetes Mellitus	30	0	30	20	10	67%	50%
#3	High Blood Pressure Control in Diabetes Mellitus	30	2	28	20	8	71%	52%
#117	Dilated Eye Exam in Diabetic Patient	30	0	30	30	0	100%	50%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	30	0	30	28	2	97%	82%
#163	Foot Exam	30	30	0	0	0	NULL	72%
Rheumatoid Arthritis Measures Group								
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	250	27	223	203	20	91%	50%
#176	Tuberculosis Screening	250	52	198	173	25	87%	82%
#177	Periodic Assessment of Disease Activity	250	0	250	192	58	77%	33%
#178	Functional Status Assessment	250	0	250	190	60	76%	52%
#179	Assessment and Classification of Disease Prognosis	250	0	250	180	70	72%	50%
#180	Glucocorticoid Management	250	20	230	159	71	69%	72%

Figure 1.19: Claims Performance Information for Measures Groups 50% Method – 12-months

Example TIN-Level Feedback Report: Table 4 (continued)



Registry Performance Information for the 80% Eligible Instances Measures Groups Method - 12 months

Measure #	Measures Groups (with Measures Titles)[5]	Reporting Numerator: Valid Quality Data Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]
	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				79%
#153	Referral for Arteriovenous (AV) Fistula	462	25				69%
	Rheumatoid Arthritis Measures Group						
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	320	32				85%
#176	Tuberculosis Screening	320	18				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	0%

Registry Performance Information for the 80% Eligible Instances Measures Groups Method - 6 months

Measure #	Measures Groups (with Measures Titles)[5]	Reporting Numerator: Valid Quality Data Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]
	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%
#153	Referral for Arteriovenous (AV) Fistula	462	25	437	300	137	69%
	Rheumatoid 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	0%

Figure 1.20: Registry Performance Information for Measures Groups 80% Method – 12-months and 6-months

Maintenance of Certification Program Incentive Feedback Report Including NPI Data

A TIN will receive a separate Table I for those NPIs who reported in the Maintenance of Certification Program Incentive. For those CMS-selected group practices participating in GPRO, all NPIs found in claims under the group practice's Tax ID will also be shown in this report. Although the incentive amount is listed separately in the *Feedback Report*, the incentive payment will be included in the lump-sum paid to the TIN.

A feedback report for Maintenance of Certification Program Incentive will include the following tables:

Table 1: Maintenance of Certification Program Incentive Summary
Figure 2.1: Maintenance of Certification Program Incentive Summary

Key Terms:

- **Maintenance of Certification Program Incentive Total Earned Incentive Amount:** The 0.5% incentive 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. The additional 0.5% is awarded to those who satisfactorily reported in 2012 PQRS for 12-months and reported in the Maintenance of Certification Program Incentive.

Note: The TIN-Level Report with Individual NPIs will include an additional box on Table 2 indicating an individual eligible professional's incentive eligibility for the Maintenance of Certification Program Incentive, if applicable. See page 12 of this document for reference.

For definition of terms related to the 2012 Physician Quality Reporting System Feedback Report, see Appendix A. Also refer to the footnotes within each table for additional content detail.

The screenshots are provided for examples only and are subject to change. Minor changes in language and/or format should be expected.

Example - Maintenance of Certification Program Summary: Table 1

2012 PHYSICIAN QUALITY REPORTING SYSTEM FEEDBACK REPORT

(MAINTENANCE OF CERTIFICATION PROGRAM INCENTIVE REPORT)

Eligible professionals may participate in the Physician Quality Reporting System (Physician Quality Reporting) either at the individual level using their unique TIN/NPI or as a member of a selected group practice under the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2012 Physician Quality Reporting included three Medicare Part B claims-based reporting methods, four qualified registry-based reporting methods, and two qualified electronic health record (EHR) methods. The twelve month reporting period will be utilized for all reporting methods with the exception of registry-based reporting, which will also have one six month reporting option available. Tax IDs reporting under the GPRO (Group Practice Reporting Option) for Physician Quality Reporting will submit data using the GPRO web interface. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2012 to December 31, 2012 (for the twelve month reporting period) and for services furnished from July 1, 2012 to December 31, 2012 (for the six month registry Measures Group reporting period) were reviewed to evaluate whether an eligible professional or group successfully reported for the Physician Quality Reporting incentive. Participation by an eligible professional or group practice is defined as submitting quality data via one of the aforementioned methods. A submission is considered valid if quality data is submitted and all measure-eligibility criteria is met (i.e., correct age, gender, diagnosis and CPT). For eligible professionals participating at the TIN/NPI level via multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their Physician Quality Reporting incentive. Additionally, in 2012 NPIs had the opportunity to qualify for a Maintenance of Certification Program incentive by submitting data via a Maintenance of Certification Program qualified entity. Please note that the Maintenance of Certification Program incentive is only available if satisfactorily reporting data via any of the reporting methods for the twelve-month reporting period. The Tax ID's Maintenance of Certification Program Incentive details for each NPI are summarized below. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/.

Table 1: Maintenance of

Sorted by NPI Number

Tax ID Name*: John Q. P

Tax ID Number: XXXXX

NPIs of those eligible professionals who participated in the Maintenance of Certification Program Incentive under the TIN

An NPI who reports for the Maintenance of Certification Program Incentive will be shown here.

NPI	NPI Name*	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period[1]	Maintenance of Certification Program Satisfactorily Reporting Participant (Yes/No)	Maintenance of Certification Total Earned Incentive Amount (0.5%)
1000000002	Susie Smith	$100,000.00	Yes	$500.00
1000000003	Not Available	$133,333.33	Yes	$666.67
1000000004	Not Available	$93,000.00	Yes	$465.00
1000000006	Not Available	$125,000.00	No	N/A
1000000008	John Beans	$40,000.00	Yes	$200.00
1000000009	Steve Smithson	$125,000.00	Yes	$625.00
1000000011	Josie Jones	$70,000.00	Yes	$350.00
1000000012	John Beans	$60,000.00	Yes	$300.00
1000000013	Not Available	$65,000.00	No	N/A
1000000015	Jane Doe	$30,000.00	Yes	$150.00
1000000016	Melissa Smith	$300,000.00	Yes	$1,500.00
			Total:	$4,756.67

Total 0.5% incentive amount earned by each individual NPI

Total 0.5% incentive amount earned by the TIN for all participating NPIs

Figure 2.1: Maintenance of Certification Program Incentive Summary

Accessing Feedback Reports

NPI-Level Reports
Eligible professionals who submitted data as an individual NPI (including sole proprietors who submitted under a SSN) can request their individual NPI-level feedback reports through the following method:

- Quality Reporting Communication Support Page (approximately 2-3 day processing), available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS under the "Related Links" section in the upper left-hand corner of the window

Individuals can access the TIN-level report (which includes NPI-level data for all individual eligible professionals under that TIN) through the Portal and Individuals Authorized Access to the CMS Computer Services (IACS) login as discussed in the next section.

TIN-Level Reports
TIN-level reports can be requested for individuals within the same practice. The TIN-level reports for non-GPRO participants will be accessible through the Portal with IACS login at https://www.qualitynet.org/pqrs. TIN-level reports can only be accessed via the Portal.

The Portal is the secured entry point to access the 2012 feedback reports. Your report is safely stored online and accessible only to you (and those you specifically authorize). Eligible professionals will need to obtain an IACS account for an "end user" role in order to access their 2012 feedback reports through the secure Portal. As shown in Figure 3.1, the *IACS Quick Reference Guides* provide step-by-step instructions to request an IACS account to access the Portal, if you do not already have one.

Downloadable *2012 Physician Quality Reporting Feedback Reports* will be available as an Adobe® Acrobat® PDF in the fall of 2013 in the Portal. The report will also be available as a Microsoft® Excel or .csv file.

Assistance
Please see the *Portal User Guide* (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS) for detailed instructions on logging into the Portal.

CMS established the QualityNet Help Desk to support access to and registration for IACS. The QualityNet Help Desk can be reached at 1-866-288-8912 (TTY 1-877-715-6222) or by e-mail at Qnetsupport@sdps.org. Hours of operation are Monday through Friday from 7:00 a.m. to 7:00 p.m. CST.

Note: *The* 2012 Physician Quality Reporting System Feedback Report *may contain a partial or "masked" Social Security Number/Social Security Account Number (SSN/SSAN) as part of the TIN field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner with which the SSN/SSAN 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.*

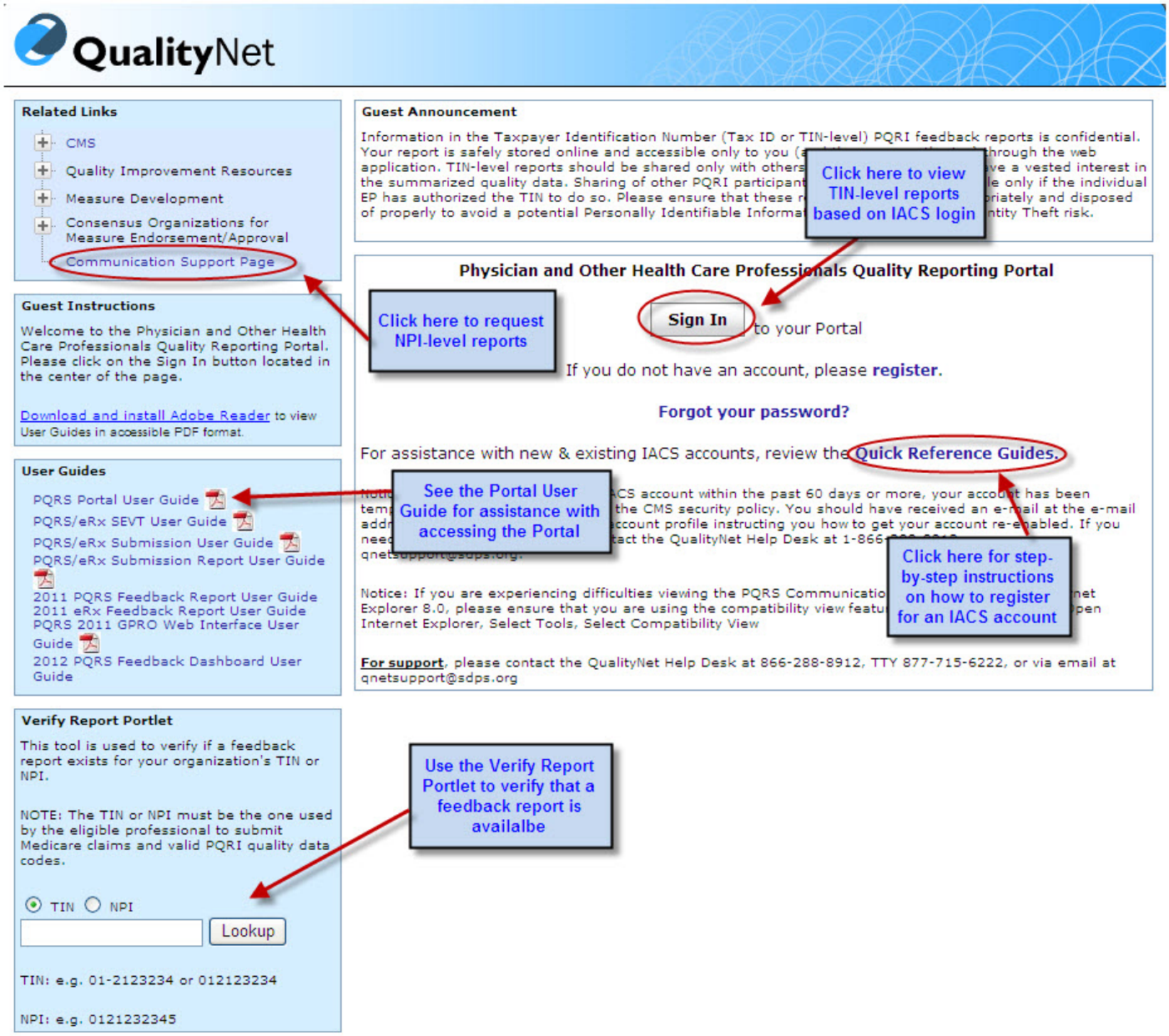


Figure 3.1 Screenshot of Physician and Other Health Care Professionals Quality Reporting Portal

Key Facts about PQRS 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), 2012 PQRS included a validation process to ensure that each eligible professional satisfactorily reported the minimum number of measures. Eligible professionals who satisfactorily submitted QDCs via claims-based reporting on one or two PQRS individual measures for at least 50% of their patients eligible for each measure reported and did not submit any QDCs on any additional measures were subject to MAV for determination of 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 or EHR-based submissions or to CMS-selected GPRO participants. For more information, refer to PQRS FAQs and the 2012 MAV documents on the CMS PQRS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Lump-Sum Incentive Payment

Payment Calculations

- The 0.5% incentive is based on CMS' estimate of all Medicare Part B PFS allowed charges for covered professional services: (1) furnished during the applicable 2012 reporting period, (2) processed by the Carrier or A/B Medicare Administrative Contractor (MAC) no later than February 22, 2013, and (3) paid under or based on the PFS. PQRS incentive payments will be aggregated at the TIN level.
- For individual incentive payment calculation, incentive eligibility is defined as a TIN/NPI who meets the PQRS criteria for satisfactory reporting for the applicable program year. A CMS-selected GPRO eligible for the incentive is defined as a TIN who met the PQRS criteria for successful reporting for the 2012 PQRS program year.
- The analysis of satisfactory reporting will be performed at the individual TIN/NPI level to identify each individual eligible professional's services and quality data. The analysis of successful reporting among eligible professionals under CMS-selected group practices participating in GPRO will be performed at the TIN level to identify the group'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 groups claims by TIN for analysis and payment purposes. As a result, a professional who submits claims under multiple TINs may earn a PQRS incentive under one of the TINs and not the other(s), or may earn an incentive under each TIN.
- For further information related to the incentive payment please refer to the 2012 PQRS program pages on the CMS website (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS), including the *Guide for Understanding 2012 Physician Quality Reporting System Incentive Payment*.

Distribution

- 2012 PQRS payments are scheduled to be issued to the TIN by the Carrier or A/B MAC in the fall of 2013 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 2012 PQRS and the 2012 Electronic Prescribing (eRx) Incentive Program will be distributed separately.
- If a TIN submits claims to multiple Medicare claims-processing contractors (Carriers or A/B MACs), each contractor may be responsible for a proportion of the TIN incentive payment equivalent to the proportion of Medicare Part B PFS claims the contractor processed for the 2012 reporting periods. *(Note: if splitting an incentive across contractors would result in any contractor issuing a PQRS 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 the lump-sum incentive payment does not arrive, contact your Carrier or A/B MAC.
- If the incentive payment amount does not match what is reflected in your PQRS feedback report, contact your Carrier or A/B MAC. The incentive amount may differ by a penny or two from what is reflected in the feedback report due to rounding. The proportion of incentive amount by Carrier or A/B MAC may not equal 100 percent due to rounding.
- The incentive payment and the PQRS feedback report will be issued at different times. The payment, with the remittance advice, will be issued by the Carrier or A/B MAC and identified as a lump-sum incentive payment. CMS will provide the 2012 PQRS 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 (PQ12) to accompany the incentive payment.
- The Paper Remittance Advice states: "This is a PQRS incentive payment."
- PQRS participants will not receive claims-specific detail in the feedback reports, but rather overall reporting detail
- 2012 PQRS feedback reports are scheduled to be available in the fall of 2013.
- PQRS 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 PQRS measure a minimum of once during the reporting period.
- Feedback reports for multiple years will now be accessible via the Portal.
- If **all** of the 2012 PQRS QDCs submitted by individual eligible professionals via claims are not denominator-eligible events for the 2012 measure, Tables 2 and 4 of the individual eligible professional's NPI-level reports will be populated with zeroes in most or all of the numeric fields of the tables. Table 3 will give NPI-level detailed information in regards to these invalid submissions.
- In some cases for eligible professionals reporting as individuals, an individual NPI will be indicated in the feedback report as incentive eligible, but the incentive payment is determined to be zero dollars. This happens when CMS cannot find any Medicare Part B PFS allowed charges for covered professional services billed under that individual's TIN/NPI combination during the reporting period. It is important to make sure you are submitting the correct TIN/NPI number when submitting data for calculation via Registry. For EHR data submission, be sure to enter the correct TIN and NPI in the proper fields within the QRDA file. The correct TIN is the one under which the professional submitted Medicare Part B claims during 2012. The correct NPI is the professional's Individual or rendering NPI.

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.
- Feedback files for PQRS are generated in the 2007 version of Miscrosoft® Excel. Microsoft offers a free viewer application for opening Office 2007 files to users running Windows Server 2003, Windows XP, or Windows Vista Operating Systems. With Excel Viewer, you can open, view, and print Excel workbooks, even if you do not have Excel installed. You can also copy data from Excel Viewer to another program. However, you cannot edit data, save a workbook, or create a new workbook. This download is a replacement for Excel Viewer 97 and all previous Excel Viewer versions. See http://www.microsoft.com/download/en/details.aspx?DisplayLang=en&id=10 to download the free Microsoft® Excel Viewer.
- One of the format options for the feedback report is Character Separated Values (.csv) files. This is a commonly recognized delimited data format that has fields/columns separated by the comma character or other character and records/rows separated by a line feed or a carriage return and line feed pair. Csv files generated for the eRx feedback report will use the [tab] as the delimiting character. The .csv file type is generally accepted by spreadsheet programs and database management systems using the application's native features.
- Users may need to turn off their web browser's Pop-up Blocker or temporarily allow Pop-up files in order to download the PQRS feedback report.
- Regardless of the format, users should preview their feedback reports prior to printing. In Microsoft® Excel, view Print Preview to ensure all worksheets show as fit to one page.
- If you need assistance with the **Individuals Authorized Access to the CMS Computer Services (IACS) registration process** (i.e., forgot ID, password resets, etc.), contact the QualityNet Help Desk at 866-288-8912

(TTY 877-715-6222) or qnetsupport@sdps.org (Monday-Friday 7:00 a.m.-7:00 p.m. CT). You may also contact them for **PQRS assistance, including accessing the Portal**.

- Contact your Carrier or A/B MAC with general payment questions. The Provider Contact Center Toll-Free Numbers Directory offers information on how to contact the appropriate provider contact center and is available for download at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNGenInfo/01_Overview.asp.

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Appendix A: 2012 PQRS Feedback Report Definitions

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

Term	Definition
Carrier or A/B MAC Identification #	Carrier and/or A/B MAC number to which the TIN bills their claims.
Tax ID Earned Incentive Amount Under Carrier or A/B MAC	The total incentive amount earned by NPIs within the Tax ID (TIN) billing to each carrier. More information regarding incentive calculations can be found on the CMS website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.
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 A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2012 PQRS 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 Estimated Allowed Medicare Part B PFS Charges	The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) allowed 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.
TIN Total Earned Incentive Amount	The 0.5% incentive based on the total estimated Medicare Part B PFS allowed charges for services performed within the length of the reporting period for which a Tax ID was eligible. If N/A, the Tax ID was not eligible to receive an incentive. If applicable, the total incentive amount will include an additional 0.5% incentive based upon eligible professionals within the Tax ID meeting the requirements for the Maintenance of Certification Program Incentive.
Physician Quality Reporting 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.
Maintenance of Certification Total Earned Incentive Amount (Maintenance of Certification Only)	The 0.5% incentive 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. The additional 0.5% is awarded to those who satisfactorily reported in 2012 PQRS *and* reported in the Maintenance of Certification Program.
Method of Reporting	The method of reporting attempted by the NPI. For those NPIs participating in PQRS by multiple reporting methods, the most advantageous method is displayed. For the EHR submission method, there are two submission options: 1) a qualified data submission vendor, which obtains its data from an eligible professional's EHR system, and 2) direct EHR submission, which represents submitting data directly from his or her qualified EHR system.
NPI	National Provider Identifier of the eligible professional billing under the TIN.
NPI Name	Eligible professional's name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization's or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2012 PQRS incentive payment, only the system's ability to populate this field in the report.
NPI Total Earned Incentive Amount	The 0.5% incentive based on the total estimated Medicare Part B PFS allowed charges for services performed within the length of the reporting period for which an NPI was eligible within the Tax ID. If N/A, the NPI was not eligible to receive an incentive. If applicable, the total incentive amount will include an additional 0.5% incentive based upon the eligible professional meeting the requirements for the Maintenance of Certification Program Incentive.

Term	Definition
Rationale	The rationale for those TIN/NPIs or TINs who were or were not eligible to receive an incentive. **NPI** **Not Eligible** o Did not pass MAV o Insufficient # of beneficiaries reported o Insufficient # of eligible instances reported o Insufficient # of measure reported o Insufficient # of minimum eligible instances **Eligible** o Sufficient # of beneficiaries reported o Sufficient # of eligible instances reported o Sufficient # of measures reported More information regarding incentive calculations can be found on the CMS website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.
Reporting Period	The 12-month or 6-month time period for which an eligible professional can submit quality data for 2012 PQRS. o 12-month (January 1 – December 31, 2012) o 6-month (July 1 – December 31, 2012, only applicable to registry reporting of measures groups)

Table 2: NPI Reporting Detail

Term	Definition
Incentive Eligible for the Reporting Method	"Yes" if satisfactorily met reporting criteria for the method of data submission and "No" if did not satisfactorily meet reporting criteria.
Reporting Method/Period Selected for Incentive Payment	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". If an eligible professional is incentive eligible utilizing more than one Physician Quality Reporting System reporting method, the methods considered for incentive eligibility will be indicated according to the following hierarchy: o 12 months - EHR - Direct Submission - Medicare EHR Incentive Program Pilot o 12 months - EHR - Direct Submission - Physician Quality Reporting o 12 months - EHR - Data Submission Vendor - Medicare EHR Incentive Program Pilot o 12 months - EHR - Data Submission Vendor - Physician Quality Reporting o 12 months - 30 Beneficiary Measures Groups Claims o 12 months - 50% Measures Groups Claims o 12 months - 30 Beneficiary Measures Groups Registry o 12 months - 80% Measures Groups Registry o 12 months - Individual Measures Claims o 12 months - Individual Measures Registry o 6 months - 80% Measures Groups Registry
Total # Measures Reported	The number of measures where quality-data codes (QDCs) or quality action data are submitted, but are not necessarily valid. These instances do not necessarily count towards reporting success.
Total # Measures Reported on Denominator-Eligible Instances	The number of measures for which the TIN/NPI reported a valid quality-data code (QDC) or quality action data. 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 PQRS data. CMS *Physician Quality Reporting System Quality Measures Specifications* document contains all codes associated with each measure and instructions for data submission through the claims system. This document can be found on the CMS 2012 PQRS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.
Total # Measures Satisfactorily Reported	The total number of measures the TIN/NPI reported at a satisfactory rate.
Reporting Numerator: QDCs Correctly Reported or Required Quality Data Reported	The number of eligible instances for which the TIN/NPI reported a valid quality-data code (QDC) or quality action data.
No QDC Reported	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. For Measures Groups reporting, this column will be populated with "N/A" for the Measures Group Title line.
Number of Instances of QDC Reporting Errors	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). For Measures Groups reporting, this column will be populated with "N/A" for the Measures Group Title line.
Reporting Rate	A satisfactorily reported measure has a reporting rate of 50% or greater for claims and 80% or greater for registry and EHR.
Medicare EHR Incentive Program Core/Alternate Core Measure (EHR reporting options only)	Indicates measure is one of the three Core or three Alternate Core Measures for the Medicare EHR Incentive Program.

Table 3: NPI QDC Submission Error Detail

Term	Definition
Number of Times Quality Data Was Reported	Number of quality-data code (QDC) submissions for a measure whether or not the QDC submission was valid and appropriate.
Number of Times Quality Data was Reported Correctly	Number of valid and appropriate quality-data code (QDC) submissions for a measure.
% of Correctly Reported Quality Data	The percentage of reported quality-data codes (QDCs) that were valid.
Quality Data Reporting Errors (with Reasons for the Errors)	The following indicate the various reasons for QDC errors: o Number of invalid quality-data code (QDC) submissions due to not matching the gender and/or age requirements for the measure o Number of invalid quality-data code (QDC) submissions resulting from an incorrect diagnosis code (DX) and/or CPT code o Number of invalid quality-data code (QDC) submissions due to a missing qualifying denominator CPT code since all lines were QDCs. **Note: A single QDC submission attempt may be counted for one or more of the errors**

Table 4: NPI Performance Detail

Term	Definition
Reporting Numerator: Valid QDCs or Quality Data Reported	Number of valid quality-data code (QDC) submissions for a measure.
Total Number of Valid Exclusions	The number of medical, patient, system or other performance exclusions reported. • **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.
Performance Denominator	The Performance Denominator is determined by subtracting the number of eligible instance excluded from the numerator eligible reporting instances. Valid reasons for exclusions may apply and are specific to each measure.
Performance Met	The number of instances the TIN/NPI submitted the appropriate QDC or quality action data satisfactorily meeting the performance requirements for the measure.
Performance Not Met	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 given or otherwise specified.
Performance Rate	The Performance Rate is calculated by dividing the Performance Met by the Performance Denominator. If "NULL", all of the measure's performance eligible instances were performance exclusions.
National Mean Performance Rate	The national mean performance rate includes performance information for all TIN/NPI combinations submitting at least one quality-data code (QDC) for the measure.
Medicare EHR Incentive Program Core/Alternate Core Measure (EHR reporting options only)	Indicates measure is one of the three Core or three Alternate Core Measures for the Medicare EHR Incentive Program.