User Guide

2011
Physician Quality Reporting System (PQRS)
Feedback Reports

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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 2011 PQRS feedback reports. The 2011 PQRS incentive payments are scheduled to be made in the fall of 2012. Feedback reports reflect data from the Medicare Part B Physician Fee Schedule (PFS) claims received with dates of service between January 1, 2011 – December 31, 2011 that were processed into the National Claims History (NCH) by February 24, 2012.

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.

The 2011 Physician Quality Reporting System continued as a pay-for-reporting program that included claims-, registry-, electronic health record (EHR)-, and Group Practice Reporting Option (GPRO)-based reporting of data on 194 individual quality measures as well as 14 measures groups. The two alternative reporting periods for this program year were: January 1, 2011 – December 31, 2011 and July 1, 2011 – December 31, 2011. There were 14 options for satisfactorily reporting quality measures data for 2011 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).

CMS-selected group practices participating in the Group Practice Reporting Option I or II (GPRO I or II) will receive an incentive payment at the Tax Identification Number (TIN)-level. A CMS-selected group practice is defined as single TIN with two 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 2011 PQRS GPRO I or II.

For more information on 2011 PQRS, please visit the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Report Overview

The 2011 PQRS 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 valid PQRS quality-data code (QDC) on a claim submitted under that TIN for services furnished during the reporting period. CMS-selected GPRO participants will not have reporting or performance data at the eligible professional level, only the TIN level. 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.

2011 PQRS included six claims-based reporting methods, six registry-based reporting methods, CMS-selected GPRO I and II, and EHR reporting. All Medicare Part B claims submitted with PQRS QDCs, all registry data, all EHR data, and all GPRO data received for services furnished from January 1, 2011 – December 31, 2011 (for the 12-month reporting period) and for services furnished from July 1, 2011 – December 31, 2011 (for the 6-month reporting period) were analyzed to determine whether the eligible professional 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 CMS-selected GPRO. Valid submissions are when a QDC was submitted and all measure-eligibility criteria were met (i.e., correct age, gender, diagnosis, and CPT). For those NPIs satisfactorily reporting using multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRS incentive.

CMS aims to distribute feedback reports as closely as possible to the incentive payment timeframe. 2011 PQRS feedback reports are scheduled to be available in the fall of 2012. 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 125 MB free disk space
- 64 MB Ram

Software

- Microsoft® Internet Explorer version 7.0
- Adobe® Acrobat® Reader version 5.0 and above
- JRE 1.6.0_21 (software available for download on the Portal)
- Windows XP operating system
- WinZip version 7.0 or greater (or compatible zip programs using default compression settings) for Zip file creation to upload data

Internet Connection

- The Physician Quality Reporting System Submission Portlet 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 2011 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. CMS-selected group practices participating in GPRO I will receive Tables 1 and 4, GPRO II participants will receive Tables 1, 2, and 4. 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.

TIN-Level Feedback Report Including NPI Data

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 Incentive.
  - **NPI Total Earned Incentive Amount:** The 1.0% incentive amount earned for each TIN/NPI. This field will display "N/A" if the eligible professional is not incentive eligible along with the rationale of why they were not considered incentive eligible. $0 will appear in the "Physician Quality Reporting NPI Total Earned Incentive Amount" column if the NPI is incentive eligible but does not have any Part B allowed charges.

- ***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 and 6-months
  Figure 1.5: EHR Data Submission Reporting Detail – 12-months

Figure 1.6: Reporting Detail of Information Submitted by Registries for Individual Measures – 12-months and 6-months
Figure 1.7: Claims Reporting Detail for Measures Groups 30 Beneficiary Method – 12-months
Figure 1.8: Reporting Detail of Information Submitted by Registries for the 30 Beneficiaries Measures Groups Method – 12-months
Figure 1.9: Claims Reporting Detail for Measures Groups 50% Method – 12-months and 6-months
Figure 1.10: 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 total number of individual measures the TIN/NPI reported at a satisfactory rate; satisfactory rate is reporting on 50% or more of eligible instances via claims and 80% or more via registry and EHR.
- **Total # Measures Reported on Denominator-Eligible Instances:** The number of measures for which the TIN/NPI reported at least one valid QDC or quality action data. If the reporting method is through measures groups, this field will be populated with 'N/A'.
- **Total # Measures Satisfactorily Reported:** The total number of measures the TIN/NPI reported at a satisfactory rate.

- ***Table 3: NPI QDC Submission Error Detail*** **(only applies to those who submitted via claims)**
Figure 1.11: QDC Submission Error Detail

Key Terms:

- **Number of Times Quality Data was Reported Correctly:** Number of valid and appropriate QDC submissions for a measure.
- **% of Correctly Reported Quality Data:** The percentage of reported QDCs that were valid.

- ***Table 4: NPI Performance Detail***
Figure 1.12: Claims Performance Information for Individual Measures – 12-months and 6-months
Figure 1.13: EHR Data Submission Performance Information – 12-months
Figure 1.14: Registry Performance Information for Individual Measures – 12-months and 6-months
Figure 1.15: Claims Performance Information for Measures Groups 30 Beneficiary Method – 12-months
Figure 1.16: Registry Performance Information for Measures Groups 30 Beneficiary Method – 12-months
Figure 1.17: Claims Performance Information for Measures Groups 50% Method – 12-months and 6 months
Figure 1.18: 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 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 otherwise specified.
- **Performance Rate:** The Performance Rate includes performance information for all TIN/NPI combinations submitting at least one QDC for the measure.

NOTE: Performance information is provided for GPRO participants or eligible professional's use to assess and improve their clinical performance. Performance rates do not affect 2011 PQRS incentive payment eligibility or amount at the individual eligible professional or practice level.

For definition of terms related to the *2011 Physician Quality Reporting System Feedback Report*, see Appendix A. Also refer to the footnotes within each table for additional content detail.

Example - TIN-Level Feedback Report: Table 1

2011 PHYSICIAN QUALITY REPORTING SYSTEM (PHYSICIAN QUALITY REPORTING) 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 one of the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2011 Physician Quality Reporting included five Medicare Part B claims-based reporting methods, five qualified registry-based reporting methods, and one qualified electronic health record (EHR) method. This includes two alternate reporting periods. TINs reporting under one of the Group Practice Reporting Options (GPRO) for Physician Quality Reporting either submitted data using the GPRO web interface (for GPRO I) or submitted claims or registry data for the appropriate reporting requirements under GPRO II. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2011 to December 31, 2011 (for the twelve month reporting period) and for services furnished from July 1, 2011 to December 31, 2011 (for the six month 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 GPRO 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 2011 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 submitting data via any of the reporting methods for the 12-month submission 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/pqrs.

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

Sorted by NPI Number and Sub-Sorted by Total Earned Incentive Amount and Method 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)[1]	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
$17,120.00	12345	$15,408.00
	67890	$1,712.00

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

Total 1% incentive amount earned by each individual NPI for Physician Quality Reporting

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	Reporting Period	Incentive Eligibility Rationale	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period[2]	Physician Quality Reporting NPI Total Earned Incentive Amount[3]
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 registry	6 months	Sufficient # of measures reported at 80%	$50,000.00	$500.00
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 at 80%	$133,333.33	$1,333.33
1000000004	Not Available	Measures Groups - 50% eligible instances via claims	6 months	Sufficient # of eligible instances reported at 50% and a minimum of 8 eligible instances	$93,000.00	$930.00

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	Reporting Period	Incentive Eligibility Rationale	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period[2]	Physician Quality Reporting NPI Total Earned Incentive Amount[3]
1000000010	John Johnson	Measures Groups - 30 beneficiaries via registry	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 at 80% and a minimum of 8 eligible instances	$70,000.00	$700.00
1000000012	John Beans	Individual measure(s) reporting via claims	12 months	Sufficient # of measures reported at 50%	$60,000.00	$600.00
1000000013	Not Available	Measures Groups - 30 eligible instances via claims	12 months	Sufficient # of eligible instances reported	$65,000.00	$650.00
1000000014	Not Available	Measures Groups - 80% eligible instances via registry	12 months	Insufficient # of minimum eligible instances	$109,000.00	N/A
1000000015	Jane Doe	Individual measure(s) reporting via claims	6 months	Sufficient # of measures reported at 80%	$30,000.00	$300.00
1000000016	Melissa Smith	reporting via electronic health records	12 months	Sufficient # of measures reported at 80%	$300,000.00	$3,000.00
1000000017	Not Available	Individual measure(s) reporting via registry	12 months	Insufficient # of measures reported at 80%	$140,000.00	NA
1000000018	Not Available	Measures Groups - 30 eligible instances via claims	12 months	Insufficient # of eligible instances reported	$79,000.00	NA
1000000019	Johnny Appleseed	Individual measure(s) reporting via electronic health	12 months	Insufficient # of measures reported at 80%	$200,000.00	NA
					Total:	$11,413.33

*Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local A/B MAC and Carrier 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 2011 Physician Quality Reporting incentive payment, only the system's ability to populate this field in the report.

Total 1% incentive earned by the TIN for all participating NPIs for Physician Quality Reporting

Explanation of Columns

[1]The amount of the incentive is based on the total estimated allowed Medicare Part B PFS charges for services performed within the leng thin the Tax ID meeting the requirements for the Maintenance of Certification Program. 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 in

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

[3]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.

Note: The registry information is based on data calculated and supplied by the 2011 Physician Quality Reporting participating registries.
Note: Physician Quality Reporting incentive payments are subject to offsets. Payments are made to the first NPI associated with the Tax ID. If the first NPI associated with the Tax ID has an offset, A/B MACs and Carriers will apply the lump sum and/or sanction.

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

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

Example - TIN-Level Feedback Report: Table 2

2011 PHYSICIAN QUALITY REPORTING SYSTEM (PHYSICIAN QUALITY REPORTING) 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 one of the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2011 Physician Quality Reporting included five Medicare Part B claims-based reporting methods, five qualified registry-based reporting methods, and one qualified electronic health record (EHR) method. This includes two alternate reporting periods. Tax IDs reporting under one of the Group Practice Reporting Options (GPRO) for Physician Quality Reporting either submitted data using the GPRO web interface (for GPRO I) or submitted claims or registry data for the appropriate reporting requirements under GPRO II. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2011 to December 31, 2011 (for the twelve month reporting period) and for services furnished from July 1, 2011 to December 31, 2011 (for the six month reporting period) were reviewed to evaluate whether an eligible professional or group successfully reported for Physician Quality Reporting. Participation by an eligible professional or GPRO 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 2011 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 submitting data via any of the reporting methods for the 12-month submission period. The methods reported and amounts earned for each TIN/NPI are summarized below. The results below include: an Incentive Detail table listing the NPI's total earned incentive amounts for the reported methods, a Participation Summary table listing all of the individual NPI's reporting methods attempted, a Maintenance of Certification Program Summary table showing the NPIs reporting summary for the Maintenance of Certification Program, a Reporting Summary table showing a summary of all reporting methods being attempted, and Reporting Detail tables listing reporting details for all methods being attempted. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/pqrs.

Table 2: NPI Reporting Detail

Participation and Reporting Detail
Reporting Detail Tables Sorted by

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

Total incentive amount earned by the NPI for 2011

Total 1.0% incentive earned by the NPI for 2011 Physician Quality Reporting

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

Incentive Summary

Total NPI Incentive Amount Earned for the Reporting Period	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting	Physician Quality Reporting Incentive Amount	Maintenance of Certification Total Earned Incentive Amount (0.5%)
$900.00	$60,000.00	$600.00	$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 NPI's reporting method(s)/period

Participation Summary

Method Reported	Reporting Period	Registry/EHR Name (If Applicable)	Incentive Eligible for Method Reported	Reporting Method/Period Selected for Incentive Payment[1]
Individual measure(s) reporting via claims	12 months	N/A	Yes	No
Individual measure(s) reporting via claims	6 months	N/A	Yes	No
Individual measure(s) reporting via EHR	12 months	Epic	Yes	Yes
Individual measure(s) reporting via registry	12 months	ICLOPS	Yes	No
Individual measure(s) reporting via registry	6 months	ICLOPS	Yes	No
Measures Groups - 30 beneficiaries via claims	12 months	N/A	Yes	No
Measures Groups - 30 beneficiaries via registry	12 months	ICLOPS	Yes	No
Measures Groups - 50% eligible instances via claims	12 months	N/A	Yes	No
Measures Groups - 50% eligible instances via claims	6 months	N/A	Yes	No
Measures Groups - 80% eligible instances via registry	12 months	Cedaron	Yes	No
Measures Groups - 80% eligible instances via registry	6 months	SVS	Yes	No

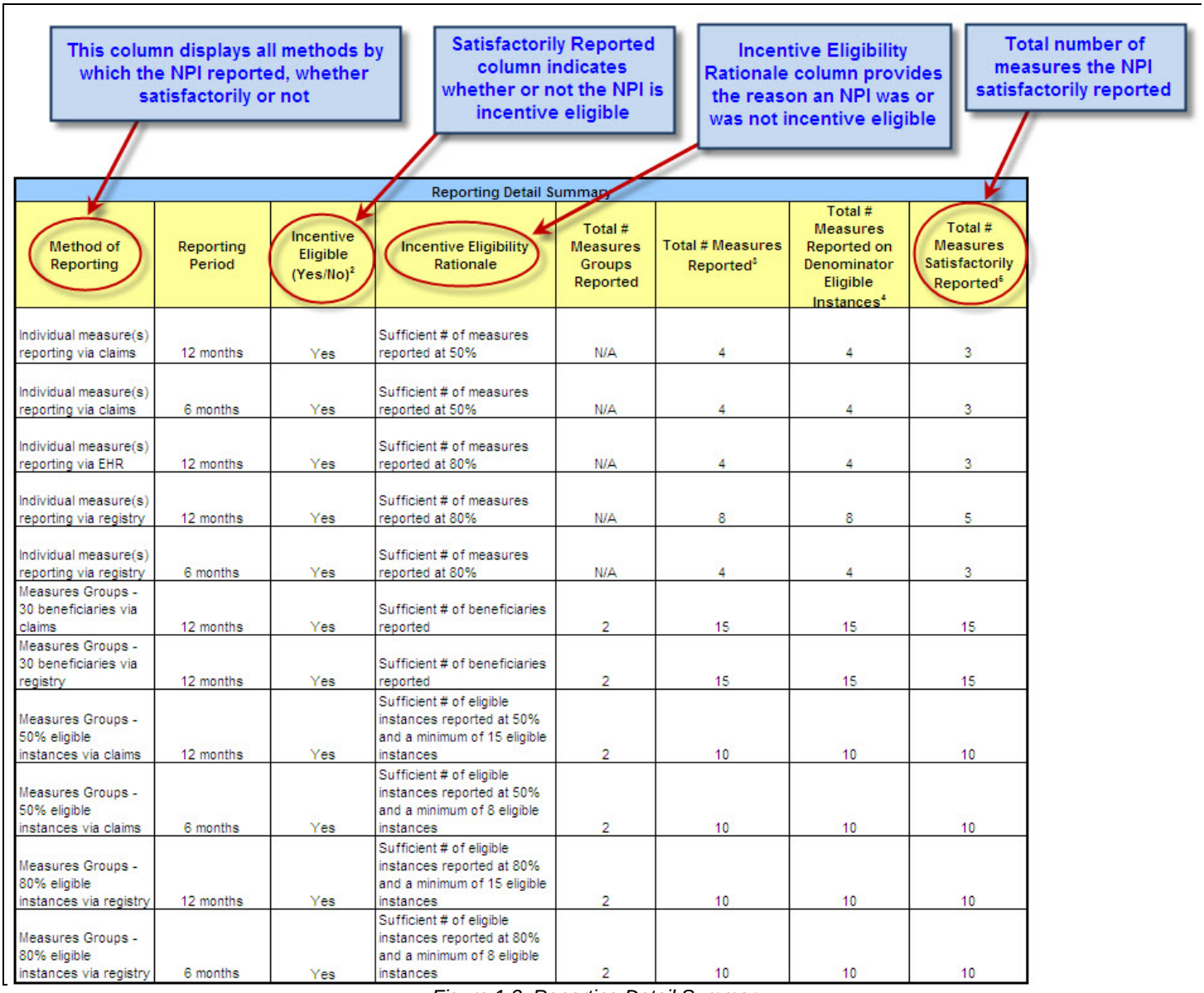
Maintenance of Certification Program Summary

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

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

Figure 1.2: NPI Reporting Detail: Incentive and Participation Summary

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

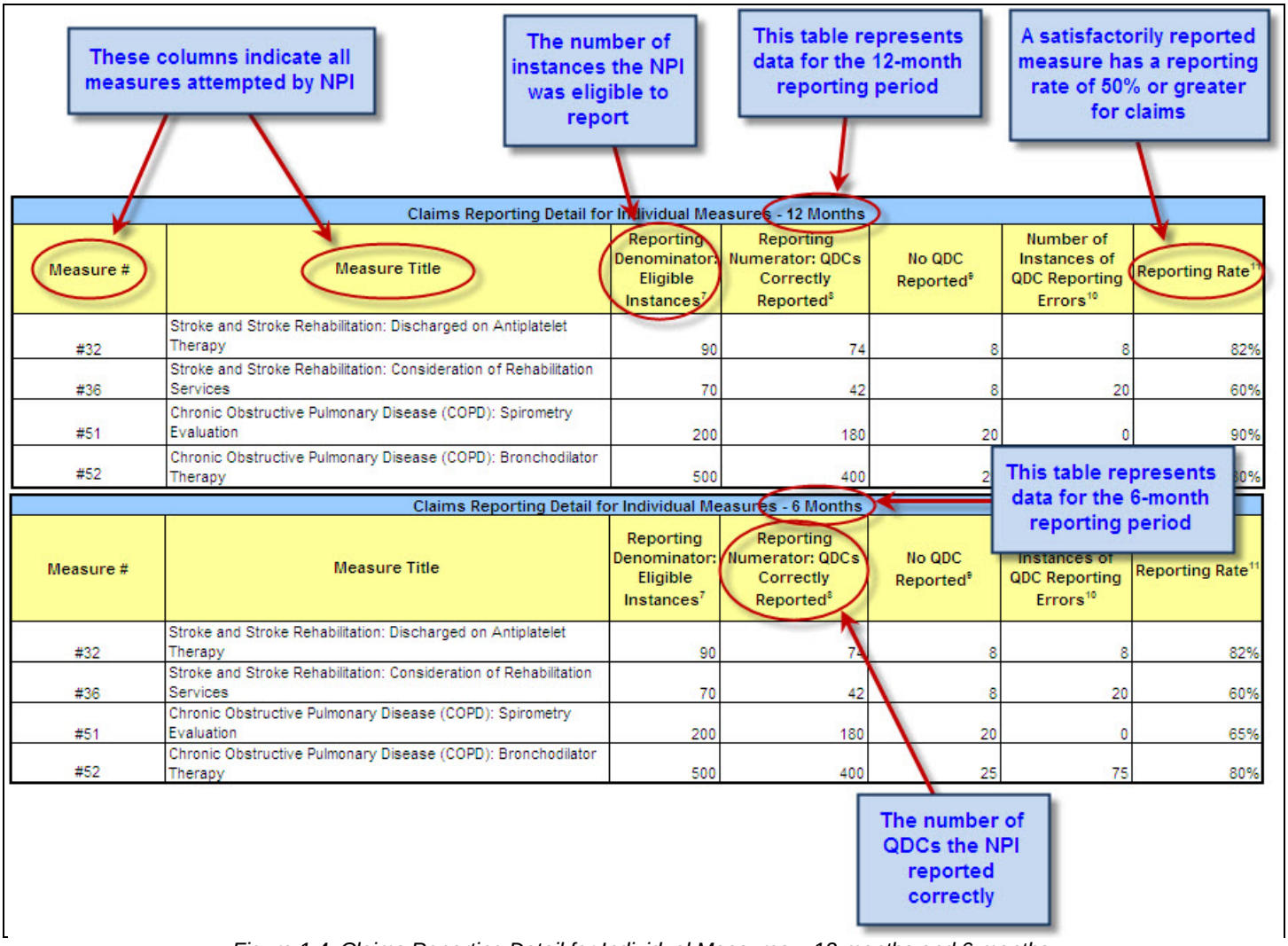


Reporting Detail Summary

Method of Reporting	Reporting Period	Incentive Eligible (Yes/No)[2]	Incentive Eligibility Rationale	Total # Measures Groups Reported	Total # Measures Reported[3]	Total # Measures Reported on Denominator Eligible Instances[4]	Total # Measures Satisfactorily Reported[5]
Individual measure(s) reporting via claims	12 months	Yes	Sufficient # of measures reported at 50%	N/A	4	4	3
Individual measure(s) reporting via claims	6 months	Yes	Sufficient # of measures reported at 50%	N/A	4	4	3
Individual measure(s) reporting via EHR	12 months	Yes	Sufficient # of measures reported at 80%	N/A	4	4	3
Individual measure(s) reporting via registry	12 months	Yes	Sufficient # of measures reported at 80%	N/A	8	8	5
Individual measure(s) reporting via registry	6 months	Yes	Sufficient # of measures reported at 80%	N/A	4	4	3
Measures Groups - 30 beneficiaries via claims	12 months	Yes	Sufficient # of beneficiaries reported	2	15	15	15
Measures Groups - 30 beneficiaries via registry	12 months	Yes	Sufficient # of beneficiaries reported	2	15	15	15
Measures Groups - 50% eligible instances via claims	12 months	Yes	Sufficient # of eligible instances reported at 50% and a minimum of 15 eligible instances	2	10	10	10
Measures Groups - 50% eligible instances via claims	6 months	Yes	Sufficient # of eligible instances reported at 50% and a minimum of 8 eligible instances	2	10	10	10
Measures Groups - 80% eligible instances via registry	12 months	Yes	Sufficient # of eligible instances reported at 80% and a minimum of 15 eligible instances	2	10	10	10
Measures Groups - 80% eligible instances via registry	6 months	Yes	Sufficient # of eligible instances reported at 80% and a minimum of 8 eligible instances	2	10	10	10

Figure 1.3: Reporting Detail Summary

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



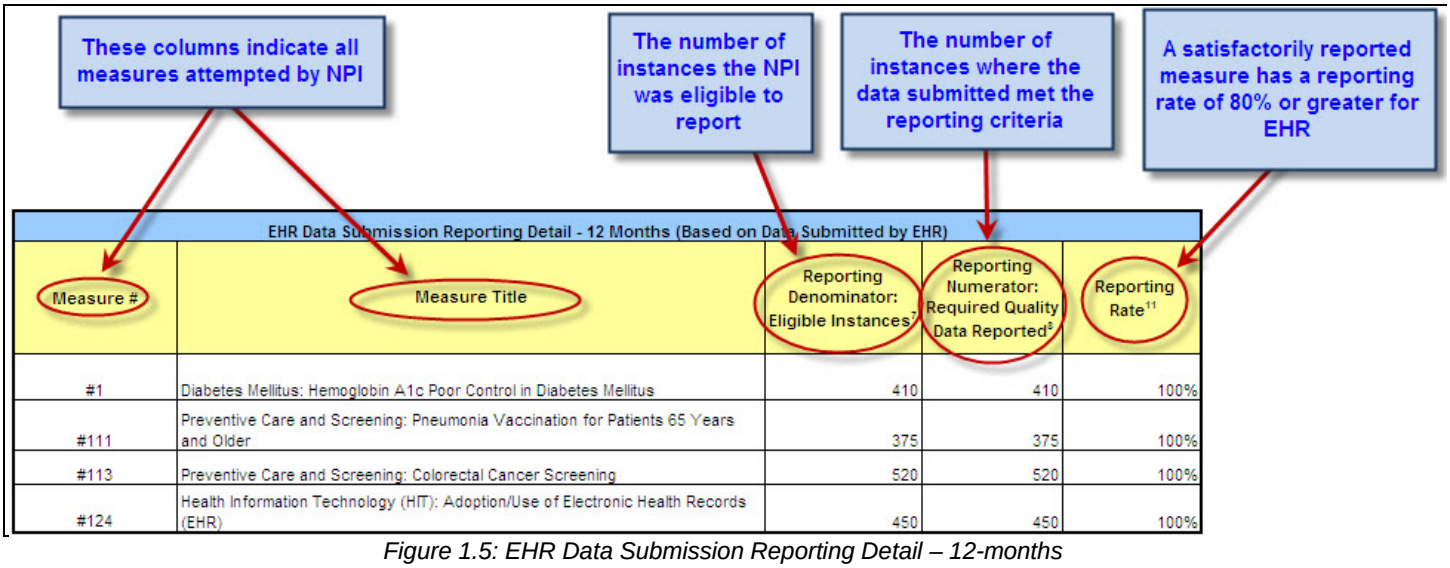
Claims Reporting Detail for Individual Measures - 12 Months

Measure #	Measure Title	Reporting Denominator: Eligible Instances[7]	Reporting Numerator: QDCs Correctly Reported[8]	No QDC Reported[9]	Number of Instances of QDC Reporting Errors[10]	Reporting Rate[11]
#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	2		0%

Claims Reporting Detail for Individual Measures - 6 Months

Measure #	Measure Title	Reporting Denominator: Eligible Instances[7]	Reporting Numerator: QDCs Correctly Reported[8]	No QDC Reported[9]	Instances of QDC Reporting Errors[10]	Reporting Rate[11]
#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	65%
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	500	400	25	75	80%

Figure 1.4: Claims Reporting Detail for Individual Measures – 12-months and 6-months

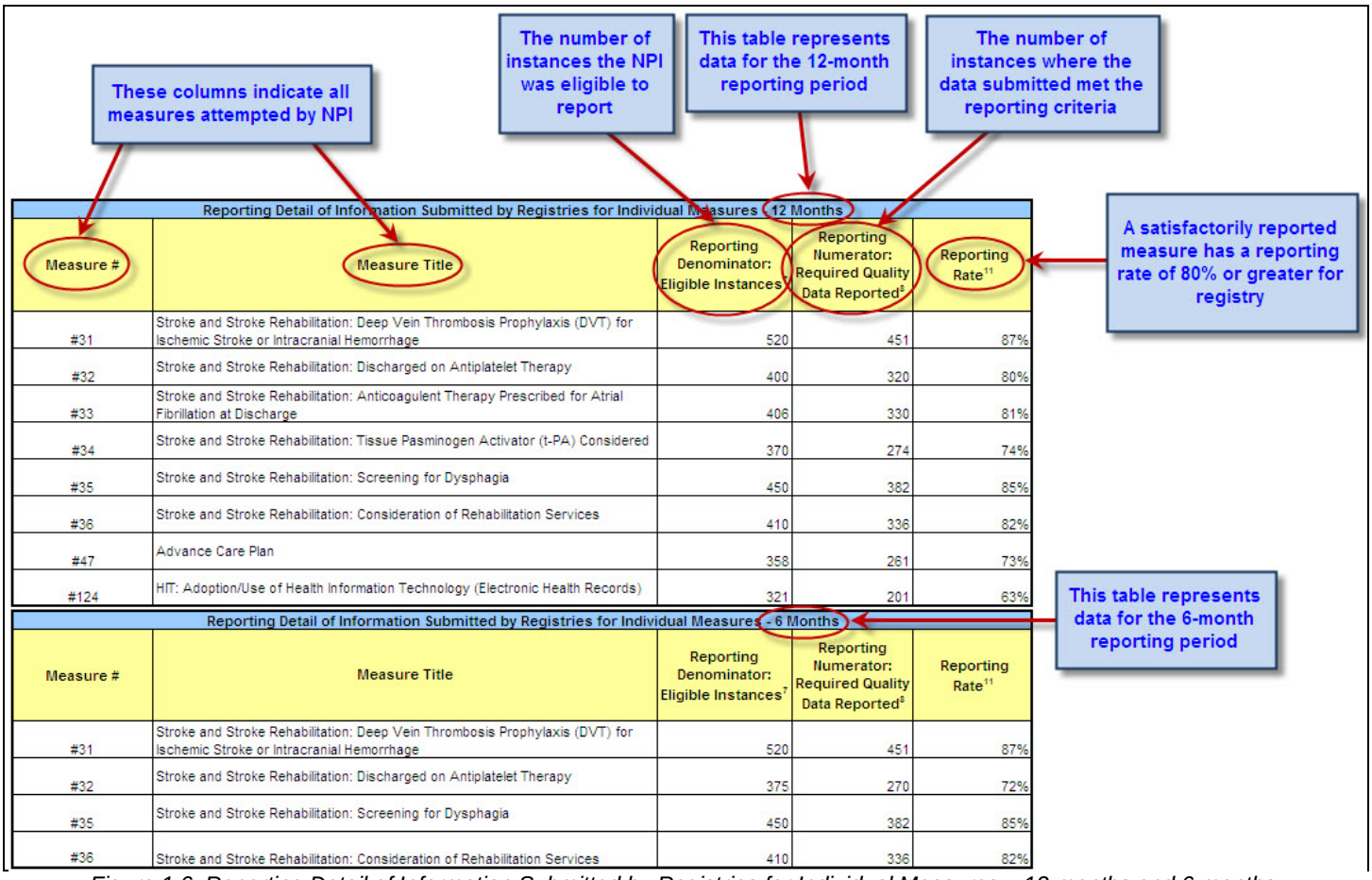


EHR Data Submission Reporting Detail - 12 Months (Based on Data Submitted by EHR)

Measure #	Measure Title	Reporting Denominator: Eligible Instances[7]	Reporting Numerator: Required Quality Data Reported[8]	Reporting Rate[11]
#1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	410	410	100%
#111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	375	375	100%
#113	Preventive Care and Screening: Colorectal Cancer Screening	520	520	100%
#124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	450	450	100%

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

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



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

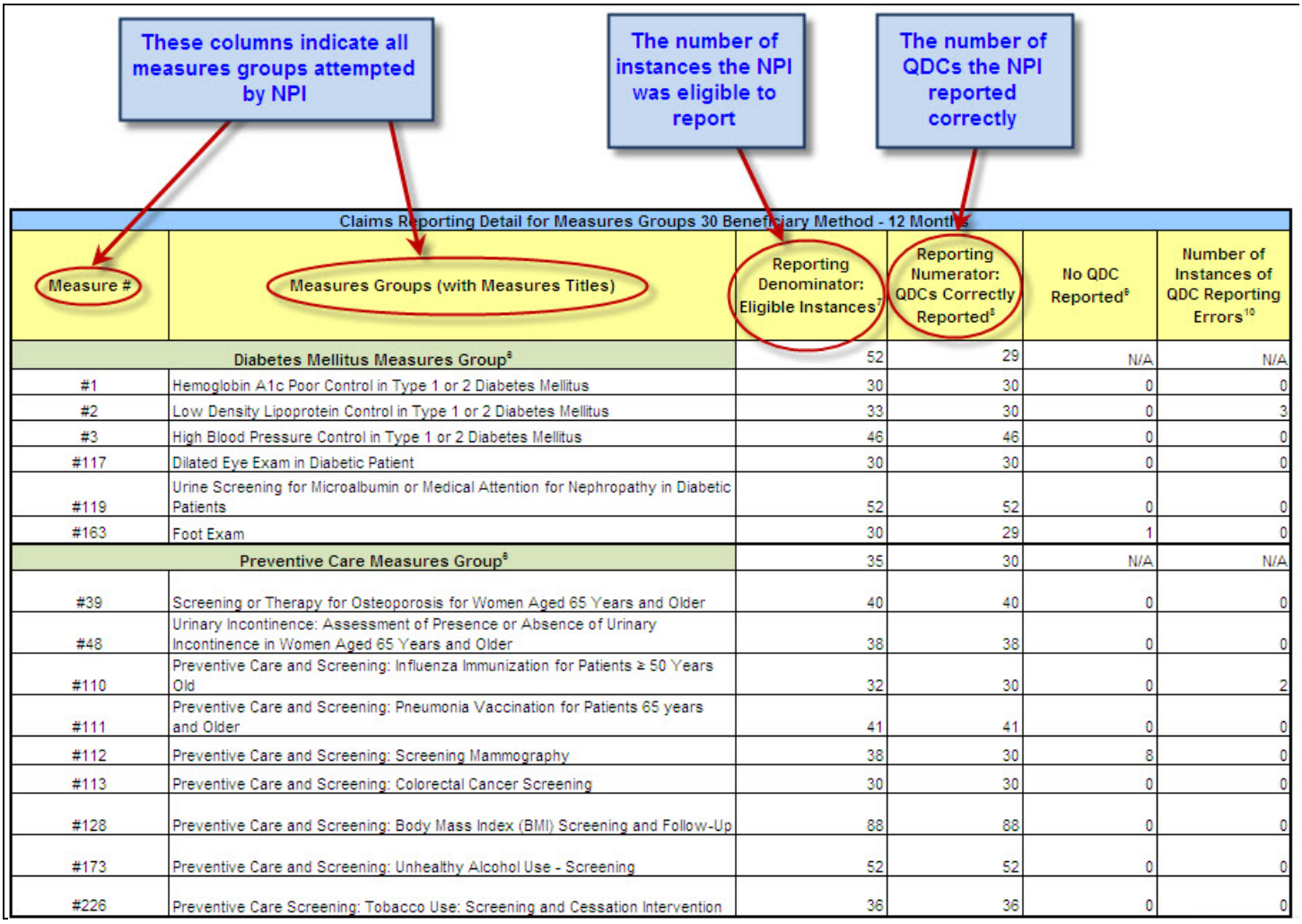
Measure #	Measure Title	Reporting Denominator: Eligible Instances[7]	Reporting Numerator: Required Quality Data Reported[8]	Reporting Rate[11]
#31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	520	451	87%
#32	Stroke and Stroke 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%

Reporting Detail of Information Submitted by Registries for Individual Measures - 6 Months

Measure #	Measure Title	Reporting Denominator: Eligible Instances[7]	Reporting Numerator: Required Quality Data Reported[8]	Reporting Rate[11]
#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	375	270	72%
#35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	450	382	85%
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	410	336	82%

Figure 1.6: Reporting Detail of Information Submitted by Registries for Individual Measures – 12-months and 6-months

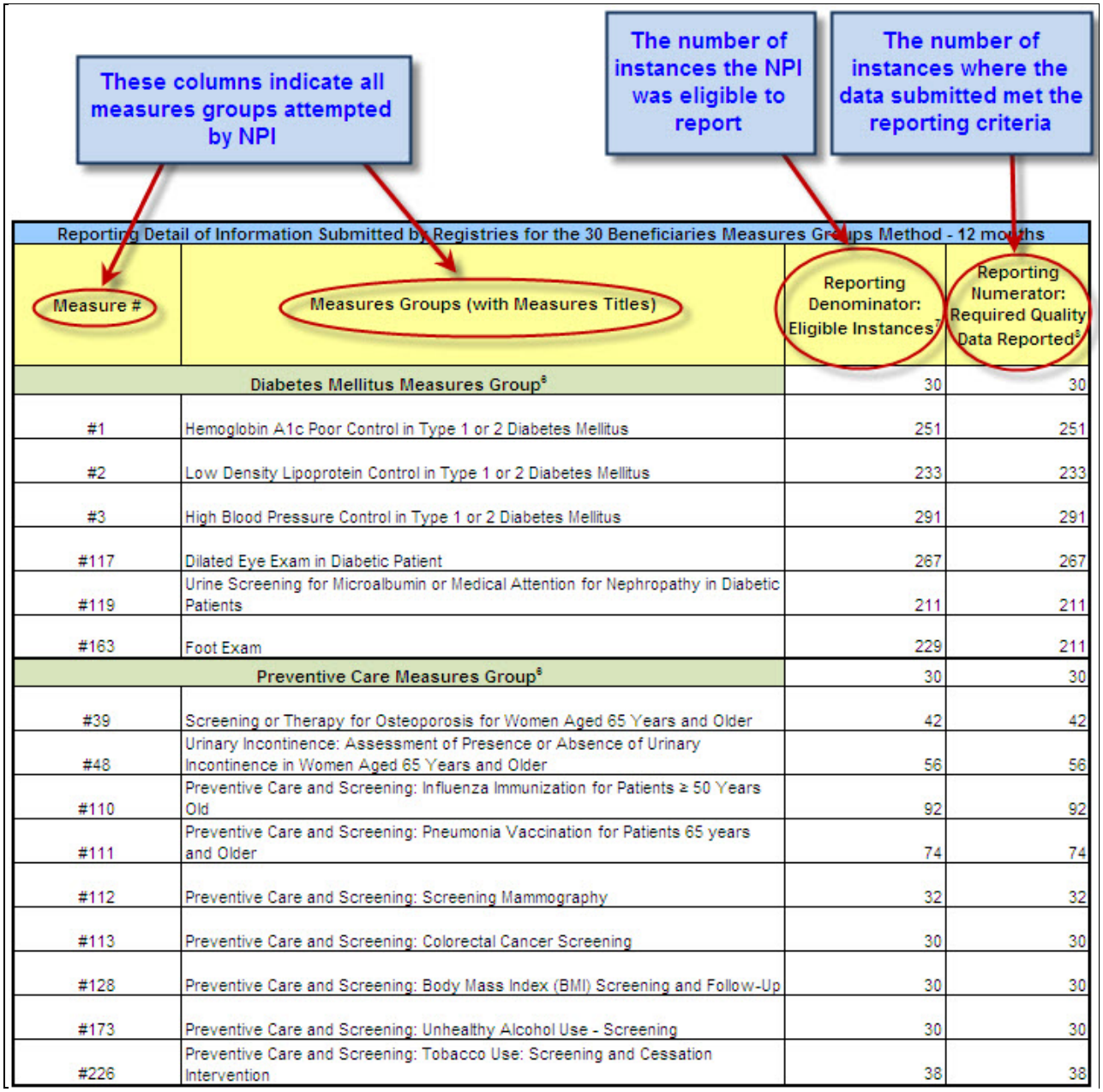
Example TIN-Level Feedback Report: Table 2 (continued)



Claims Reporting Detail for Measures Groups 30 Beneficiary Method - 12 Months					
Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[7]	Reporting Numerator: QDCs Correctly Reported[8]	No QDC Reported[9]	Number of Instances of QDC Reporting Errors[10]
Diabetes Mellitus Measures Group[6]		52	29	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[6]		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 1.7: Claims Reporting Detail for Measures Groups 30 Beneficiary Method – 12-months

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

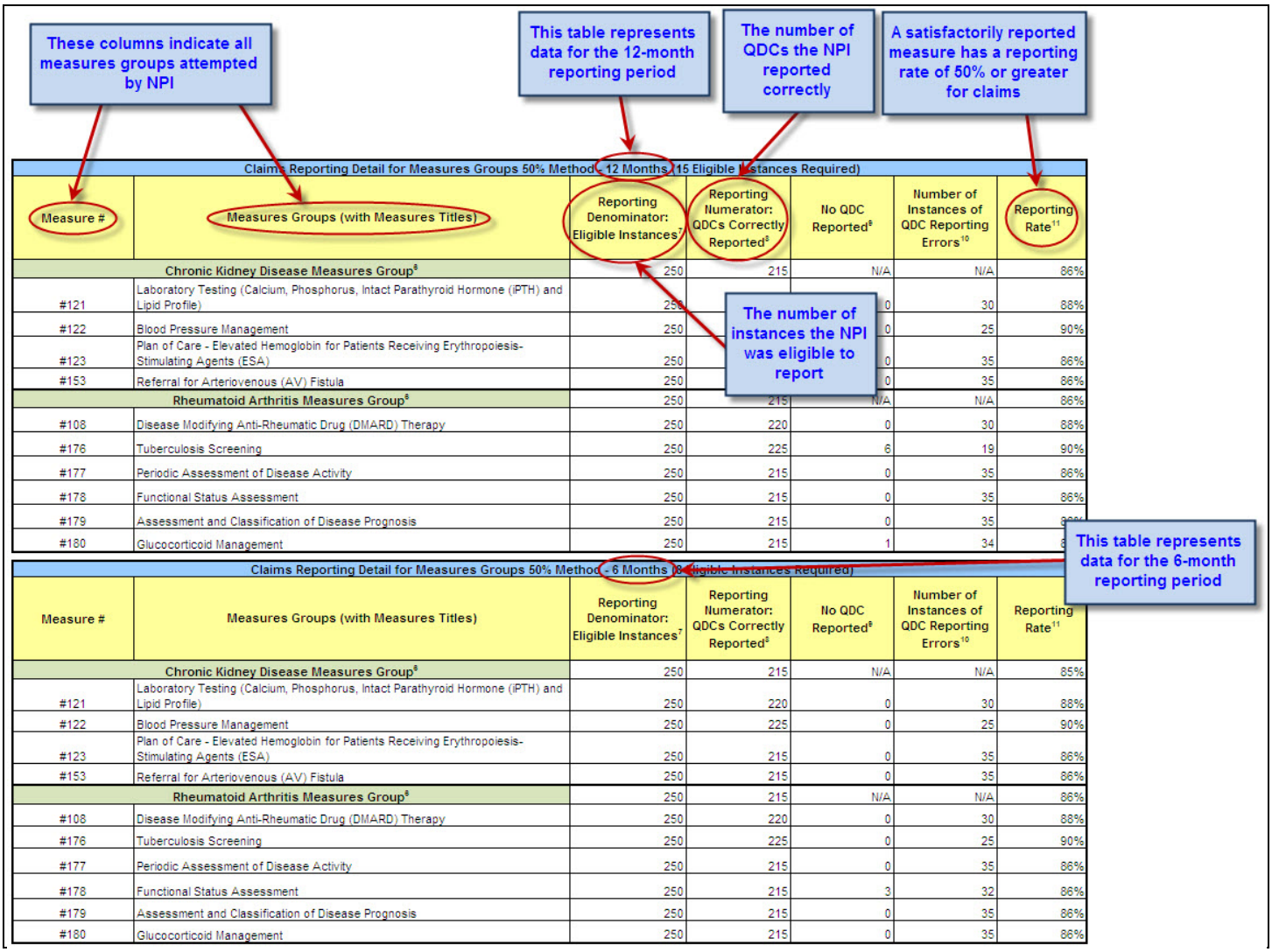


Reporting Detail of Information Submitted by Registries for the 30 Beneficiaries Measures Groups Method - 12 months

Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[7]	Reporting Numerator: Required Quality Data Reported[8]
	Diabetes Mellitus Measures Group[6]	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[6]	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 1.8: 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 Measures Groups 50% Method - 12 Months (15 Eligible Instances Required)

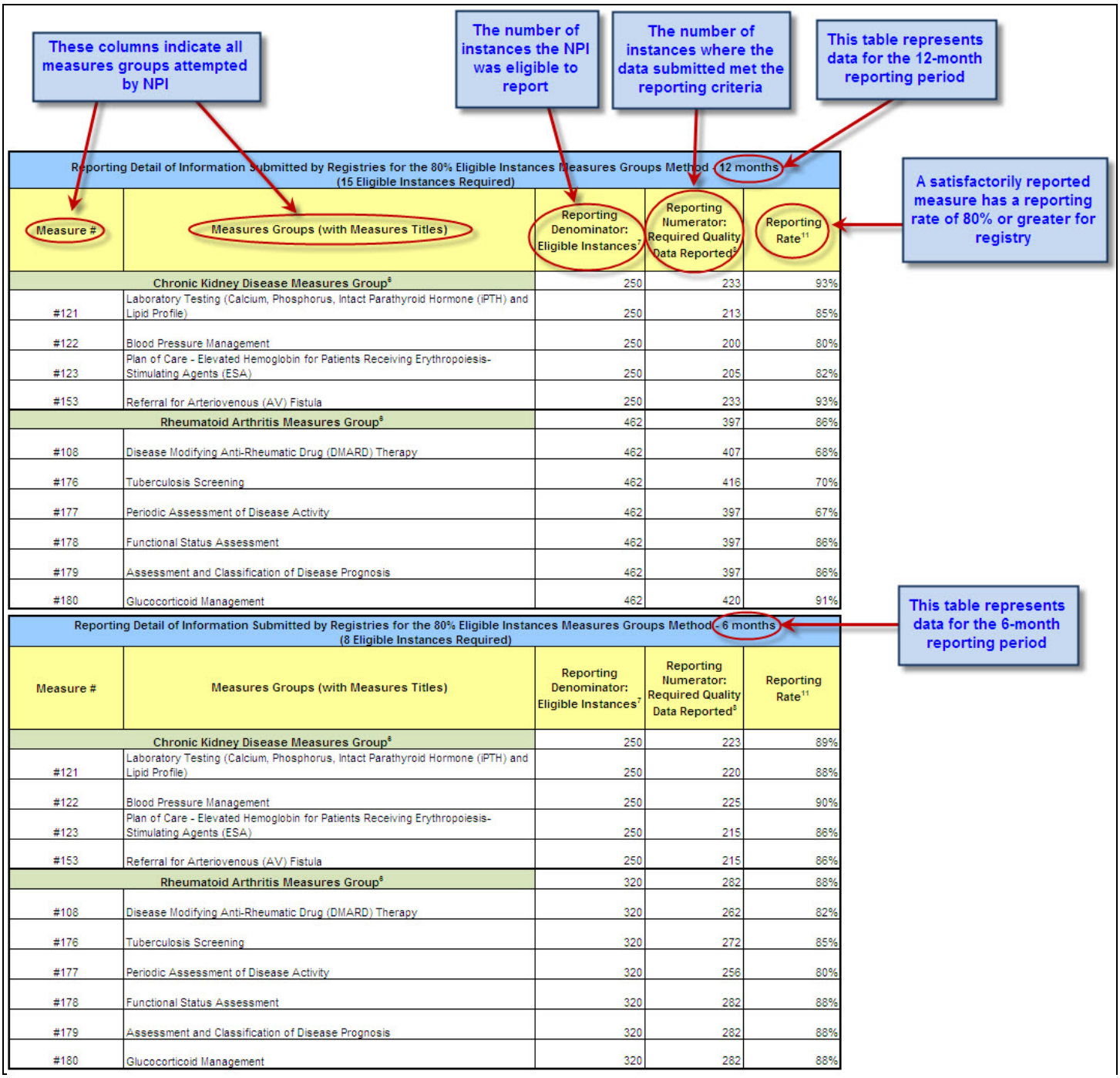
Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[7]	Reporting Numerator: QDCs Correctly Reported[8]	No QDC Reported[9]	Number of Instances of QDC Reporting Errors[10]	Reporting Rate[11]
	Chronic Kidney Disease Measures Group[6]	250	215	N/A	N/A	86%
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	250		0	30	88%
#122	Blood Pressure Management	250		0	25	90%
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	250		0	35	86%
#153	Referral for Arteriovenous (AV) Fistula	250		0	35	86%
	Rheumatoid Arthritis Measures Group[6]	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%

Claims Reporting Detail for Measures Groups 50% Method - 6 Months (8 Eligible Instances Required)

Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[7]	Reporting Numerator: QDCs Correctly Reported[8]	No QDC Reported[9]	Number of Instances of QDC Reporting Errors[10]	Reporting Rate[11]
	Chronic Kidney Disease Measures Group[6]	250	215	N/A	N/A	85%
#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[6]	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	0	25	90%
#177	Periodic Assessment of Disease Activity	250	215	0	35	86%
#178	Functional Status Assessment	250	215	3	32	86%
#179	Assessment and Classification of Disease Prognosis	250	215	0	35	86%
#180	Glucocorticoid Management	250	215	0	35	86%

Figure 1.9: Claims Reporting Detail for Measures Groups 50% Method – 12-months and 6-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[7]	Reporting Numerator: Required Quality Data Reported[5]	Reporting Rate[11]
	Chronic Kidney Disease Measures Group[8]	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[8]	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[7]	Reporting Numerator: Required Quality Data Reported[5]	Reporting Rate[11]
	Chronic Kidney Disease Measures Group[8]	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[8]	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 1.10: 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

(INDIVIDUAL NPI SUBMISSION ERROR REPORT - 12 MONTH REPORTING PERIOD)

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 one of the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2011 Physician Quality Reporting included five Medicare Part B claims-based reporting methods, five qualified registry-based reporting methods, and one qualified electronic health record (EHR) method. This includes two alternate reporting periods. Tax IDs reporting under one of the Group Practice Reporting Options (GPRO) for Physician Quality Reporting either submitted data using the GPRO web interface (for GPRO I) or submitted claims or registry data for the appropriate reporting requirements under GPRO II. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2011 to December 31, 2011 (for the twelve month reporting period) and for services furnished from July 1, 2011 to December 31, 2011 (for the six month reporting period) were reviewed to evaluate whether an eligible professional or group successfully reported for the Physician Quality Reporting System incentive. Participation by an eligible professional or GPRO 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 2011 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 submitting data via any of the reporting methods for the 12-month submission period. The individual NPIs 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/pqrs

This table represents data for the 12-month reporting period

The percentage of QDCs that were reported correctly

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

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

Table 3: NPI QDC Submission E
Sorted by Measure

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

Note: Counts reported u all mutually exclusive. If there is osis, it will only fall into the cell noted with fo fall into the other cells.

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 Gender[4]	Measure Reported on an Instance with an Incorrect Age[5]	Measure Reported on an Instance with an Incorrect CPT Code[6]	Measure Reported on an Instance with an Incorrect DX Code[7]	Measure Reported on an Instance with an Incorrect CPT Code and an Incorrect DX Code[8]	Measure Reported on an Instance with a Missing CPT Code[9]	Measure Reported on an Instance with a Missing CPT Code and an Incorrect DX Code[10]
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	99	74	74.7%	0	0	13	5	4	1	2
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	54	42	77.8%	0	0	5	2	0	5	0
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	210	180	85.7%	0	0	21	2	7	0	0
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	410	400	97.6%	0	0	3	7	0	0	0

Table 3: NPI QDC Submission Error Detail
Sorted by Measure

Tax ID Name*: John Q. Public Clinic
NPI Name*: John Beans
NPI Number: 1000000012
Method of Reporting: Individual measure(s) reporting via claims for 6 months

This table represents data for the 6-month reporting period

Note: Counts reported under columns with footnotes 6-10 are all mutually exclusive. If there is an incorrect CPT code and also an incorrect diagnosis, it will only fall into the cell noted with footnote 8 for that measure and will not fall into the other cells.

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 Gender[4]	Measure Reported on an Instance with an Incorrect Age[5]	Measure Reported on an Instance with an Incorrect CPT Code[6]	Measure Reported on an Instance with an Incorrect DX Code[7]	Measure Reported on an Instance with an Incorrect CPT Code and an Incorrect DX Code[8]	Measure Reported on an Instance with a Missing CPT Code[9]	Measure Reported on an Instance with a Missing CPT Code and an Incorrect DX Code[10]
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	99	74	74.7%	0	0	13	5	4	1	2
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	54	42	77.8%	0	0	5	2	0	5	0
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	210	180	85.7%	0	0	21	2	7	0	0
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	410	400	97.6%	0	0	3	7	0	0	0

Figure 1.11: NPI QDC Submission Error Detail – 12-months and 6-months

Example - TIN-Level Feedback Report: Table 4

2011 PHYSICIAN QUALITY REPORTING SYSTEM (PHYSICIAN QUALITY REPORTING) 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 one of the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2011 Physician Quality Reporting included five Medicare Part B claims-based reporting methods, five qualified registry-based reporting methods, and one qualified electronic health record (EHR) method. This includes two alternate reporting periods. Tax IDs reporting under one of the Group Practice Reporting Options (GPRO) for Physician Quality Reporting either submitted data using the GPRO web interface (for GPRO I) or submitted claims or registry data for the appropriate reporting requirements under GPRO II. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2011 to December 31, 2011 (for the twelve month reporting period) and for services furnished from July 1, 2011 to December 31, 2011 (for the six month reporting period) were reviewed to evaluate whether an eligible professional or group successfully reported for Physician Quality Reporting. Participation by an eligible professional or GPRO 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 2011 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 submitting data via any of the reporting methods for the 12-month submission period. The results below include a Performance Detail table listing all of the measures and measures groups reported by the individual NPI's with the performance rates. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/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
NPI Name*: John Doe
NPI Number: 1000000012

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

This table represents data for the 12-month reporting period

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

"NULL" means all of the measure's performance eligible instances were performance exclusions

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	NULL	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		

This table represents data for the 6-month reporting period

Claims Performance Information for Individual Measures - 6 Months

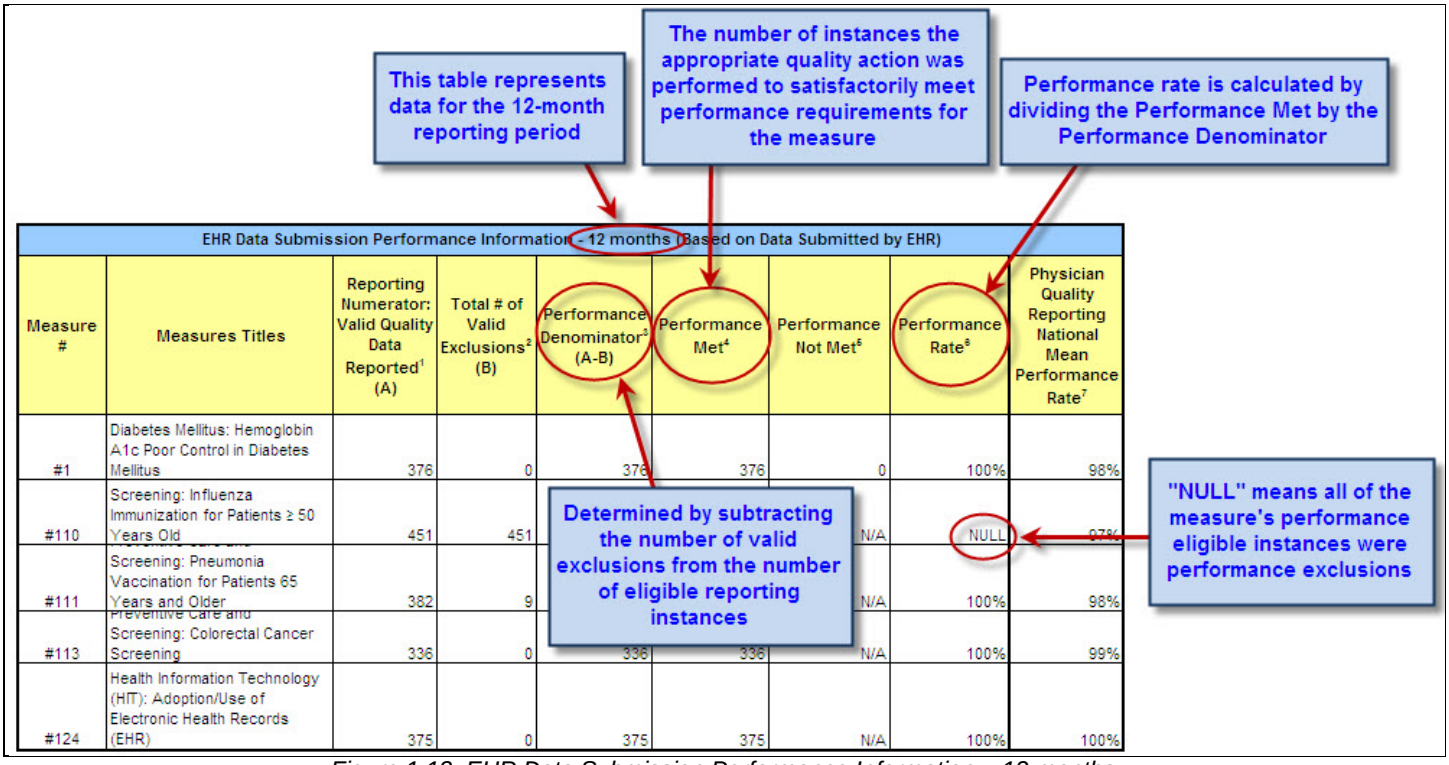
Measure #	Measure Title	Reporting Numerator: Valid QDCs Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]	Physician Quality Reporting National Mean Performance Rate[7]
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy			0			NULL	52%
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services			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%

The number of medical, patient, system, or other performance exclusions reported

Determined by subtracting the number of valid exclusions from the number of valid QDCs reported

Figure 1.12: Claims Performance Information for Individual Measures – 12-months and 6-months

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

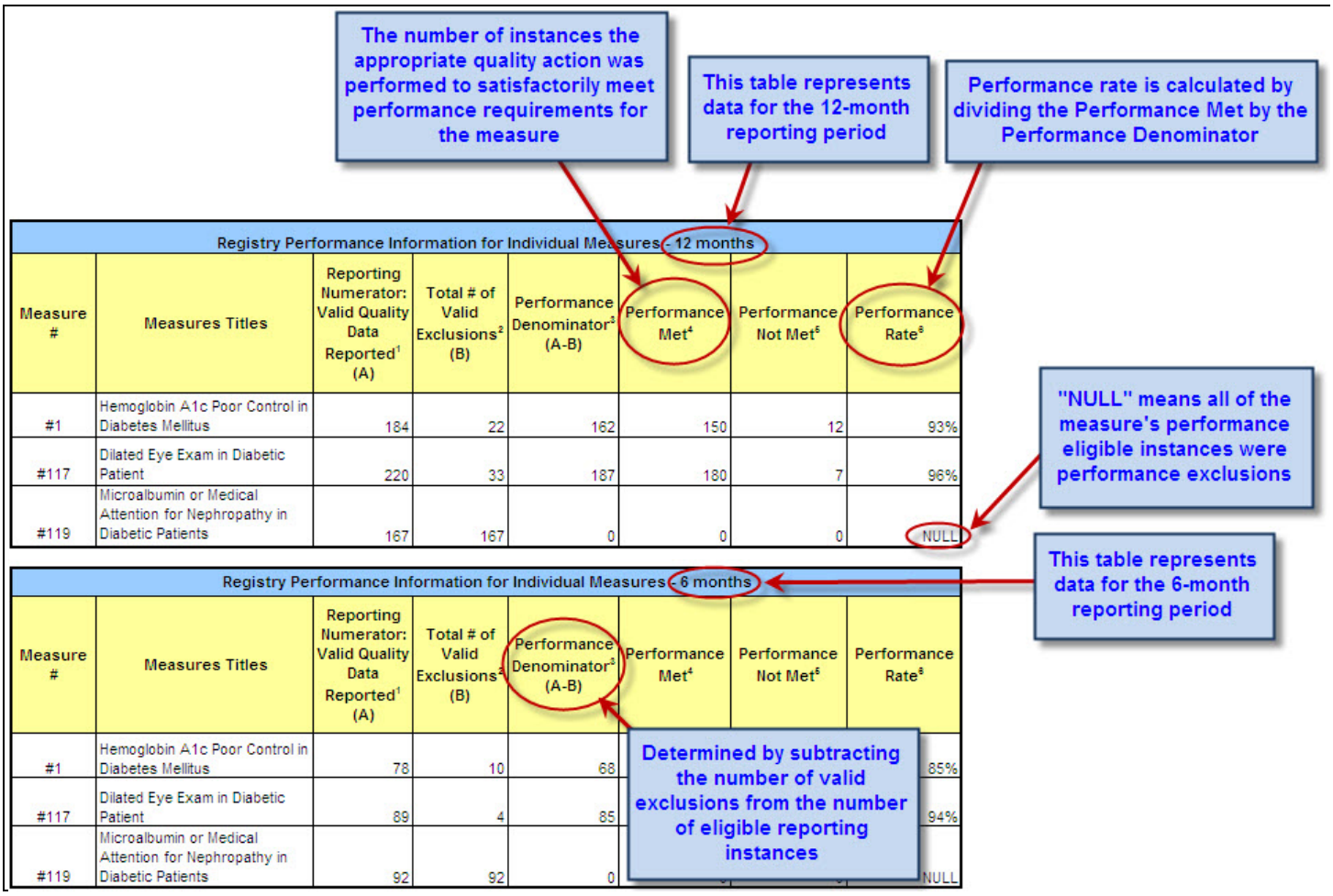


EHR Data Submission Performance Information - 12 months (Based on Data Submitted by EHR)

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]	Physician Quality Reporting National Mean Performance Rate[7]
#1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	376	0	376	376	0	100%	98%
#110	Screening: Influenza Immunization for Patients ≥ 50 Years Old	451	451			N/A	NULL	97%
#111	Screening: Pneumonia Vaccination for Patients 65 Years and Older	382	9			N/A	100%	98%
#113	Preventive Care and Screening: Colorectal Cancer Screening	336	0	336	336	N/A	100%	99%
#124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	375	0	375	375	N/A	100%	100%

Figure 1.13: EHR Data Submission Performance Information – 12-months

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



Registry Performance Information for Individual Measures - 12 months

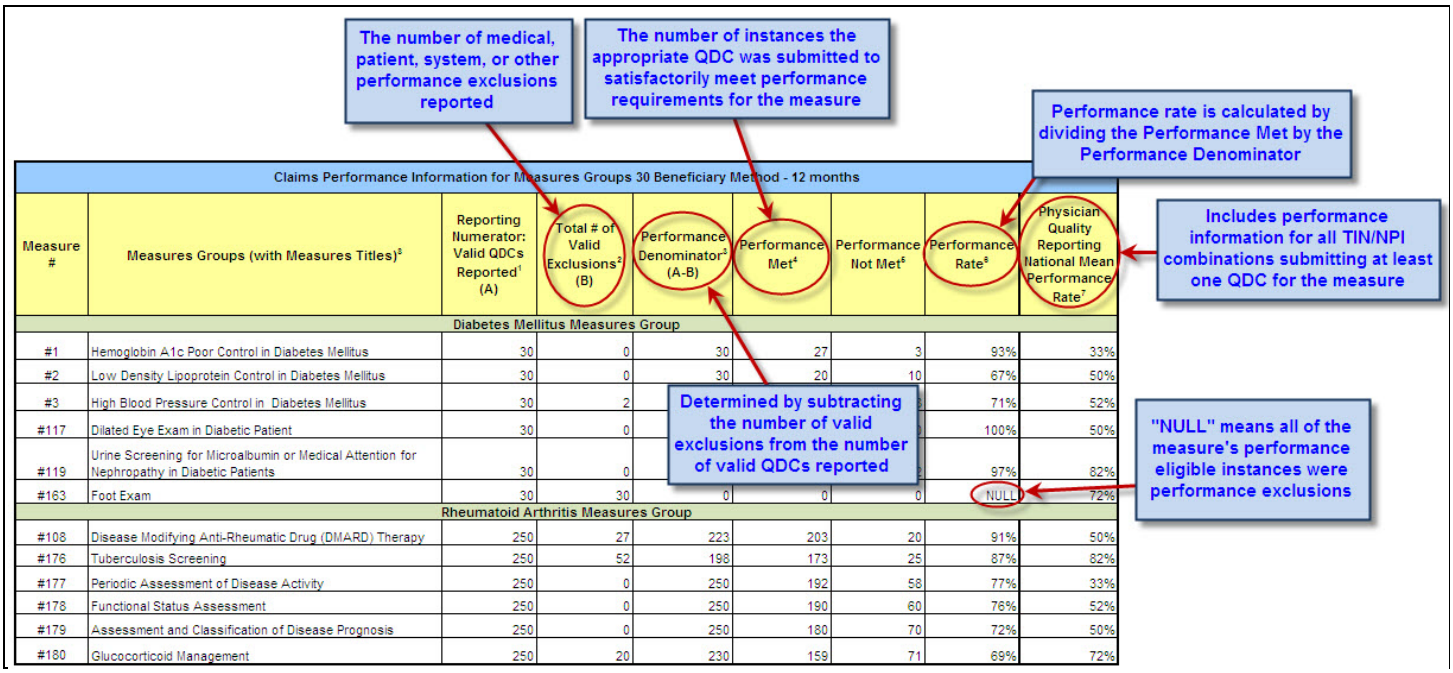
Measure #	Measures Titles	Reporting Numerator: Valid Quality Data Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]
#1	Hemoglobin A1c Poor Control in Diabetes Mellitus	184	22	162	150	12	93%
#117	Dilated Eye 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	NULL

Registry Performance Information for Individual Measures - 6 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	78	10	68			85%
#117	Dilated Eye Exam in Diabetic Patient	89	4	85			94%
#119	Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	92	92	0			NULL

Figure 1.14: Registry Performance Information for Individual Measures – 12-months and 6-months

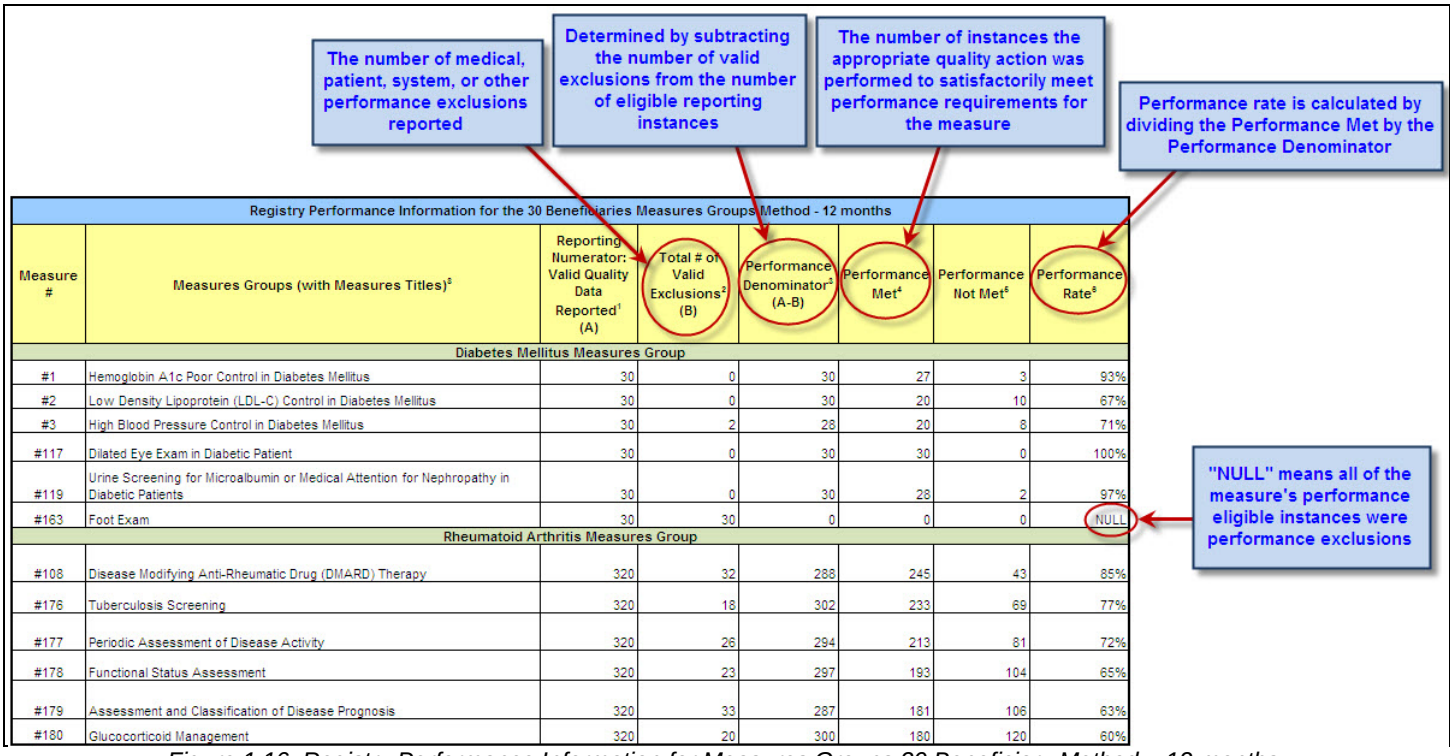
Example TIN-Level Feedback Report: Table 4 (continued)



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

Measure #	Measures Groups (with Measures Titles)[3]	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				71%	52%
#117	Dilated Eye Exam in Diabetic Patient	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	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 1.15: Claims Performance Information for Measures Groups 30 Beneficiary Method – 12-months

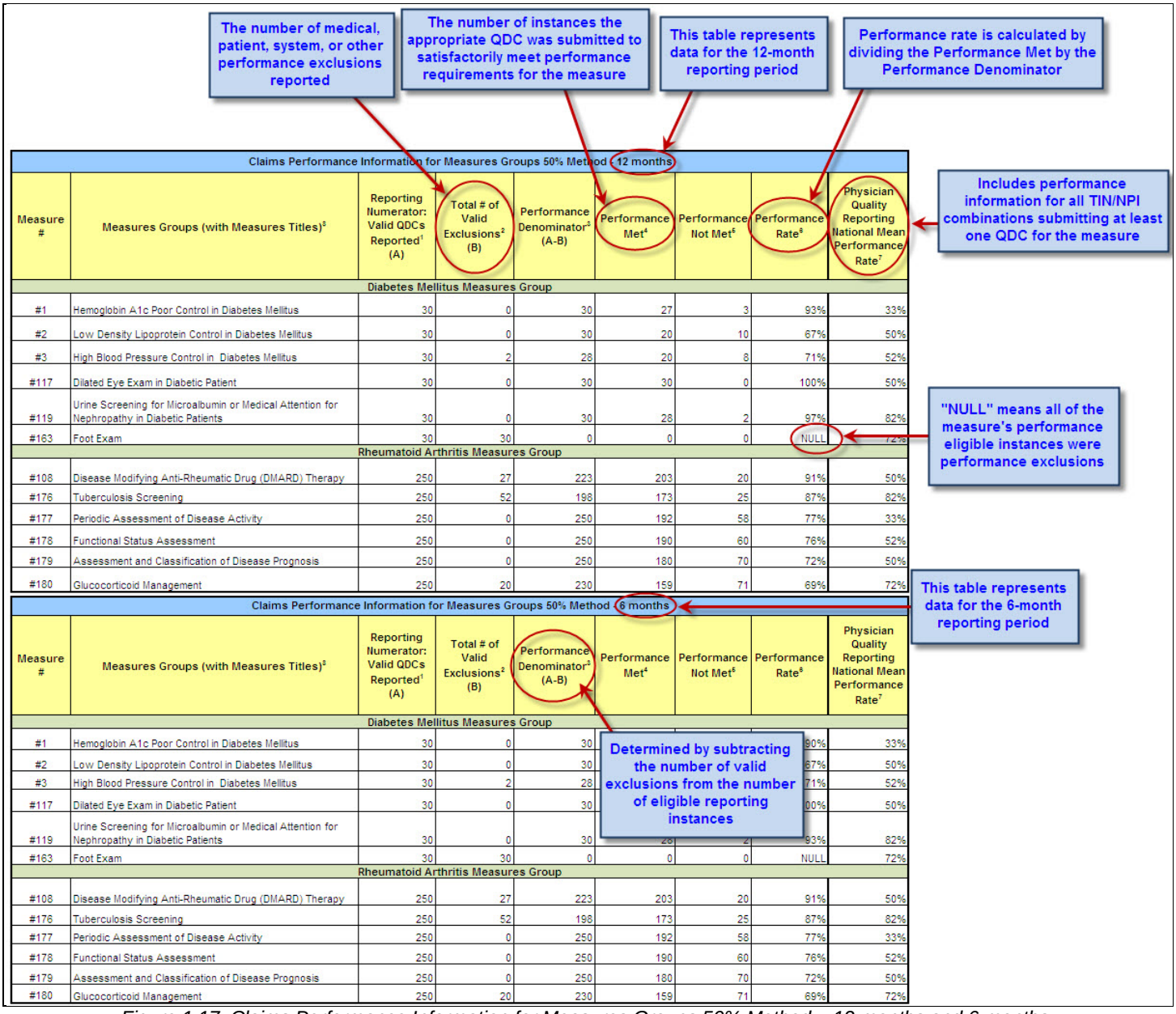


Registry Performance Information for the 30 Beneficiaries Measures Groups Method - 12 months

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

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



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

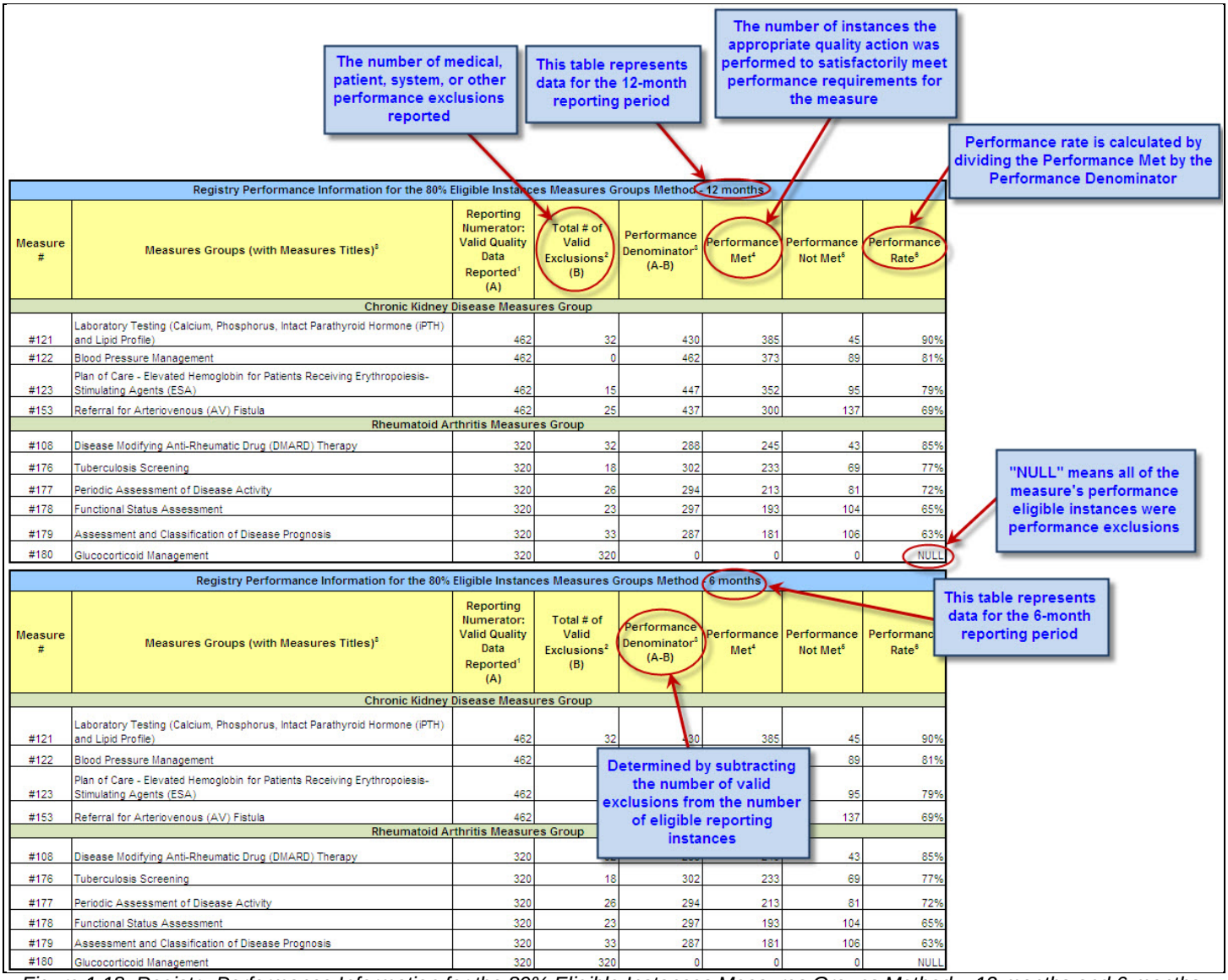
Measure #	Measures Groups (with Measures Titles)[5]	Reporting Numerator: Valid QDCs Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]	Physician Quality Reporting National Mean Performance Rate[7]
Diabetes 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%

Claims Performance Information for Measures Groups 50% Method - 6 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			90%	33%
#2	Low Density Lipoprotein Control in Diabetes Mellitus	30	0	30			67%	50%
#3	High Blood Pressure Control in Diabetes Mellitus	30	2	28			71%	52%
#117	Dilated Eye Exam in Diabetic Patient	30	0	30			00%	50%
#119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	30	0	30			93%	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 1.17: Claims Performance Information for Measures Groups 50% Method – 12-months and 6-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)[3]	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	NULL

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

Measure #	Measures Groups (with Measures Titles)[3]	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]	Performanc 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				89	81%
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	462				95	79%
#153	Referral for Arteriovenous (AV) Fistula	462				137	69%
Rheumatoid Arthritis Measures Group							
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	320				43	85%
#176	Tuberculosis Screening	320	18	302	233	69	77%
#177	Periodic Assessment of Disease Activity	320	26	294	213	81	72%
#178	Functional Status Assessment	320	23	297	193	104	65%
#179	Assessment and Classification of Disease Prognosis	320	33	287	181	106	63%
#180	Glucocorticoid Management	320	320	0	0	0	NULL

Figure 1.18: Registry Performance Information for the 80% Eligible Instances Measures Groups Method – 12-months and 6-months

GPRO I TIN-Level Feedback Report

Each CMS-selected GPRO I TIN who submitted via the Web Interface for Medicare Part B Physician Fee Schedule (PFS) covered professional services will receive Tables 1 and 4. No NPI data is included in the GPRO I feedback report.

A feedback report for a GPRO I TIN-level report will include the following tables:

- ***Table 1: Earned Incentive Summary for TIN – GPRO I***
  Figure 2.1: Earned Incentive Summary for TIN

  Key Terms:
  - **Total Tax ID 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 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 the eligible professionals within the Tax ID meeting the requirements for the Maintenance of Certification Program Incentive.
  - **Disease Module/Preventive Care Measures:** The 2011 GPRO I PQRS disease module or preventive care measures titles.
  - I**ncentive Eligibility Rationale:** The rationale for those TIN/NPIs or TINs who were or were not eligible to receive an incentive.

- ***Table 4: Performance Detail for TIN – GPRO I***
  Figure 2.2: Performance Detail for TIN

  Key Terms:
  - **Performance Met:** The number of Patients/Visits that met the measure's performance criteria.
  - **Performance Not Met:** The number of Patients/Visits that did not meet the performance requirements for the measure.
  - **Performance Rate:** The Performance Rate is calculated by dividing the Performance Met by the Performance Denominator.

  NOTE: Performance information is provided for GPRO participants or eligible professional's use to assess and improve their clinical performance. Performance rates do not affect 2011 PQRS incentive payment eligibility or amount at the individual eligible professional or practice level.

For definition of terms related to the *2011 Physician Quality Reporting System Feedback Report*, see Appendix A. Also refer to the footnotes within each table for additional content detail.

Example - GPRO I TIN-Level Feedback Report: Table 1

2011 PHYSICIAN QUALITY REPORTING SYSTEM (PHYSICIAN QUALITY REPORTING) FEEDBACK REPORT

(GPRO I 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 one of the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2011 Physician Quality Reporting included five Medicare Part B claims-based reporting methods, five qualified registry-based reporting methods, and one qualified electronic health record (EHR) method. This includes two alternate reporting periods. Tax IDs reporting under one of the Group Practice Reporting Options (GPRO) for the Physician Quality Reporting either submitted data using the GPRO web interface (for GPRO I) or submitted claims or registry data for the appropriate reporting requirements under GPRO II. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2011 to December 31, 2011 (for the twelve month reporting period) and for services furnished from July 1, 2011 to December 31, 2011 (for the six month 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 GPRO 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 2011 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 submitting data via any of the reporting methods for the 12-month submission period. The GPRO I results reported and amount earned for the Tax ID are summarized below. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/pqrs.

Table 1: Earned Incentive Summary for [redacted] **ax ID) - GPRO I**
Sorted by DM/PCM

Tax ID Name*: Jane Q. Public Clinic
Tax ID Number: XXXXX5678

Total incentive amount earned for the CMS-selected GPRO I (TIN)

Total incentive amount earned for the CMS-selected GPRO I under each Carrier and A/B MAC (includes Maintenance of Certification Program Incentive)

Total Tax ID Earned Incentive Amount[1]:	Total Estimated Allowed Medicare Part B PFS Charges[2]:	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
$38,654.82	$3,865,482.20	12345	$27,032.13
		67890	$11,622.69

Satisfactorily Reported and Incentive Eligibility Rationale columns indicate whether or not a disease module/preventive care measure was satisfactorily reported. In this example, the CMS-selected GPRO I met all of the reporting requirements for consecutively completed cases.

To be considered incentive eligible, the GPRO I must satisfactorily report each disease module/preventive

Disease Module/Preventive Care Measure (DM/PCM)	Satisfactorily Reported (Yes/No)[3]	Incentive Eligibility Rationale
Coronary Artery Disease	Yes	Met reporting requirements for consecutively completed cases
Diabetes Mellitus	Yes	Met reporting requirements for consecutively completed cases
Heart Failure	Yes	Met reporting requirements for consecutively completed cases
Hypertension	Yes	Met reporting requirements for consecutively completed cases
Preventive Care and Screening: Colorectal Cancer Screening	Yes	Met reporting requirements for consecutively completed cases
Preventive Care and Screening: Influenza Immunization for Patients ≥ 50	Yes	Met reporting requirements for consecutively completed cases
Preventive Care and Screening: Pneumonia Vaccination for Patients 65	No	Did not meet reporting requirements for consecutively completed cases
Preventive Care and Screening: Screening Mammography	No	Did not meet reporting requirements for consecutively completed cases

*Name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local A/B MAC and Carrier 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 2011 Physician Quality Reporting incentive payment, only the system's ability to populate this field in the report.

Explanation of Columns

[1]The amount of th[redacted]timated 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[redacted]an incentive. If applicable, the total incentive amount will include an additional incentive based upon eligible professionals within the Tax ID meeting the requir[redacted]tification Program.

Columns are explained with footnotes

[2]The total estimate[redacted]charges associated with services rendered during the reporting period.

[3]The percentage o[redacted] by the Tax ID, split across A/B MACs and Carriers based on the proportionate split of the Tax ID's total estimated allowed Medicare Part B Physician Fee Schedule (PFS) charges billed across the A/B MACs and Carriers. (100% of incentive will be distributed by a single A/B MAC and Carrier if a single A/B MAC and Carrier processed all claims within the reporting period for the Tax ID).

[4]A Tax ID satisfactorily reporting on all selected beneficiaries for each disease module and preventive measure and passing the applicable validation process is eligible to receive a Physician Quality Reporting incentive. More information regarding the incentive calculations is available on the CMS website.

Note: Physician Quality Reporting incentive payments are subject to offsets. Payments are made to the first NPI associated with the Tax ID. If the first NPI associated with the Tax ID has an offset, A/B MACs and Carriers will apply the lump sum and/or sanction.

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

Figure 2.1: Earned Incentive Summary for TIN – GPRO I

Example - GPRO I TIN-Level Feedback Report: Table 4

2011 PHYSICIAN QUALITY REPORTING SYSTEM (PHYSICIAN QUALITY REPORTING) FEEDBACK REPORT

(GPRO I 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 one of the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2011 Physician Quality Reporting included five Medicare Part B claims-based reporting methods, five qualified registry-based reporting methods, and one qualified electronic health record (EHR) method. This includes two alternate reporting periods. Tax IDs reporting under one of the Group Practice Reporting Options (GPRO) for Physician Quality Reporting either submitted data using the GPRO web interface (for GPRO I) or submitted claims or registry data for the appropriate reporting requirements under GPRO II. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2011 to December 31, 2011 (for the twelve month reporting period) and for services furnished from July 1, 2011 to December 31, 2011 (for the six month reporting period) were reviewed to evaluate whether an eligible professional or group successfully reported for Physician Quality Reporting. Participation by an eligible professional or GPRO 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 2011 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 submitting data via any of the reporting methods for the 12-month submission period. The results below include a Performance Detail table listing all of the measures reported by the GPRO I (Ta formation regarding Physician Quality Reporting is available on the CMS

Table 4: Performance Detail for Taxpayer Identification Number (Tax ID
Sorted by Measure #

Tax ID Name*: John Q. Jr. Public Clinic
Tax ID Number: XXXXX1234

Determined by subtracting the number of denominator exclusions from the number of patients/visits

The number of patients/visits that met the performance requirements for the measure

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

Performance Information							
Measure #	Measures Title	Total Patients/Visits[1] (A)	Performance Denominator Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[5]	Performance Not Met[4]	Performance Rate[5]
CAD-1	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	400	100	300	300	0	100%
CAD-2	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	400	100	300	100	200	33%
CAD-3	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	300	200	100	0	100	100%
CAD-7	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction	300	0	300	100	200	33%
DM-1	Diabetes Mellitus: Hemoglobin A1c Testing	400	0	400	400	0	100%
DM-2	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	400	0	400	200	200	50%
DM-3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	400	0	400	200	200	50%
DM-5	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	400	0	400	100	300	25%
DM-6	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	400	0	400	400	0	100%
DM-7	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	400	0	400	400	0	100%
DM-8	Diabetes Mellitus: Foot Exam	400	100	300	300	0	100%
DM-9	Diabetes Mellitus: Lipid Profile	400	0	400	300	100	75%
HF-1	Heart Failure: Left Ventricular Function (LVF) Assessment	600	0	600	300	300	50%
HF-2	Heart Failure: Left Ventricular Function (LVF) Testing	600	100	500	300	200	60%
HF-3	Heart Failure: Weight Measurement	360	0	360	320	40	89%
HF-5	Heart Failure: Patient Education	600	0	600	300	300	50%
HF-6	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	400	200	200	100	100	50%
HF-7	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	400	0	400	200	200	50%
HF-8	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation	500	0	500	300	200	60%
HTN-1	Hypertension (HTN): Blood Pressure Measurement	390	0	390	80	310	21%
HTN-2	Hypertension (HTN): Blood Pressure Control	70	0	70	10	60	14%
HTN-3	Hypertension (HTN): Plan of Care	50	0	50	30	20	60%
PREV-5	Preventive Care and Screening: Screening Mammography	70	0	70	60	10	86%
PREV-6	Preventive Care and Screening: Colorectal Cancer Screening	50	0	50	30	20	60%
PREV-7	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50	70	0	70	70	0	100%
PREV-8	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	30	0	30	30	0	100%

For DM-2, a lower performance rate indicates better control

Figure 2.2: Performance Detail for TIN – GPRO I

GPRO II TIN-Level Feedback Report

Each group practice (TIN) who self-nominated and was selected to participate in 2011 GPRO II will receive Tables 1, 2, and 4. No NPI data is included in the GPRO II feedback report.

A feedback report for a CMS-selected GPRO I TIN-level report will include the following tables:

- ***Table 1: Earned Incentive Summary for the TIN – GPRO II***
  Figure 3.1: Earned Incentive Summary for the TIN – GPRO II (Pass)
  Figure 3.2: Earned Incentive Summary for the TIN – GPRO II (Fail)

  Key Terms:
  - **Total Tax ID 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 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 the eligible professionals within the Tax ID meeting the requirements for the Maintenance of Certification Program Incentive.
  - **GPRO II Group Size Tier:** The tier size of a GPRO II as determined by CMS after self-nomination. 2011 GPRO II reporting requirements were based upon a group's size.

- ***Table 2: Reporting Detail for the TIN – (GPRO II)***
  Figure 3.3: GPRO II Claims Incentive Detail
  Figure 3.4: GPRO II Claims Reporting Detail for Measures Groups Method
  Figure 3.5: GPRO II Claims Reporting Detail for Individual Measures Method
  Figure 3.6: GPRO II Registry Incentive Detail
  Figure 3.7: GPRO II Registry Reporting Detail for Measures Groups Method
  Figure 3.8: GPRO II Registry Reporting Detail for Individual Measures Method

  Key Terms:
  - **Reporting Denominator-Eligible Instances:** The # of reporting instances meeting the common denominator inclusion criteria for the measures group or the number of instances the Tax ID was eligible to report on a specific individual measure.
  - **Reporting Rate:** A satisfactorily reported measure has a reporting rate of 50% for claims and 80% for registry.

- ***Table 4: Performance Detail for the TIN – (GPRO II)***
  Figure 3.9: Performance Detail for Measures Groups – Claims
  Figure 3.10: Performance Detail for Individual Measures – Claims
  Figure 3.11: Performance Detail for Measures Groups – Registry
  Figure 3.12: Performance Detail for Individual Measures – Registry

  Key Terms:
  - **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 otherwise specified.
  - **Performance Rate:** The Performance Rate includes performance information for all TIN/NPI combinations submitting at least one QDC for the measure.
  - **National Mean Performance Rate:** The national mean performance rate includes performance information for all TIN/NPI combinations submitting at least one QDC for the measure.

  NOTE: Performance information is provided for GPRO participants or eligible professional's use to assess and improve their clinical performance. Performance rates do not affect 2011 PQRS incentive payment eligibility or amount at the individual eligible professional or practice level.

For definition of terms related to the *2011 Physician Quality Reporting System Feedback Report*, see Appendix A. Also refer to the footnotes within each table for additional content detail.

Example - GPRO II TIN-Level Feedback Report: Table 1 (Pass)

(GPRO II 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 one of the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2011 Physician Reporting included five Medicare Part B claims-based reporting methods, five qualified registry-based reporting methods, and one qualified electronic health record (EHR) method. This includes two alternate reporting periods. Tax IDs reporting under one of the Group Practice Reporting Options (GPRO) for Physician Quality Reporting either submitted data using the GPRO web interface (for GPRO I) or submitted claims or registry data for the appropriate reporting requirements under GPRO II. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2011 to December 31, 2011 (for the twelve month reporting period) and for services furnished from July 1, 2011 to December 31, 2011 (for the six month 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 GPRO 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 2011 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 submitting data via any of the reporting methods for the 12-month submission period. The GPRO II methods reported and amounts earned for each Tax ID are summarized below. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/pqrs.

Table 1: Earned Incentive Summary for Taxpa

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

Total Tax ID Earned Incentive Amount[1]:	Total Estimated Allowed Medicare Part B PFS Charges[2]:	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
$10,500.00	$1,050,000.00	12345	$9,450.00
		67890	$1,050.00

GPRO II Group Size Tier	Pre-Selected Method of Reporting	Incentive Eligible for Physician Quality Reporting (Yes/No)[3]	Incentive Eligibility Rationale
2-10	Claims	Yes	Sufficiently met the group size's measure and measures groups reporting requirements
2-10	Registry	Yes	Sufficiently met the group size's measure and measures groups reporting requirements
11-25	Claims	Yes	Sufficiently met the group size's measure and measures groups reporting requirements
11-25	Registry	Yes	Sufficiently met the group size's measure and measures groups reporting requirements
26-50	Claims	Yes	Sufficiently met the group size's measure and measures groups reporting requirements
26-50	Registry	Yes	Sufficiently met the group size's measure and measures groups reporting requirements
51-100	Claims	Yes	Sufficiently met the group size's measure and measures groups reporting requirements
51-100	Registry	Yes	Sufficiently met the group size's measure and measures groups reporting requirements
101-199	Claims	Yes	Sufficiently met the group size's measure and measures groups reporting requirements
101-199	Registry	Yes	Sufficiently met the group size's measure and measures groups reporting requirements

Total incentive amount earned for the CMS-selected GPRO II (TIN)

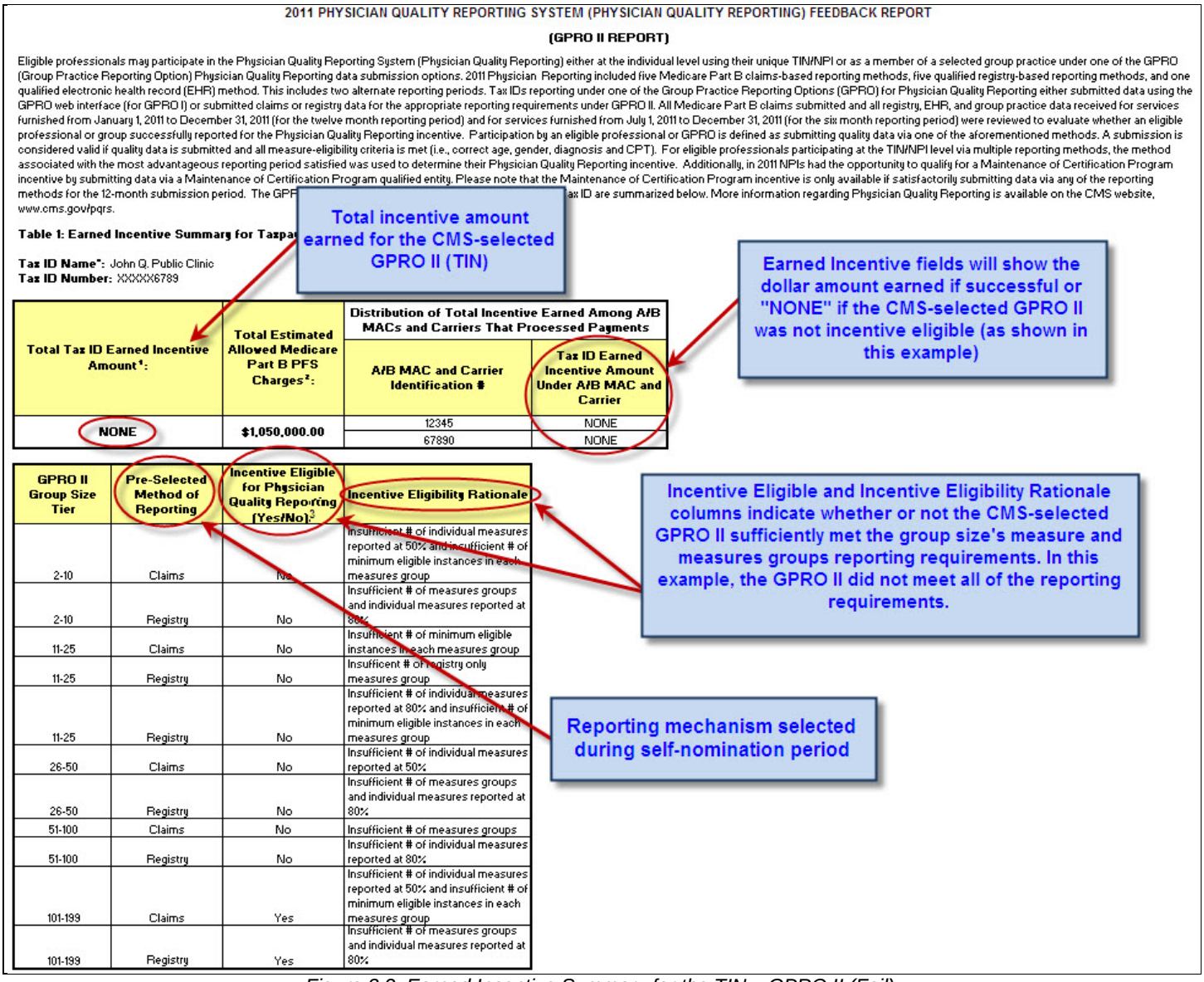
Total incentive amount earned for the CMS-selected GPRO II under each Carrier and A/B MAC (includes Maintenance of Certification Program Incentive)

Incentive Eligible and Incentive Eligibility Rationale columns indicate whether or not the CMS-selected GPRO II sufficiently met the group size's measure and measures groups reporting requirements. In this example, the GPRO II met all of the reporting requirements.

Reporting mechanism selected during self-nomination period

Figure 3.1: Earned Incentive Summary for the TIN – GPRO II (Pass)

Example - GPRO II TIN-Level Feedback Report: Table 1 (Fail)



2011 PHYSICIAN QUALITY REPORTING SYSTEM (PHYSICIAN QUALITY REPORTING) FEEDBACK REPORT

(GPRO II 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 one of the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2011 Physician Reporting included five Medicare Part B claims-based reporting methods, five qualified registry-based reporting methods, and one qualified electronic health record (EHR) method. This includes two alternate reporting periods. Tax IDs reporting under one of the Group Practice Reporting Options (GPRO) for Physician Quality Reporting either submitted data using the GPRO web interface (for GPRO I) or submitted claims or registry data for the appropriate reporting requirements under GPRO II. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2011 to December 31, 2011 (for the twelve month reporting period) and for services furnished from July 1, 2011 to December 31, 2011 (for the six month 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 GPRO 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 2011 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 submitting data via any of the reporting methods for the 12-month submission period. The GPR… …ax ID are summarized below. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/pqrs.

Table 1: Earned Incentive Summary for Taxpa…

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

Total Tax ID Earned Incentive Amount[1]:	Total Estimated Allowed Medicare Part B PFS Charges[2]:	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
NONE	$1,050,000.00	12345	NONE
		67890	NONE

GPRO II Group Size Tier	Pre-Selected Method of Reporting	Incentive Eligible for Physician Quality Reporting (Yes/No)[3]	Incentive Eligibility Rationale
2-10	Claims	No	Insufficient # of individual measures reported at 50% and insufficient # of minimum eligible instances in each measures group
2-10	Registry	No	Insufficient # of measures groups and individual measures reported at 80%
11-25	Claims	No	Insufficient # of minimum eligible instances in each measures group
11-25	Registry	No	Insufficent # of registry only measures group
11-25	Registry	No	Insufficient # of individual measures reported at 80% and insufficient # of minimum eligible instances in each measures group
26-50	Claims	No	Insufficient # of individual measures reported at 50%
26-50	Registry	No	Insufficient # of measures groups and individual measures reported at 80%
51-100	Claims	No	Insufficient # of measures groups
51-100	Registry	No	Insufficient # of individual measures reported at 80%
101-199	Claims	Yes	Insufficient # of individual measures reported at 50% and insufficient # of minimum eligible instances in each measures group
101-199	Registry	Yes	Insufficient # of measures groups and individual measures reported at 80%

Total incentive amount earned for the CMS-selected GPRO II (TIN)

Earned Incentive fields will show the dollar amount earned if successful or "NONE" if the CMS-selected GPRO II was not incentive eligible (as shown in this example)

Incentive Eligible and Incentive Eligibility Rationale columns indicate whether or not the CMS-selected GPRO II sufficiently met the group size's measure and measures groups reporting requirements. In this example, the GPRO II did not meet all of the reporting requirements.

Reporting mechanism selected during self-nomination period

Figure 3.2: Earned Incentive Summary for the TIN – GPRO II (Fail)

Example - GPRO II TIN-Level Feedback Report: Table 2

2011 PHYSICIAN QUALITY REPORTING SYSTEM (PHYSICIAN QUALITY REPORTING) FEEDBACK REPORT

(GPRO II CLAIMS 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 one of the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2011 Physician Quality Reporting included five Medicare Part B claims-based reporting methods, five qualified registry-based reporting methods, and one qualified electronic health record (EHR) method. This includes two alternate reporting periods. Tax IDs reporting under one of the Group Practice Reporting Options (GPRO) for Physician Quality Reporting either submitted data using the GPRO web interface (for GPRO I) or submitted claims or registry data for the appropriate reporting requirements under GPRO II. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2011 to December 31, 2011 (for the twelve month reporting period) and for services furnished from July 1, 2011 to December 31, 2011 (for the six month reporting period) were reviewed to evaluate whether an eligible professional or group successfully reported for Physician Quality Reporting. Participation by an eligible professional or GPRO 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 2011 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 submitting data via any of the reporting methods for the 12-month submission period. The methods reported and amounts earned for the GPRO 2 Tax ID are summarized below. The results below include: an Incentive Detail table listing the Tax ID's total earned incentive amount for the reported method, a Measures Groups Reporting Detail table listing all of the measures groups reported by the Tax ID with the reporting rates, and an Individual Measures Reporting Detail table listing all of the measures reported by the Tax ID with the reporting rates. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/pqrs.

These columns list the minimum reporting requirements according to tier size
Note: Actual reports will be specific to the TIN's CMS assigned tier

Detail from Table 1

Table 2: Reporting Detail for Taxpayer Identification Number (Tax ID) - Claims (GPRO II)
Measures Groups Table - Sorted by Measures Group and Sub-Sorted by Measure #
Individual Measures Table - Sorted by Measure #

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

GPRO II Claims Incentive Detail

GPRO II Group Tier Size	Minimum Number of Individual Measures Required To Be Reported	Minimum Number of Measures Groups Required To Be Reported	Minimum Number of Eligible Instances for Each Measures Group Required To Be Reported	Pre-Selected Method of Reporting	Incentive Eligible for Physician Quality Reporting (Yes/No)[1]	Incentive Eligibility Rationale	Total Estimated Allowed Medicare Part B PFS Charges[2]	Tax ID Total Earned Incentive Amount[3]
2-10	3	1	35	Claims	Yes	Sufficiently met the group size's measure and measures groups reporting requirements	$133,333.33	$1,333.33
11-25	3	1	50	Claims	Yes	Sufficiently met the group size's measure and measures groups reporting requirements	$133,333.33	$1,333.33
26-50	4	2	50	Claims	Yes	Sufficiently met the group size's measure and measures groups reporting requirements	$133,333.33	$1,333.33
51-100	5	3	60	Claims	Yes	Sufficiently met the group size's measure and measures groups reporting requirements	$133,333.33	$1,333.33
101-199	6	4	100	Claims	Yes	Sufficiently met the group size's measure and measures groups reporting requirements	$133,333.33	$1,333.33

Figure 3.3: GPRO II Claims Incentive Detail

These columns indicate all measures groups attempted by TIN

Number of instances eligible for reporting

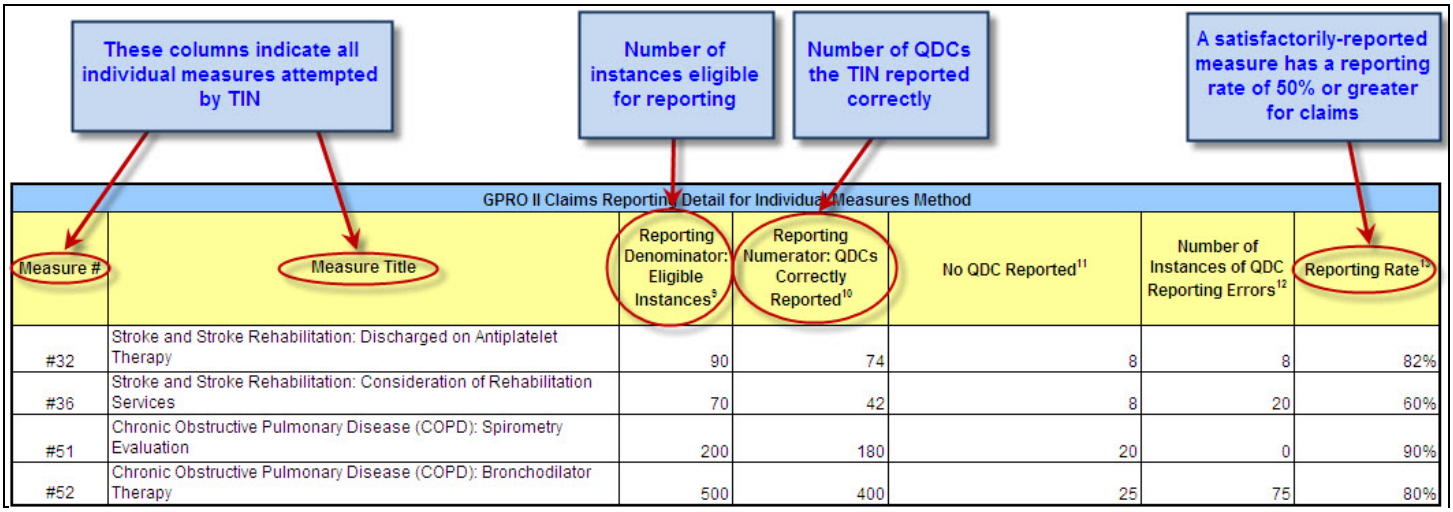
Number of QDCs the TIN reported correctly

GPRO II Claims Reporting Detail for Measures Groups Method

Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[5]	Reporting Numerator: QDCs Correctly Reported[6]	No QDC Reported[7]	Number of Instances of QDC Reporting Errors[8]
	Chronic Kidney Disease Measures Group[4]	250	210	N/A	N/A
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and	250	220	0	30
#122	Blood Pressure Management	250	225	0	25
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-	250	210	0	35
#153	Referral for Arteriovenous (AV) Fistula	250	210	0	35
	Rheumatoid Arthritis Measures Group[4]	250	215	N/A	N/A
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	250	220	0	30
#176	Tuberculosis Screening	250	225	6	19
#177	Periodic Assessment of Disease Activity	250	215	0	35
#178	Functional Status Assessment	250	215	0	35
#179	Assessment and Classification of Disease Prognosis	250	215	0	35
#180	Glucocorticoid Management	250	215	1	34

Figure 3.4: GPRO II Claims Reporting Detail for Measures Groups Method

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



GPRO II Claims Reporting Detail for Individual Measures Method

Measure #	Measure Title	Reporting Denominator: Eligible Instances[9]	Reporting Numerator: QDCs Correctly Reported[10]	No QDC Reported[11]	Number of Instances of QDC Reporting Errors[12]	Reporting Rate[13]
#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 3.5: GPRO II Claims Reporting Detail for Individual Measures Method

2011 PHYSICIAN QUALITY REPORTING SYSTEM (PHYSICIAN QUALITY REPORTING) FEEDBACK REPORT

(GPRO II REGISTRY 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 one of the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2011 Physician Quality Reporting included five Medicare Part B claims-based reporting methods, five qualified registry-based reporting methods, and one qualified electronic health record (EHR) method. This includes two alternate reporting periods. Tax IDs reporting under one of the Group Practice Reporting Options (GPRO) for Physician Quality Reporting either submitted data using the GPRO web interface (for GPRO I) or submitted claims or registry data for the appropriate reporting requirements under GPRO II. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2011 to December 31, 2011 (for the twelve month reporting period) and for services furnished from July 1, 2011 to December 31, 2011 (for the six month reporting period) were reviewed to evaluate whether an eligible professional or group successfully reported for Physician Quality Reporting. Participation by an eligible professional or GPRO 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 2011 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 submitting data via any of the reporting methods for the 12-month submission period. The methods reported and amounts earned for the GPRO II Tax ID are summarized below. The results below include: an Incentive Detail table listing the Tax IDs total earned incentive amount for the reported method, a Measures Groups Reporting Detail table listing all of the measures groups reported by the Tax ID with the reporting rates, and an Individual Measures Reporting Detail table listing all of the measures reported by the TIN with the reporting rates. More information regarding Physician Quality Reporting is available on the CMS website: www.cms.gov/pqrs

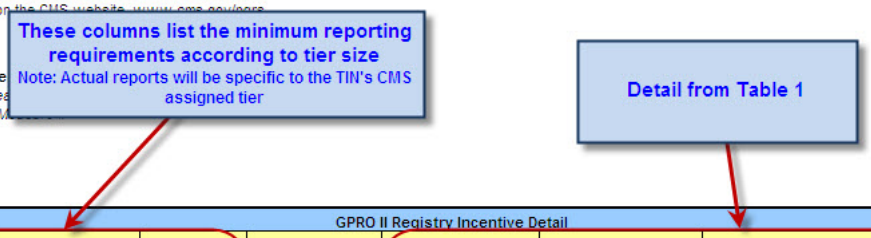


Table 2: Reporting Detail for Taxpaye
Measures Groups Table - Sorted by Mea
Individual Measures Table - Sorted by M

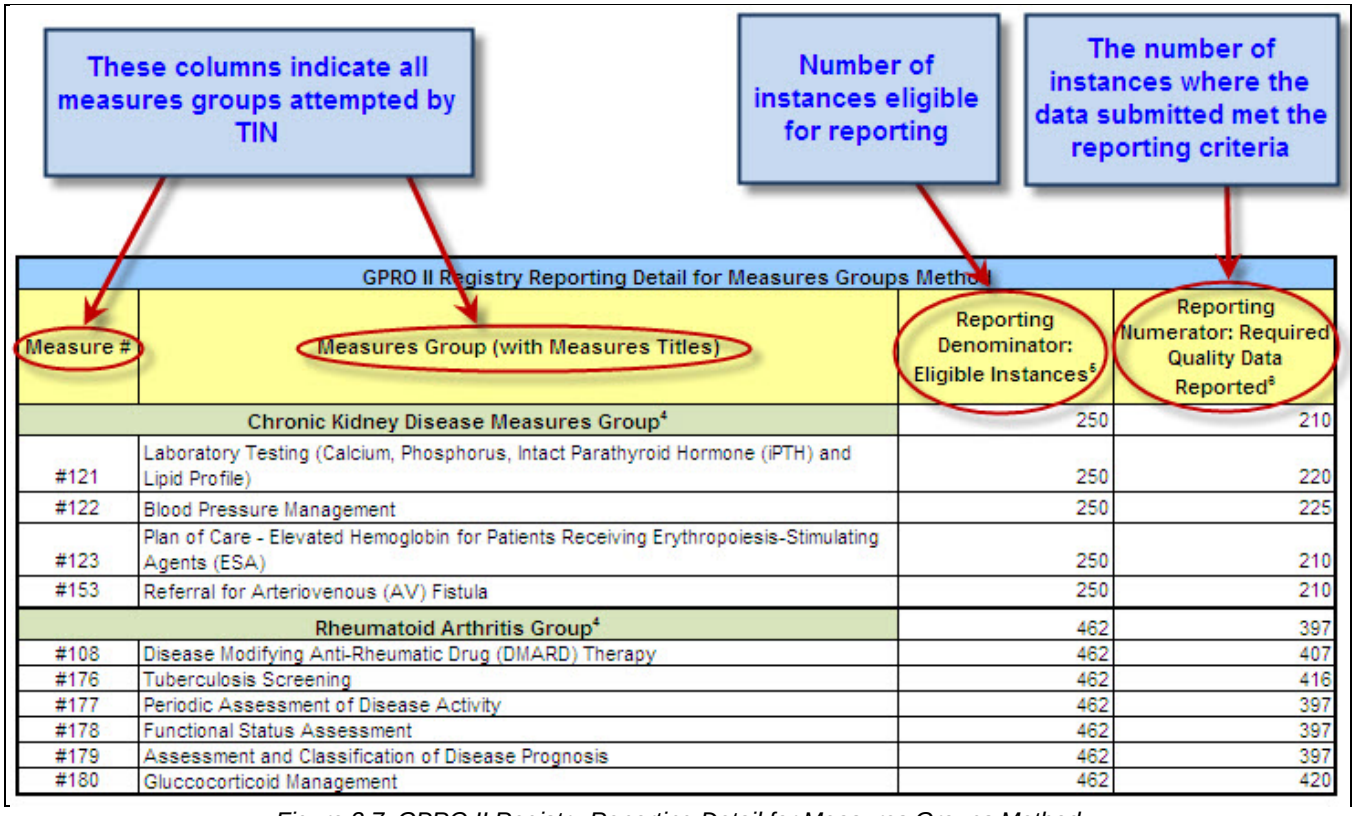
Tax ID Name*: John Q. Public Clinic
Tax ID Number: XXXXX6789

GPRO II Registry Incentive Detail

GPRO II Group Tier Size	Minimum Number of Individual Measures Required To Be Reported	Minimum Number of Measures Groups Required To Be Reported	Minimum Number of Eligible Instances for Each Measures Group Required To Be Reported	Registry Name	Pre-Selected Method of Reporting	Incentive Eligible for Physician Quality Reporting (Yes/No)[1]	Incentive Eligibility Rationale	Total Estimated Allowed Medicare Part B PFS Charges[2]	Tax ID Total Earned Incentive Amount[3]
2-10	3	1	35	ACC	Registry	Yes	Sufficiently met the group size's measure and measures groups reporting requirements	$133,333.33	$1,333.33
11-25	3	1	50	ACC	Registry	Yes	Sufficiently met the group size's measure and measures groups reporting requirements	$133,333.33	$1,333.33
26-50	4	2	50	ACC	Registry	Yes	Sufficiently met the group size's measure and measures groups reporting requirements	$133,333.33	$1,333.33
51-100	5	3	60	ACC	Registry	Yes	Sufficiently met the group size's measure and measures groups reporting requirements	$133,333.33	$1,333.33
101-199	6	4	100	ACC	Registry	Yes	Sufficiently met the group size's measure and measures groups reporting requirements	$133,333.33	$1,333.33

Figure 3.6: GPRO II Registry Incentive Detail

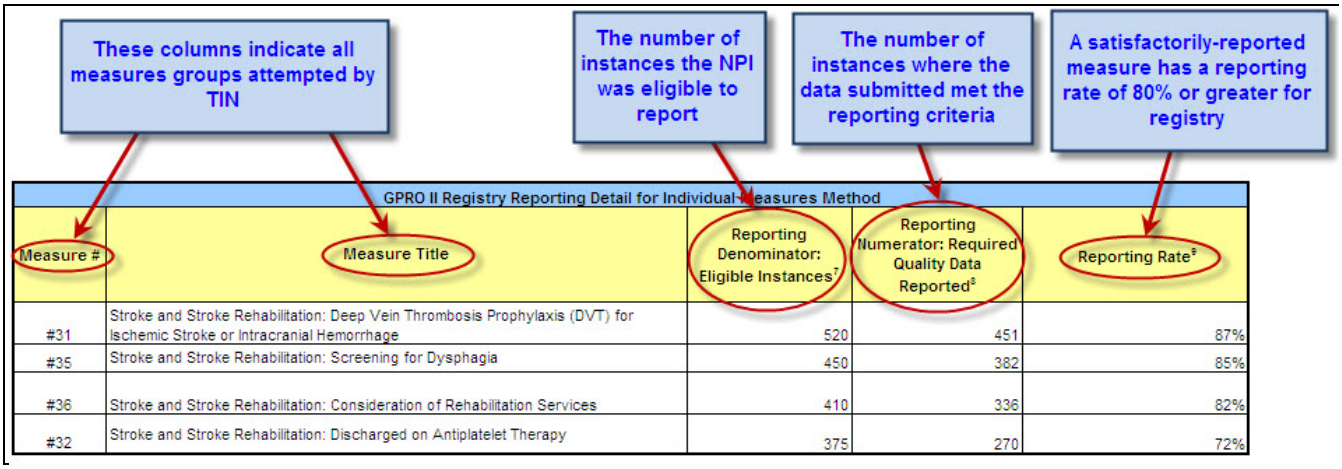
Example GPRO II TIN-Level Feedback Report: Table 2 (continued)



GPRO II Registry Reporting Detail for Measures Groups Method

Measure #	Measures Group (with Measures Titles)	Reporting Denominator: Eligible Instances[5]	Reporting Numerator: Required Quality Data Reported[6]
	Chronic Kidney Disease Measures Group[4]	250	210
#121	Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	250	220
#122	Blood Pressure Management	250	225
#123	Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	250	210
#153	Referral for Arteriovenous (AV) Fistula	250	210
	Rheumatoid Arthritis Group[4]	462	397
#108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	462	407
#176	Tuberculosis Screening	462	416
#177	Periodic Assessment of Disease Activity	462	397
#178	Functional Status Assessment	462	397
#179	Assessment and Classification of Disease Prognosis	462	397
#180	Glucocorticoid Management	462	420

Figure 3.7: GPRO II Registry Reporting Detail for Measures Groups Method



GPRO II Registry Reporting Detail for Individual Measures Method

Measure #	Measure Title	Reporting Denominator: Eligible Instances[7]	Reporting Numerator: Required Quality Data Reported[8]	Reporting Rate[9]
#31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	520	451	87%
#35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	450	382	85%
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	410	336	82%
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	375	270	72%

Figure 3.8: GPRO II Registry Reporting Detail for Individual Measures Method

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 4.1: 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 2011 PQRS 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 10 of this document for reference.

For definition of terms related to the *2011 Physician Quality Reporting System Feedback Report*, see Appendix A. Also refer to the footnotes within each table for additional content detail.

Example - Maintenance of Certification Program Summary: Table 1

(MAINTENANCE OF CERTIFICATION PROGRAM 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 one of the GPRO (Group Practice Reporting Option) Physician Quality Reporting data submission options. 2011 Physician Reporting included five Medicare Part B claims-based reporting methods, five qualified registry-based reporting methods, and one qualified electronic health record (EHR) method. This includes two alternate reporting periods. Tax IDs reporting under one of the Group Practice Reporting Options (GPRO) for Physician Quality Reporting either submitted data using the GPRO web interface (for GPRO I) or submitted claims or registry data for the appropriate reporting requirements under GPRO II. All Medicare Part B claims submitted and all registry, EHR, and group practice data received for services furnished from January 1, 2011 to December 31, 2011 (for the twelve month reporting period) and for services furnished from July 1, 2011 to December 31, 2011 (for the six month 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 GPRO 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 2011 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 submitting data via any of the reporting methods for the 12-month submission period. The Tax ID's Maintenance of Certification Incentive details for each NPI are summarized below. More information regarding Physician Quality Reporting is available on the CMS website, www.cms.gov/pqrs.

Table 1: Maintenance of Certification Program Incentive Summary

Sorted by NPI Number

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

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

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

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

Total 0.5% incentive amount earned by each individual NPI

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

NPI	NPI Name*	Total Estimated Allowed Medicare Part B PFS Charges[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

Figure 4.1: Maintenance of Certification Program Incentive Summary

Accessing Feedback Reports

NPI-Level Reports (Not Available to CMS-Selected GPRO Participants)
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 (Available to CMS-Selected GPRO Participants)
TIN-level reports can be requested for individuals within the same practice or for CMS-selected group practices participating in GPRO I or II. The TIN-level reports will be accessible through the Portal with IACS login at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS. TIN-level reports can only be accessed via the Portal.

The Portal is the secured entry point to access the 2011 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 2011 feedback reports through the secure Portal. As shown in Figure 5.1, 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 *2011 Physician Quality Reporting Feedback Reports* will be available as an Adobe® Acrobat® PDF in the fall of 2012 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* 2011 PQRS Incentive Payment 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 5.1 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), the 2011 Physician Quality Reporting System 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 I and II participants. For more information, refer to PQRS FAQs and the 2011 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 1.0% incentive is based on CMS' estimate of all Medicare Part B PFS allowed charges for covered professional services: (1) furnished during the applicable 2011 reporting period, (2) processed by the Carrier or A/B Medicare Administrative Contractor (MAC) no later than February 24, 2012, 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 I or II eligible for the incentive is defined as a TIN who met the PQRS criteria for successful reporting for the 2011 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 I or II 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 2011 PQRS program pages on the CMS website (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS), including the *Guide for Understanding 2011 Physician Quality Reporting System Incentive Payment*.

Distribution

- 2011 PQRS payments are scheduled to be issued to the TIN by the Carrier or A/B MAC in the fall of 2012 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 2011 PQRS and the 2011 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 2011 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 2011 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 (PQ11) 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
- 2011 PQRS feedback reports are scheduled to be available in the fall of 2012.
- 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 and will not be archived.
- If **all** of the 2011 PQRS QDCs submitted by individual eligible professionals are not denominator-eligible events for the 2011 measure, Tables 1, 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 via registry or EHR, an individual NPI will be indicated in the feedback report as incentive eligible, but the incentive payment is determined to be zero dollars. This is due to when the incentive payment calculation for the individual NPI indicates they do not have any total estimated Medicare Part B PFS allowed charges for covered professional services billed under the reflected TIN/NPI combination.

Help/Troubleshooting

Following are helpful hints and troubleshooting information:

- Adobe® Acrobat® Reader is required to view the feedback report in PDF format. You can download a free copy of the latest version of Adobe® Acrobat® Reader from http://www.adobe.com/products/acrobat/readstep2.html?promoid=BUIGO.
- The report may not function optimally, correctly, or at all with some older versions of Microsoft® Windows, Microsoft® Internet Explorer, Mozilla® Firefox, or Adobe® Acrobat® Reader.
- 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/MLNGenInfo/01_Overview.asp.

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Appendix A: 2011 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.
Disease Module/Preventive Care Measures (GPRO I Only)	The 2011 GPRO I PQRS disease module or preventive care measures title.
GPRO II Group Size Tier (GPRO II Only)	The tier size of a CMS-selected GPRO II as determined by CMS after self-nomination. 2011 GPRO II reporting requirements were based upon a group's size.
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 2011 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 covered professional services rendered during the reporting period. Date of service on the claim is used to determine the reporting period. The PFS claims included were based on the 12- or 6-month reporting period for the method by which the NPI was incentive eligible.
TIN Total Earned Incentive Amount	The 1.0% incentive based on the total estimated 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 Incentive.
Total Tax ID Earned Incentive Amount for NPIs (Individual Only)	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 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 2011 PQRS *and* reported in the Maintenance of Certification Program.

Term	Definition
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. The fourteen reporting methods are: o 12 months – individual measures via claims o 12 months – individual measures via registry o 12 months – individual measures via EHR o 12 months – 30 beneficiary measures groups via registry o 12 months – 80% measures groups via registry o 12 months – 50% measures groups via claims o 12 months – 30 beneficiary measures groups via claims o 12 months – Group Practice Reporting Option I o 12 months – Group Practice Reporting Option II via claims o 12 months – Group Practice Reporting Option II via registry o 6 months – individual measures via claims o 6 months – individual measures via registry o 6 months – 80% measures groups via registry o 6 months – 50% measures groups via claims
NPI (Individual Only)	National Provider Identifier of the eligible professional billing under the TIN.
NPI Name (Individual Only)	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 2011 PQRS incentive payment, only the system's ability to populate this field in the report.
NPI Total Earned Incentive Amount (Individual Only)	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.

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 at 50% (Claims) o Insufficient # of measures reported at 80% (Registry, EHR) o Insufficient # of minimum eligible instances o Insufficient % of eligible instances reported **Eligible** o Sufficient # of beneficiaries reported o Sufficient # of eligible instances reported o Sufficient # of eligible instances reported at 50% and a minimum of 15 eligible instances o Sufficient # of eligible instances reported at 50% and a minimum of 8 eligible instances o Sufficient # of eligible instances reported at 80% and a minimum of 15 instances o Sufficient # of eligible instances reported at 80% and a minimum of 8 eligible instances o Sufficient # of measures reported at 50% (Claims) o Sufficient # of measures reported at 80% (Registry, EHR) **GPRO I** **Not Eligible** o Did not meet reporting requirements for consecutively completed cases **Eligible** o Met reporting requirements for consecutively completed cases **GPRO II** **Not Eligible** o Insufficient # of registry only measures groups o Insufficient # of individual measures reported at 50%(Claims) o Insufficient # of individual measures reported at 50% and insufficient # of minimum eligible instances in each measures group (Claims) o Insufficient # of individual measures reported at 80% (Registry) o Insufficient # of individual measures reported at 80% and insufficient # of minimum eligible instances in each measures group (Registry) o Insufficient # of measures groups o Insufficient # of measures groups and individual measures reported at 80% (Registry) o Insufficient # of minimum eligible instances in each measures group **Eligible** o Sufficiently met the group size's measure and measures groups reporting requirements More information regarding incentive calculations can be found on the CMS website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Term	Definition
Reporting Period	The 12-month or 6-month time period for which and eligible professional can submit quality data for 2011 PQRS. o 12-month (January 1 – December 31, 2011) o 6-month (July 1 – December 31, 2011)
Yes/No	"Yes" indicates if the TIN/NPI is eligible for the incentive payment and "No" indicates if the TIN/NPI is not eligible for the incentive payment.

Table 2: NPI Reporting Detail

Term	Definition
Incentive Eligible	"Yes" if satisfactorily met reporting criteria and "No" if did not satisfactorily meet reporting criteria.
Reporting Method/Period Used for Incentive	The method/period of reporting satisfactorily meeting the reporting criteria and deemed most advantageous will be indicated with a "Yes". If the NPI did not qualify for an incentive through any reporting methods/periods, the reporting method/period will be populated with "N/A".
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 toward reporting success.
Total # Measures Reported on Denominator-Eligible Instances	The number of measures for which the TIN/NPI reported at least one valid QDC or quality action data. If the reporting method is through measures groups, this field will be populated with 'N/A'. o **Quality-Data Code:** Specified CPT Category II codes with or without modifiers (and G-codes where CPT II codes are not yet available) used for submission of PQRS data. CMS *Physician Quality Reporting Quality Measures Specifications* document contains all codes associated with each measure and instructions for data submission through the administrative claims system. This document can be found on the 2011 PQRS program page on the CMS 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 Denominator: Eligible Instances	The number of instances the TIN/NPI was eligible to report the measure or measures group.
Reporting Numerator: QDCs Correctly Reported	The number of reporting instances where the QDCs or quality action data submitted met the measure-specific reporting criteria.
No QDC Reported	The number of instances where reporting was not met due to no 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 no 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.

Table 3: NPI QDC Submission Error Detail

Term	Definition
Number of Times Quality Data Was Reported	The Number of 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 QDC submissions for a measure.
% of Correctly Reported Quality Data	The percentage of reported QDCs that were valid.
Quality Data Reporting Errors (with Reasons for the Errors)	The following indicate the various reasons for QDC errors: o Measure Reported on an Instance with an Incorrect Gender – invalid QDC submissions due to not matching the gender requirements for the measure o Measure Reported on an Instance with an Incorrect Age – invalid QDC submissions due to not matching the age requirements for the measure o Measure Reported on an Instance with an Incorrect CPT Code – invalid QDC submissions resulting from an incorrect CPT code submitted for the measure o Measure Reported on an Instance with an Incorrect DX Code – invalid QDC submissions resulting from an incorrect diagnosis code (DX) submitted for the measure o Measure Reported on an Instance with an Incorrect CPT Code and an Incorrect Code – invalid QDC submissions resulting from a combination of incorrect CPT code and incorrect diagnosis code submitted for the measure o Measure Reported on an Instance with a Missing CPT Code – invalid QDC submissions due to missing a qualifying denominator CPT code since all lines were QDCs o Measure Reported on an Instance with a Missing CPT Code and an Incorrect DX Code – invalid QDC submissions due to a missing qualifying denominator code since all lines were QDCs and the diagnosis codes were incorrect

Table 4: NPI Performance Detail

NOTE: Performance information is provided for CMS-selected GPRO participants or eligible professional's use to assess and improve their clinical performance. Performance rates do not affect 2011 Physician Quality Reporting incentive payment eligibility or amount at the individual eligible professional or practice

Term	Definition
Reporting Numerator: Valid QDCs or Quality Data Reported	The number of reporting instances where the QDCs or quality action data submitted met the measure-specific reporting criteria.
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 Met (GPRO I only)	The number of Patients/Visits eligible for the measure (met the measure's inclusion criteria

Term	Definition
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 Not Met (GPRO I only)	The number of Patients/Visits that did not meet the performance requirements for the measure
Performance Rate	The Performance Rate includes performance information for all TIN/NPI combinations submitting at least one QDC for the measure.
Performance Rate (GPRO I only)	The Performance Rate is calculated by dividing the Performance Met by the Performance Denominator.
Total Patients/Visits (GPRO I only)	The number of Patients/Visits eligible for the measure (met the measure's inclusion criteria).
National Mean Performance Rate	The national mean performance rate includes performance information for all TIN/NPI combinations submitting at least one QDC for the measure.