User Guide

2013 Physician Quality Reporting System (PQRS) Feedback Reports

Disclaimer

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User Guide 2013 Physician Quality Reporting System (PQRS) Feedback Reports

Purpose

The Physician Quality Reporting System (PQRS) Feedback Report User Guide is designed to assist eligible professionals (EPs) and their authorized users with accessing and interpreting the 2013 PQRS feedback reports. The 2013 PQRS incentive payments are scheduled to be made in the fall of 2014. Feedback reports reflect data from the Medicare Part B Physician Fee Schedule (PFS) claims received with January 1, 2013 – December 31, 2013 dates of service that were processed into the National Claims History (NCH) by February 28, 2014.

The *2013 PQRS Feedback Report* does not indicate subjectivity to future PQRS payment adjustments. Those that reported satisfactorily for the 2013 program year and received an incentive also avoided the 2015 PQRS payment adjustment. See the CMS website for information on PQRS payment adjustments, and the *PQRS Payment Adjustment Feedback Reports*.

PQRS Overview

The 2006 Tax Relief and Health Care Act (TRHCA) authorized a physician quality reporting system, including an incentive payment for EPs who satisfactorily reported data on quality measures for Medicare Part B Physician Fee Schedule (PFS) covered professional services furnished to Medicare Fee-for-Service beneficiaries during the second half of 2007. CMS named this program the 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. The Affordable Care Act (ACA) of 2010 also calls for PQRS payment adjustments starting in 2015. 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 EPs.

2013 PQRS continued as a quality reporting program that included claims-, registry-, electronic health record (EHR)-, and Group Practice Reporting Option (GPRO) Web Interface-based or registry reporting of data on individual quality measures as well as measures groups. The reporting period for this program year was: January 1, 2013 – December 31, 2013. There were 10 options for satisfactorily reporting quality measures data for 2013 PQRS that differed based on the reporting period, the reporting option (individual measures or measures groups), the selected data collection method (claims, qualified registry, or qualified EHR) as well as successful participation in other quality programs (such as Medicare Shared Savings Program [MSSP], Comprehensive Primary Care Initiative [CPCI], and Pioneer Accountable Care Organizations [ACOs]). “Satisfactory reporting” refers to participating in 2013 PQRS to earn the incentive payment (and avoid the 2015 payment adjustment).

Physicians who are incentive eligible for PQRS can receive an additional 0.5% incentive payment when Maintenance of Certification Program Incentive requirements have been met. This physician-only incentive will be paid at the same time as the 2013 PQRS incentive for those physicians who qualify. Physicians cannot receive more than one additional 0.5% Maintenance of Certification Program Incentive, even if they complete a Maintenance of Certification Program in more than one specialty.

For more information on 2013 PQRS, please visit the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Report Overview

The 2013 PQRS feedback reports, not including the Quality Resource Use Report (QRUR), are packaged at the TIN-level, with individual-level reporting (by NPI) and performance information for each EP who reported at least one PQRS quality-data code (QDC) on a claim submitted under that TIN for services furnished during the reporting period. Reports include information on reporting rates, clinical performance, and incentives earned by individual professionals, with summary information on reporting success and incentives earned at the practice (TIN) level. Reports for individual measures via claims also include information on the measure-applicability validation (MAV) process and any impact it may have had on the eligible professional's incentive eligibility. For more information about MAV, go to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

2013 PQRS included two claims-based reporting, two registry-based reporting, the GPRO Web Interface, and EHR Direct and Data Submission Vendor reporting options. All Medicare Part B claims submitted with PQRS QDCs, all registry data, all EHR data, and all GPRO Web Interface data received for services furnished from January 1, 2013 – December 31, 2013 were analyzed to determine whether the EP or group practice met satisfactory reporting criteria and earned a PQRS incentive payment. Each TIN/NPI had the opportunity to participate in PQRS via multiple reporting methods. Participation is defined as EPs submitting at least one QDC via claims or submitting data via a qualified registry, qualified EHR, or GPRO Web Interface. For claims reporting, a valid submission was counted when a QDC was submitted and all measure-eligibility criteria were met (i.e., correct age, gender, diagnosis, and CPT). For registry, EHR, and GPRO Web Interface reporting, a valid submission was counted when PQRS quality data was correctly submitted. For those NPIs satisfactorily reporting using multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRS incentive.

CMS aims to distribute feedback reports as closely as possible to the PQRS incentive payment timeframe. 2013 PQRS feedback reports are scheduled to be available in the fall of 2014. For more information on that process, see http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_IACS-Organizations_12192012.pdf.

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

System Requirements

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

Hardware

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

Minimum Software

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

Internet Connection

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

Participant Feedback Report Content and Appearance

Four tables may be included in the 2013 PQRS feedback reports. Feedback reports will be generated for each TIN with at least one EP reporting *any* QDC. Participants reporting as individuals will receive Tables 1-4. The TIN-level feedback report is only accessible by the TIN. It is up to the TIN to distribute the information in Tables 2-4 to the individual NPI. The length of the feedback report will depend on the number of TIN/NPIs participating in PQRS. For TIN/NPIs reporting via multiple reporting methods, the feedback report will display each reporting method. A total incentive payment amount will be calculated for all TIN/NPIs. A breakdown of each individual NPI and their earned incentive amount will also be included. Those individuals who participated in the Maintenance of Certification Program Incentive will receive that data on Table 1 and will see additional detail on Table 2. For more information on accessing 2013 PQRS feedback reports, group practices participating in the PQRS Group Practice Reporting Option (GPRO) should go to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

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

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

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

Key Terms:

- **Total Tax ID Earned 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.
- **PQRS NPI Total Earned Incentive Amount:** The amount of the incentive is based on the total estimated allowed Medicare Part B PFS charges for services performed within the length of the reporting period for which a TIN/NPI was eligible. If N/A, the NPI was not eligible to receive an incentive.

Table 2: NPI Reporting Detail
Figure 1.2: NPI Reporting Detail: Incentive and Participation Summary

Figure 1.3: Reporting Detail Summary

Figure 1.4: Claims Reporting Detail for Individual Measures

Figure 1.5: EHR Direct Submission Reporting Detail

Figure 1.6: EHR Data Submission Vendor Submission Reporting Detail

Figure 1.7: Reporting Detail of Information Submitted by Registries for Individual Measures

Figure 1.8: Claims Reporting Detail for Measures Groups 20 Beneficiary Method

Figure 1.9: Reporting Detail of Information Submitted by Registries for the 20 Patients Measures Groups Method

Key Terms:

- **Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period:** The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) allowed charges associated with covered professional services rendered during the reporting period. The PFS claims included were based on the reporting period for the method by which the NPI was incentive eligible.
- **Total # Measures Reported:** The number of measures where QDCs or quality action data are submitted, but are not necessarily valid. These instances do not count towards reporting success.
- **Total # Measures Reported on Denominator Eligible Instances:** The number of measures for which the TIN/NPI reported a valid QDC or quality action data.
- **Total # Measures Satisfactorily Reported:** The total number of measures the TIN/NPI reported at a satisfactory rate.
    - Satisfactorily reported measures are those measures that meet certain analytical requirements such as reporting frequency, performance timeframes and timeliness of data submission. Requirements for each measure and measures group are outlined in the *2013 Physician Quality Reporting (PQRS) Claims/Registry Measures Specifications* and *2013 Physician Quality Reporting (PQRS) Measures Groups Specifications*. Performance detail can be found in Table 4 of the feedback report.

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

Key Terms:

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

Table 4: NPI Performance Detail
Figure 1.13: Claims Performance Information for Individual Measures

Figure 1.14: EHR Direct Data Submission Performance Information

Figure 1.15: EHR Data Submission Vendor Submission Performance Information

Figure 1.16: Registry Performance Information for Individual Measures

Figure 1.17: Claims Performance Information for Measures Groups 20 Beneficiary Method

Figure 1.18: Registry Performance Information for Measures Groups 20 Patient Method

Key Terms:

- **Performance Met:** The number of instances the TIN/NPI submitted the appropriate QDCs or quality action data satisfactorily meeting the performance requirements for the measure.
- **Performance Not Met:** Includes instances where an 8P modifier, G-code or CPT II code is used to indicate the quality action was not provided for a reason not otherwise specified.
- **Performance Rate:** The Performance Rate is calculated by dividing the Performance Met by the Performance Denominator.
    - If "NULL", all of the measure's performance eligible instances were performance exclusions.

  Measures with a 0% performance rate and measures groups containing a measure with a 0% performance rate will not be counted. *The recommended clinical quality action must be performed on at least one patient for each individual measure reported by the eligible professional. A 0% performance rate could be due to the fact that none of the provider's eligible patients were in compliance for the measure or that the provider did not provide the correct quality action to the patient. Exceptions for the 0% performance rate are those measures where a lower rate indicate better performance (i.e., #1, #123 and #146).*
- **National Mean Performance Rate:** Includes performance information for all TIN/NPI combinations submitting at least one quality-data code (QDC) for the measure.

NOTE: Performance information is provided for eligible professionals' use to assess and improve their clinical performance. This rate is different from the Value-Based Modifier (VM) benchmarks.

For definition of terms related to the *2013 Physician Quality Reporting System Feedback Report*, see Appendix A. Also refer to the footnotes within each table for additional content detail.

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

Example - TIN-Level Feedback Report: Table 1

<*insert program year*> PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) INCENTIVE FEEDBACK REPORT

(TIN-LEVEL REPORT WITH INDIVIDUAL NPIs)

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

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

Sorted by NPI Number and Sub-Sorted by Total Earned Inc

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/C MAC (includes Maintenance of Certification)

Total Tax ID Earned Incentive Amount for NPIs (listed below): $5283.83	Distribution of Total Incentive Earned Among A/B MACs and Carriers That Processed Payments	
	A/B MAC and Carrier Identification #	Tax ID Earned Incentive Amount Under A/B MAC and Carrier
	12345	$3,081.33
	67890	$2,202.50

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

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

NPI	NPI Name*	Method of Reporting[2]	Incentive Eligibility Rationale	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period[3]	PQRS NPI Total Earned Incentive Amount[4]
1000000001	Tom Anderson	Pioneer ACO Participant	Successful Pioneer ACO participant	$80,000.00	$392.00
1000000002	Susie Smith	Individual measure(s) reporting via electronic health records (Data Submission Vendor)	Sufficient # of measures reported	$100,000.00	$490.00

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[2]	Incentive Eligibility Rationale	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period[3]	PQRS NPI Total Earned Incentive Amount[4]
1000000012	John Beans	Individual measure(s) reporting via claims	Sufficient # of measures reported	$60,000.00	$294.00
1000000013	Not Available	Measures Groups - 20 beneficiaries via claims	Sufficient # of beneficiaries and measures groups reported	$65,000.00	$318.50
1000000014	Tobias Daniels	CMS Calculated Administrative Claims	Reporting mechanism not available for incentive	$90,000.00	N/A
1000000015	John Bender	CPC Participant	Successful CPC participant	$90,000.00	$441.00
1000000016	Melissa Smith	Individual measure(s) reporting via electronic health records (Data Submission Vendor)	Sufficient # of measures reported	$150,000.00	$735.00
1000000017	Heather Chandler	CPC Participant	Unsuccessful CPC participant	$90,000.00	N/A
1000000018	Not Available	Individual measure(s) reporting via electronic health records (Direct EHR)	Insufficient # of measures reported	$250,000.00	N/A
1000000019	Not Available	Individual measure(s) reporting via electronic health records (Direct EHR)	Sufficient # of measures reported	$150,000.00	$735.00
1000000021	Not Available	Individual measure(s) reporting via electronic health records (Data Submission Vendor)	Insufficient # of measures reported	$200,000.00	N/A
				Total:	$5,283.83

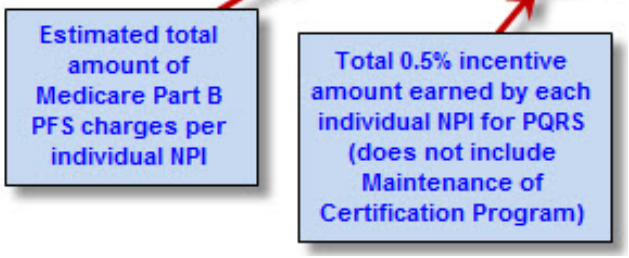
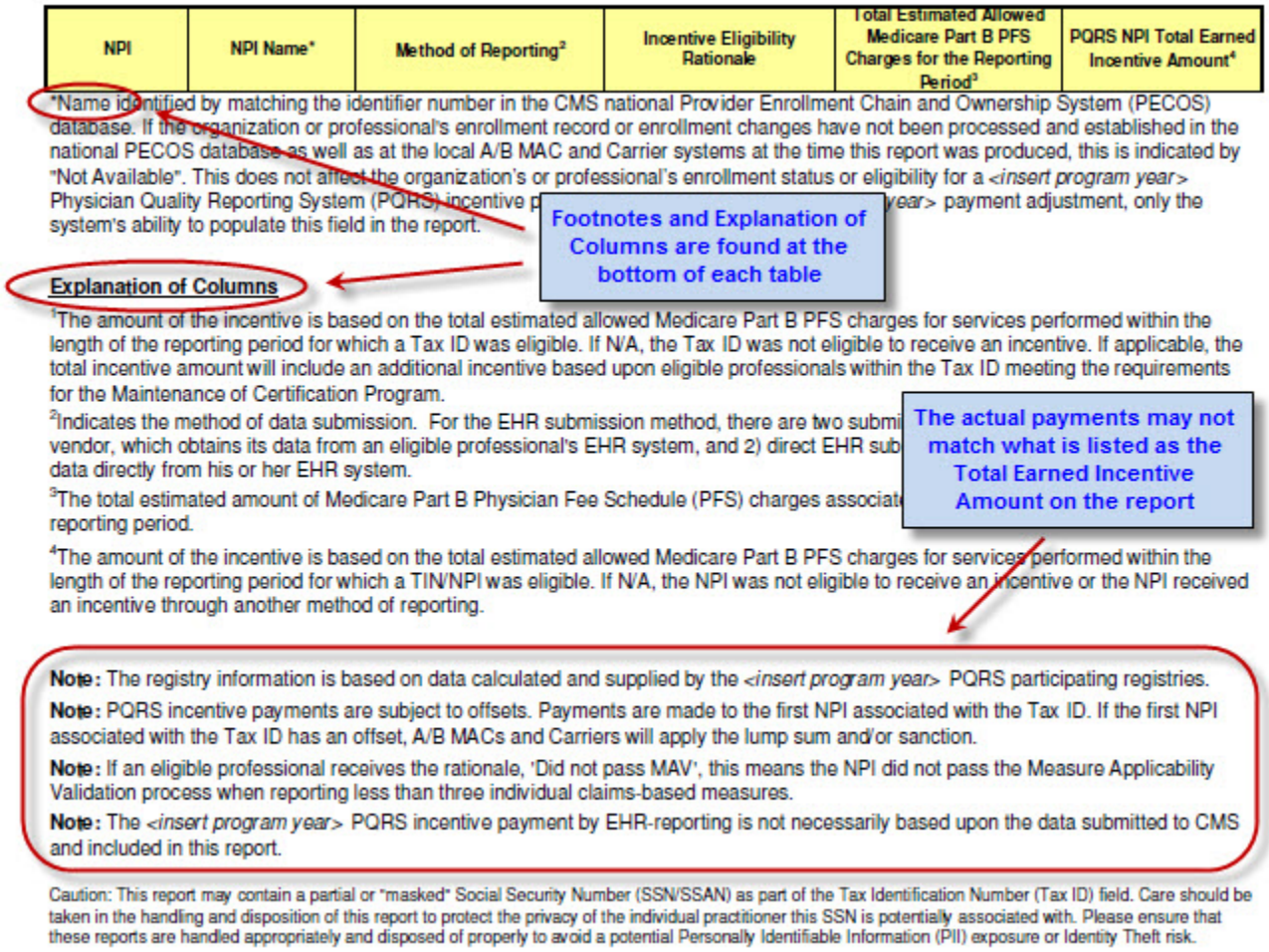


Figure 1.1: Earned Incentive Summary for Taxpayer Identification Number (Tax ID)

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



NPI	NPI Name*	Method of Reporting[2]	Incentive Eligibility Rationale	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period[3]	PQRS NPI Total Earned Incentive Amount[4]

*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 <*insert program year*> Physician Quality Reporting System (PQRS) incentive p... <*year*> payment adjustment, only the system's ability to populate this field in the report.

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 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.

[2]Indicates the method of data submission. For the EHR submission method, there are two submi... vendor, which obtains its data from an eligible professional's EHR system, and 2) direct EHR sub... data directly from his or her EHR system.

[3]The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) charges associat... reporting period.

[4]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 or the NPI received an incentive through another method of reporting.

Note: The registry information is based on data calculated and supplied by the <*insert program year*> PQRS participating registries.

Note: PQRS 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.

Note: If an eligible professional receives the rationale, 'Did not pass MAV', this means the NPI did not pass the Measure Applicability Validation process when reporting less than three individual claims-based measures.

Note: The <*insert program year*> PQRS incentive payment by EHR-reporting is not necessarily based upon the data submitted to CMS and included in this report.

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 (cont.): Earned Incentive Summary for Taxpayer Identification Number (Tax ID)

Example - TIN-Level Feedback Report: Table 2

<insert program year> PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) INCENTIVE FEEDBACK REPORT

(INDIVIDUAL NPI REPORT)

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

Table 2: NPI Reporting Detail

Participation Summary Table Sorted by Reporting Method Selected for Incentive Eligibility
Reporting Detail Summary Table Sorted by Method Reported
Reporting Detail Tables Sorted by Measure # for Individual Measure Methods *Sorted by Measure # for Measures Groups Methods*

Tax ID Name*: John Q. Public Clini
Tax ID Number: XXXXX5789
NPI Name*: John Beans
NPI Number: 1000000012

Total incentive amount earned by the NPI for 2013

Total 0.5% incentive amount earned by the NPI for 2013 PQRS

Total 0.5% incentive amount earned by the NPI for 2013 Maintenance of Certification Program

Incentive Summary			
Total NPI Incentive Amount Earned for the Reporting Period	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period	PQRS Incentive Amount	Maintenance of Certification Program Incentive Total Earned Incentive Amount
$588.00	$60,000.00	$294.00	$294.00

Detail from Table 1 for the reporting method(s)/period for which the NPI did or did not earn an incentive

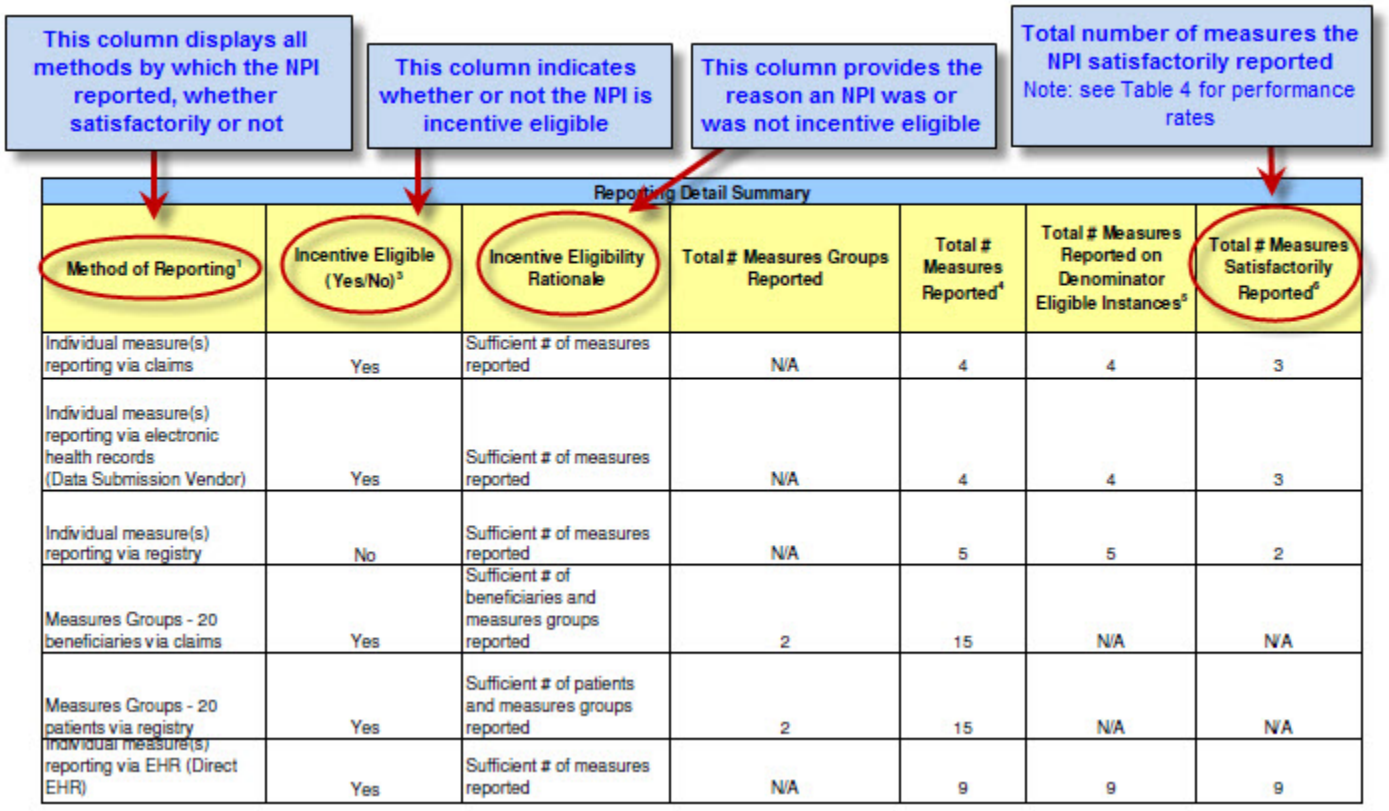
Participation Summary			
Method Reported[1]	Registry/EHR Name (If Applicable)	Incentive Eligible for Method Reported	Reporting Method Selected for Incentive Payment[2]
Individual measure(s) reporting via electronic health records (Direct EHR)	Epic	Yes	Yes
Individual measure(s) reporting via electronic health records (Data Submission Vendor)	Epic	Yes	N/A
Measures Groups - 20 patients via registry	ICLOPS	Yes	N/A
Measures Groups - 20 beneficiaries via claims	N/A	No	N/A
Individual measure(s) reporting via claims	N/A	Yes	N/A
Individual measure(s) reporting via registry	ICLOPS	No	N/A

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

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

Figure 1.2: NPI Reporting Detail: Incentive and Participation Summary

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

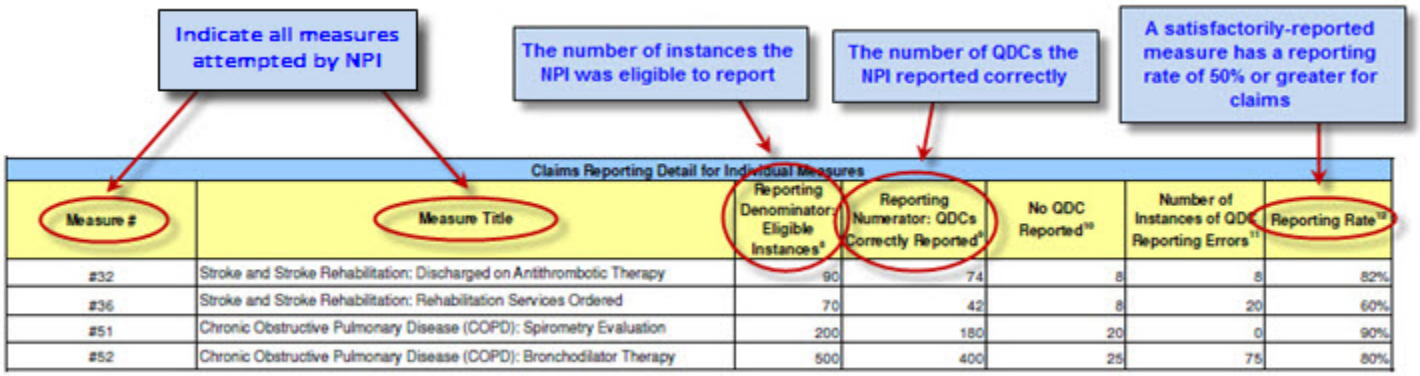


Reporting Detail Summary

Method of Reporting[1]	Incentive Eligible (Yes/No)[3]	Incentive Eligibility Rationale	Total # Measures Groups Reported	Total # Measures Reported[4]	Total # Measures Reported on Denominator Eligible Instances[5]	Total # Measures Satisfactorily Reported[6]
Individual measure(s) reporting via claims	Yes	Sufficient # of measures reported	N/A	4	4	3
Individual measure(s) reporting via electronic health records (Data Submission Vendor)	Yes	Sufficient # of measures reported	N/A	4	4	3
Individual measure(s) reporting via registry	No	Sufficient # of measures reported	N/A	5	5	2
Measures Groups - 20 beneficiaries via claims	Yes	Sufficient # of beneficiaries and measures groups reported	2	15	N/A	N/A
Measures Groups - 20 patients via registry	Yes	Sufficient # of patients and measures groups reported	2	15	N/A	N/A
Individual measure(s) reporting via EHR (Direct EHR)	Yes	Sufficient # of measures reported	N/A	9	9	9

Figure 1.3: Reporting Detail Summary

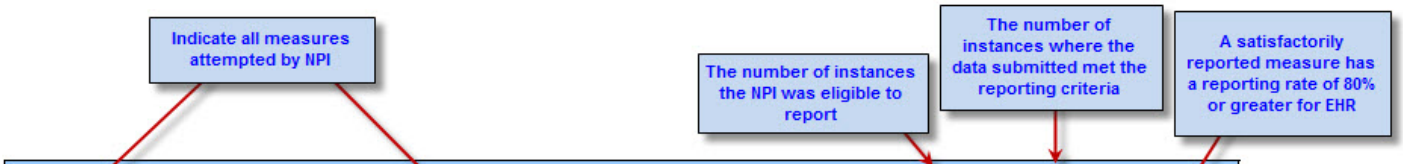
Examples TIN-Level Feedback Report: Table 2 (continued)



Claims Reporting Detail for Individual Measures

Measure #	Measure Title	Reporting Denominator: Eligible Instances[8]	Reporting Numerator: QDCs Correctly Reported[9]	No QDC Reported[10]	Number of Instances of QDC Reporting Errors[11]	Reporting Rate[12]
#32	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy	90	74	8	8	82%
#36	Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered	70	42	8	20	60%
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	200	180	20	0	90%
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	500	400	25	75	80%

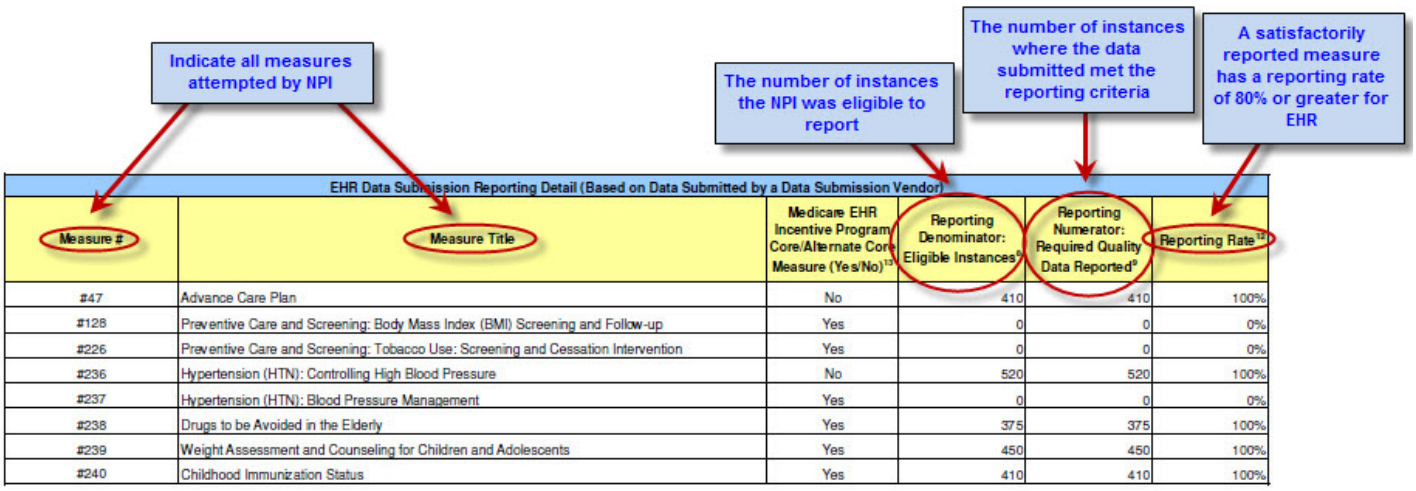
Figure 1.4: Claims Reporting Detail for Individual Measures



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

Measure #	Measure Title	Medicare EHR Incentive Program Core/Alternate Core Measure (Yes/No)[13]	Reporting Denominator: Eligible Instances[8]	Reporting Numerator: Required Quality Data Reported[9]	Reporting Rate[12]
#1	Diabetes Mellitus: Hemoglobin A1c Poor Control	No	410	410	100%
#111	Preventive Care and Screening: Pneumococcal Vaccination for Patients 65 Years and Older	No	375	375	100%
#113	Preventive Care and Screening: Colorectal Cancer Screening	No	520	520	100%

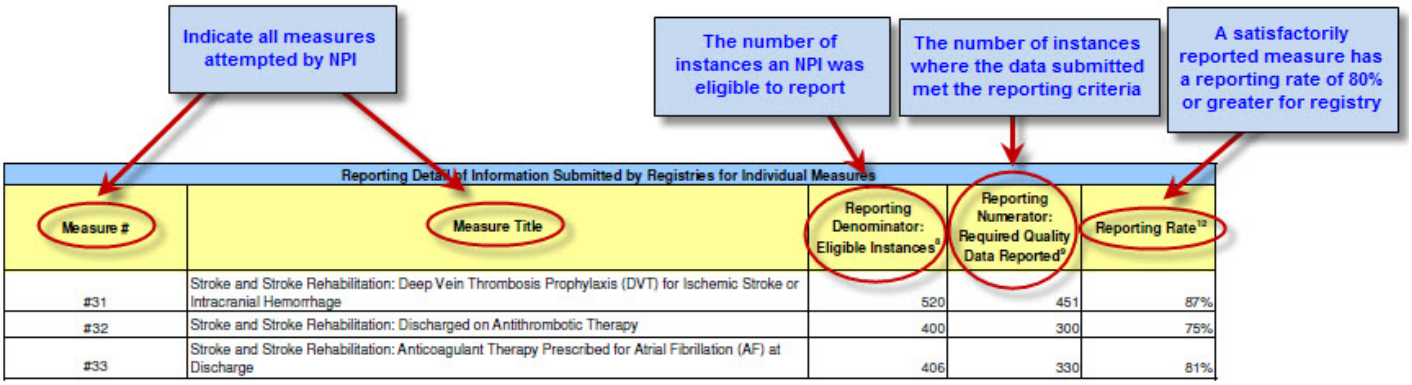
Figure 1.5: EHR Direct Submission Reporting Detail



EHR Data Submission Reporting Detail (Based on Data Submitted by a Data Submission Vendor)

Measure #	Measure Title	Medicare EHR Incentive Program Core/Alternate Core Measure (Yes/No)[13]	Reporting Denominator: Eligible Instances[9]	Reporting Numerator: Required Quality Data Reported[9]	Reporting Rate[12]
#47	Advance Care Plan	No	410	410	100%
#128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up	Yes	0	0	0%
#226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Yes	0	0	0%
#236	Hypertension (HTN): Controlling High Blood Pressure	No	520	520	100%
#237	Hypertension (HTN): Blood Pressure Management	Yes	0	0	0%
#238	Drugs to be Avoided in the Elderly	Yes	375	375	100%
#239	Weight Assessment and Counseling for Children and Adolescents	Yes	450	450	100%
#240	Childhood Immunization Status	Yes	410	410	100%

Figure 1.6: EHR Data Submission Vendor Submission Reporting Detail

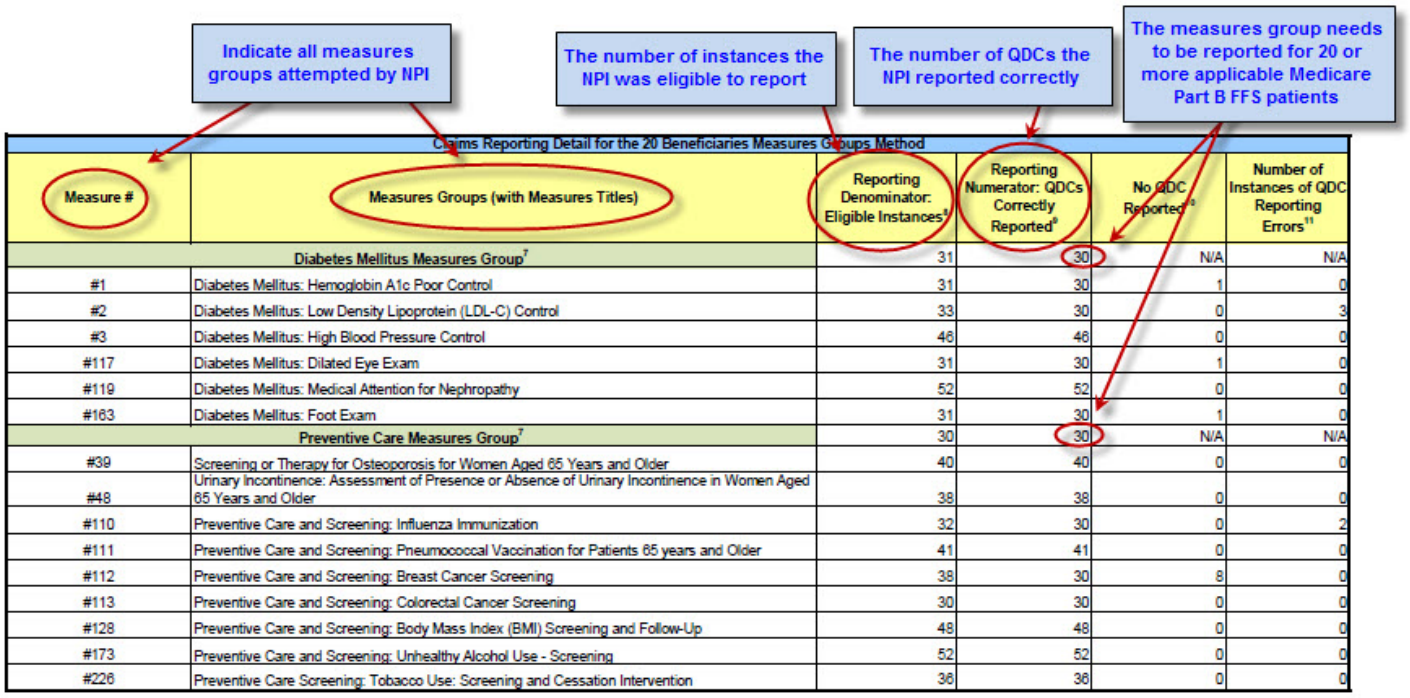


Reporting Detail of Information Submitted by Registries for Individual Measures

Measure #	Measure Title	Reporting Denominator: Eligible Instances[9]	Reporting Numerator: Required Quality Data Reported[9]	Reporting Rate[12]
#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 Antithrombotic Therapy	400	300	75%
#33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge	406	330	81%

Figure 1.7: Reporting Detail of Information Submitted by Registries for Individual Measures

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

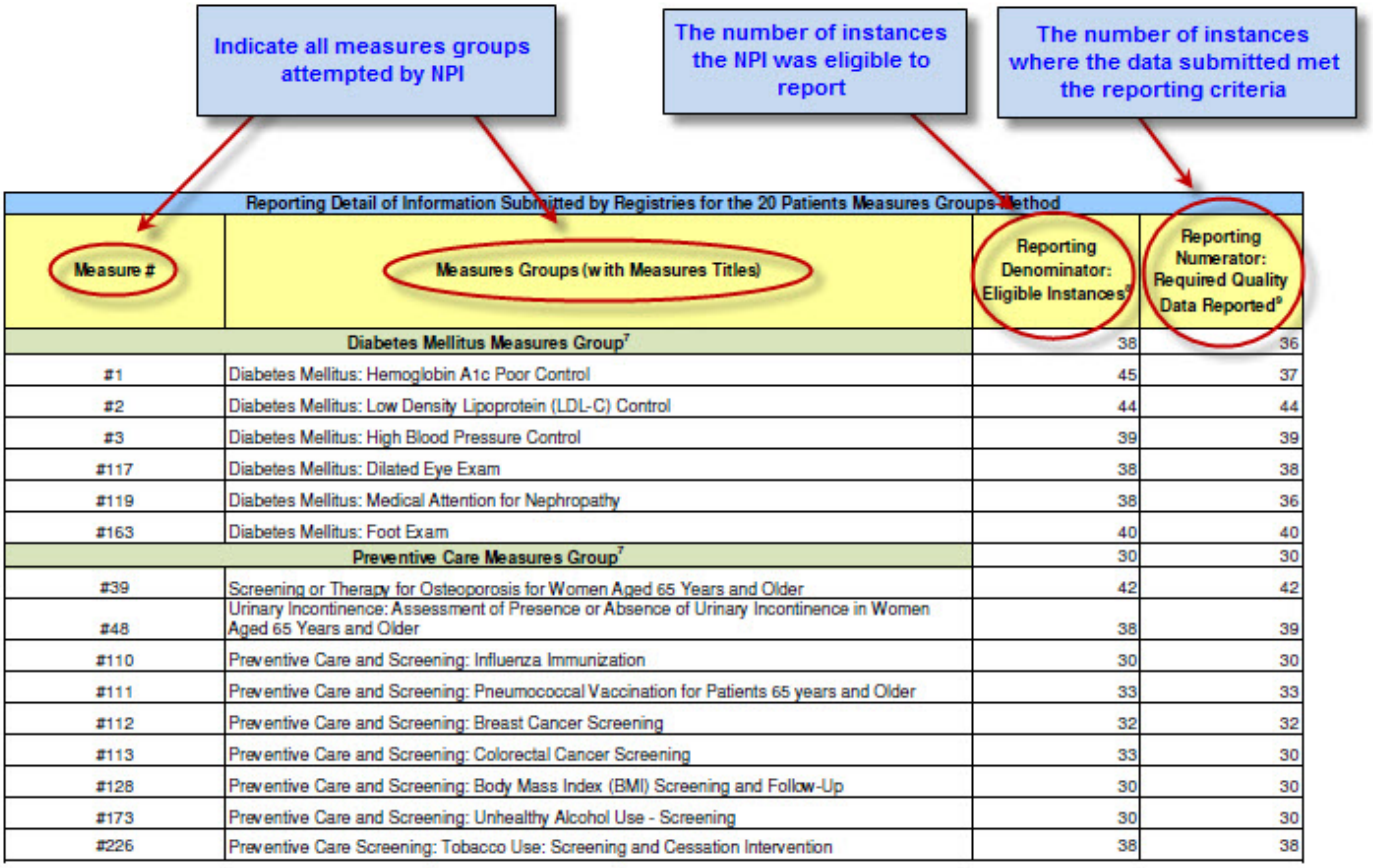


Claims Reporting Detail for the 20 Beneficiaries Measures Groups Method

Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[8]	Reporting Numerator: QDCs Correctly Reported[9]	No QDC Reported[10]	Number of Instances of QDC Reporting Errors[11]
	Diabetes Mellitus Measures Group[7]	31	30	N/A	N/A
#1	Diabetes Mellitus: Hemoglobin A1c Poor Control	31	30	1	0
#2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control	33	30	0	3
#3	Diabetes Mellitus: High Blood Pressure Control	46	46	0	0
#117	Diabetes Mellitus: Dilated Eye Exam	31	30	1	0
#119	Diabetes Mellitus: Medical Attention for Nephropathy	52	52	0	0
#163	Diabetes Mellitus: Foot Exam	31	30	1	0
	Preventive Care Measures Group[7]	30	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	32	30	0	2
#111	Preventive Care and Screening: Pneumococcal Vaccination for Patients 65 years and Older	41	41	0	0
#112	Preventive Care and Screening: Breast Cancer Screening	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	48	48	0	0
#173	Preventive Care and Screening: Unhealthy Alcohol Use - Screening	52	52	0	0
#226	Preventive Care Screening: Tobacco Use: Screening and Cessation Intervention	36	36	0	0

Figure 1.8: Claims Reporting Detail for Measures Groups 20 Beneficiary Method

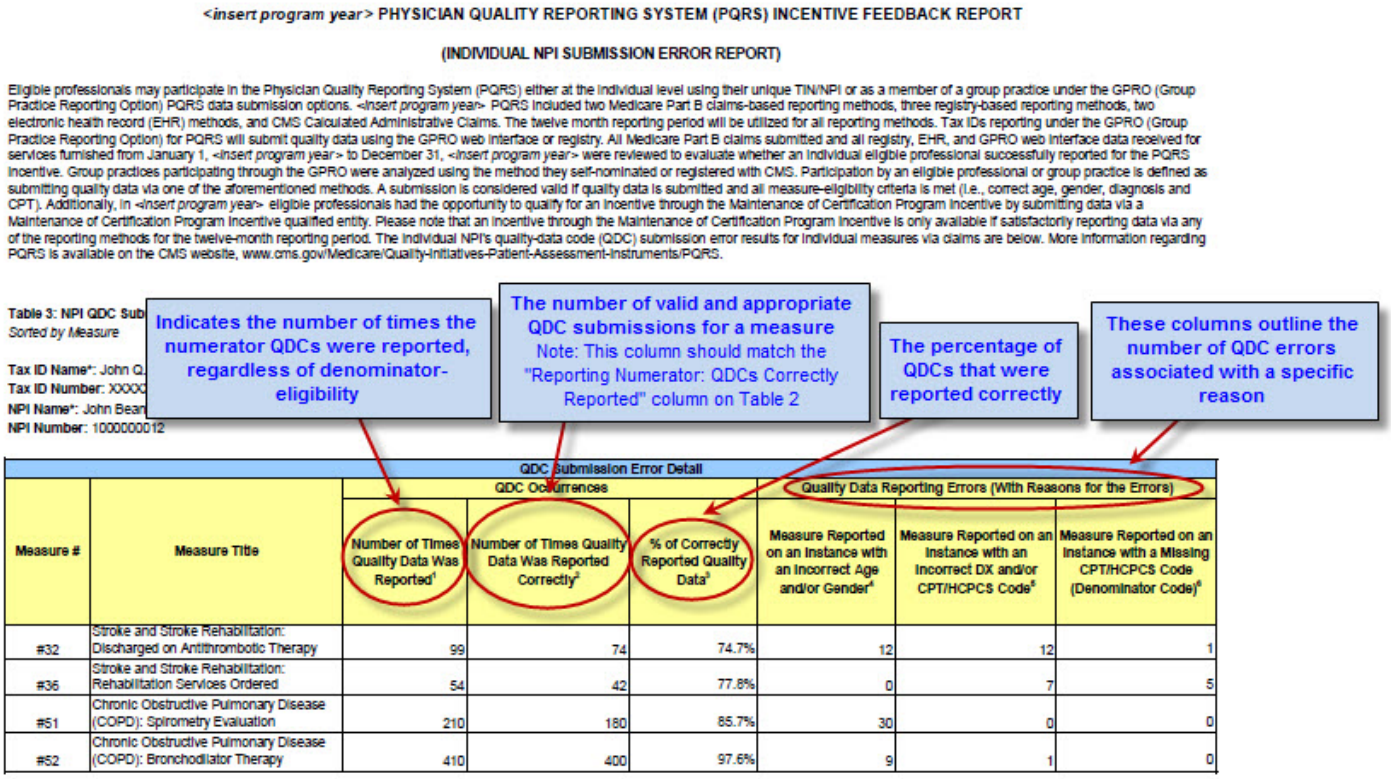
Example TIN-Level Feedback Report: Table 2 (continued)



Reporting Detail of Information Submitted by Registries for the 20 Patients Measures Groups Method			
Measure #	Measures Groups (with Measures Titles)	Reporting Denominator: Eligible Instances[8]	Reporting Numerator: Required Quality Data Reported[9]
Diabetes Mellitus Measures Group[7]		38	36
#1	Diabetes Mellitus: Hemoglobin A1c Poor Control	45	37
#2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control	44	44
#3	Diabetes Mellitus: High Blood Pressure Control	39	39
#117	Diabetes Mellitus: Dilated Eye Exam	38	38
#119	Diabetes Mellitus: Medical Attention for Nephropathy	38	36
#163	Diabetes Mellitus: Foot Exam	40	40
Preventive Care Measures Group[7]		30	30
#39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	42	42
#48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	38	39
#110	Preventive Care and Screening: Influenza Immunization	30	30
#111	Preventive Care and Screening: Pneumococcal Vaccination for Patients 65 years and Older	33	33
#112	Preventive Care and Screening: Breast Cancer Screening	32	32
#113	Preventive Care and Screening: Colorectal Cancer Screening	33	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 Screening: Tobacco Use: Screening and Cessation Intervention	38	38

Figure 1.9: Reporting Detail of Information Submitted by Registries for the 20 Patients Measures Groups Method

Example - TIN-Level Feedback Report: Table 3



<*insert program year*> PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) INCENTIVE FEEDBACK REPORT

(INDIVIDUAL NPI SUBMISSION ERROR REPORT)

Eligible professionals may participate in the Physician Quality Reporting System (PQRS) either at the individual level using their unique TIN/NPI or as a member of a group practice under the GPRO (Group Practice Reporting Option) PQRS data submission options. <*insert program year*> PQRS included two Medicare Part B claims-based reporting methods, three registry-based reporting methods, two electronic health record (EHR) methods, and CMS Calculated Administrative Claims. The twelve month reporting period will be utilized for all reporting methods. Tax IDs reporting under the GPRO (Group Practice Reporting Option) for PQRS will submit quality data using the GPRO web interface or registry. All Medicare Part B claims submitted and all registry, EHR, and GPRO web interface data received for services furnished from January 1, <*insert program year*> to December 31, <*insert program year*> were reviewed to evaluate whether an individual eligible professional successfully reported for the PQRS incentive. Group practices participating through the GPRO were analyzed using the method they self-nominated or registered with CMS. Participation by an eligible professional or group practice is defined as submitting quality data via one of the aforementioned methods. A submission is considered valid if quality data is submitted and all measure-eligibility criteria is met (i.e., correct age, gender, diagnosis and CPT). Additionally, in <*insert program year*> eligible professionals had the opportunity to qualify for an incentive through the Maintenance of Certification Program incentive by submitting data via a Maintenance of Certification Program incentive qualified entity. Please note that an incentive through the Maintenance of Certification Program incentive is only available if satisfactorily reporting data via any of the reporting methods for the twelve-month reporting period. The individual NPI's quality-data code (QDC) submission error results for individual measures via claims are below. More information regarding PQRS is available on the CMS website, www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Table 3: NPI QDC Sub
Sorted by Measure

Tax ID Name*: John Q.
Tax ID Number: XXXX
NPI Name*: John Bean
NPI Number: 1000000012

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

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

The percentage of QDCs that were reported correctly

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

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

Figure 1.12: NPI QDC Submission Error Detail

Note: This table does not determine incentive eligibility.

Example - TIN-Level Feedback Report: Table 4

<*insert program year*> PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) INCENTIVE FEEDBACK REPORT

(INDIVIDUAL NPI REPORT)

Eligible professionals may participate in the Physician Quality Reporting System (PQRS) either at the individual level using their unique TIN/NPI or as a member of a group practice under the GPRO (Group Practice Reporting Option) PQRS data submission options. <*Insert program year*> PQRS included two Medicare Part B claims-based reporting methods, three registry-based reporting methods, two electronic health record (EHR) methods, and CMS Calculated Administrative Claims. The twelve month reporting period will be utilized for all reporting methods. Tax IDs reporting under the GPRO (Group Practice Reporting Option) for PQRS will submit quality data using the GPRO web interface or registry. All Medicare Part B claims submitted and all registry, EHR, and GPRO web interface data received for services furnished from January 1, <*Insert program year*> to December 31, <*Insert program year*> were reviewed to evaluate whether an individual eligible professional successfully reported for the PQRS incentive. Group practices participating through the GPRO were analyzed using the method they self-nominated or registered with CMS. Participation by an eligible professional or group practice is defined as submitting quality data via one of the aforementioned methods. A submission is considered valid if quality data is submitted and all measure-eligibility criteria is met (i.e., correct age, gender, diagnosis and CPT). Additionally, in <*Insert program year*> eligible professionals had the opportunity to qualify for an incentive through the Maintenance of Certification Program Incentive by submitting data via a Maintenance of Certification Program Incentive qualified entity. Please note that an incentive through the Maintenance of Certification Program Incentive is only available if satisfactorily reporting data via any of the reporting methods for the twelve-month reporting period. The results below include a Performance Detail table listing all of the measures and measures groups reported by the individual NPIs with the performance rates. More information regarding PQRS is available on the CMS website, www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Table 4: NPI Performance Detail
Measures Groups Table(s) - Sorted by Measures Group and Sub-Sorted by Individual Measures Table(s) - Sorted by Measure #

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

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

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

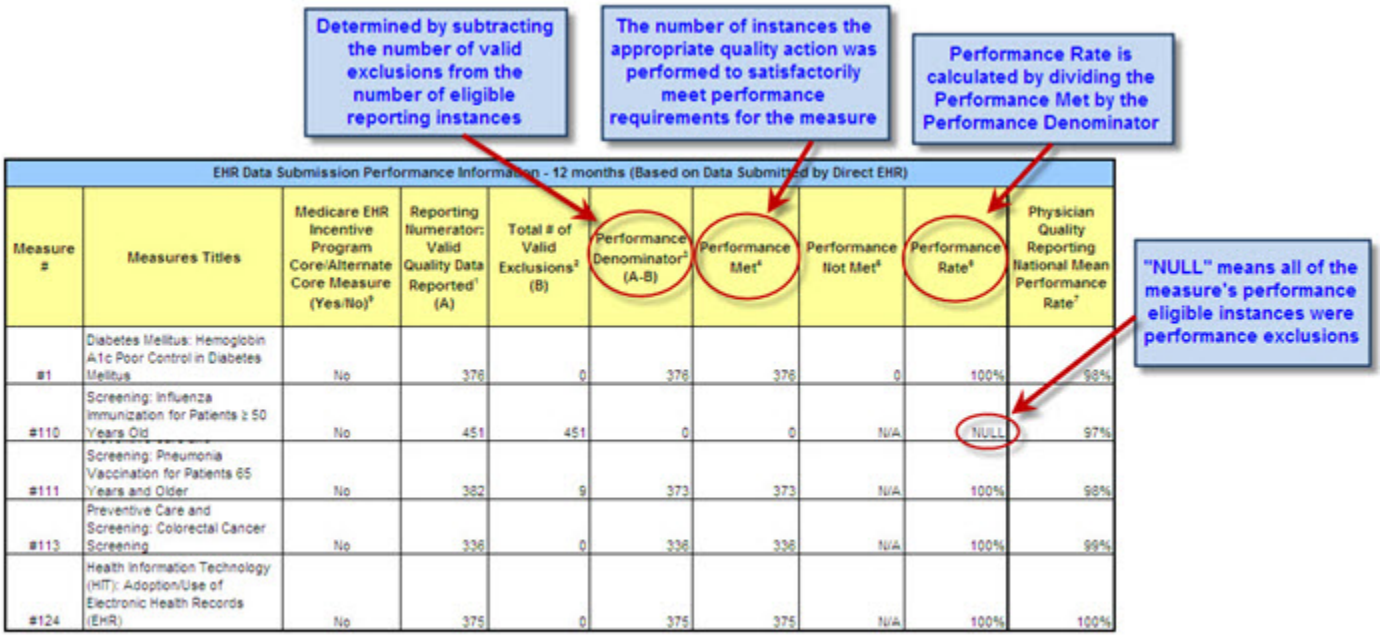
Includes performance information for all TIN/NPI combinations submitting at least one QDC for the measure

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

Claims Performance Information for Individual Measures								
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]	PQRS National Mean Performance Rate[7]
#32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	74	74	0	0	0	NULL	82%
#36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	42	10	32	18	14	56%	82%
#51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	180	80	100	80	20	80%	50%
#52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	400	25	375	175	200	47%	33%

Figure 1.13: Claims Performance Information for Individual Measures

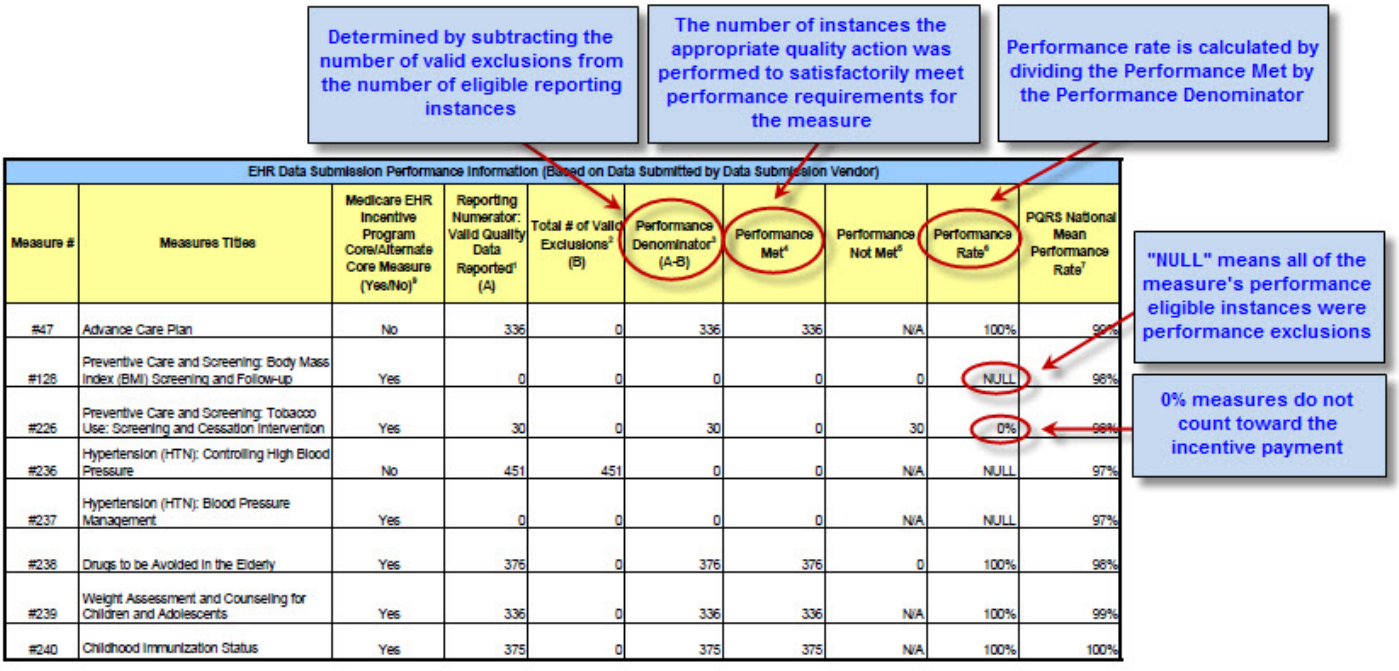
Example TIN-Level Feedback Report: Table 4 (continued)



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

Measure #	Measures Titles	Medicare EHR Incentive Program Core/Alternate Core Measure (Yes/No)[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]	Physician Quality Reporting National Mean Performance Rate[7]
#1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	No	376	0	376	376	0	100%	98%
#110	Screening: Influenza Immunization for Patients ≥ 50 Years Old	No	451	451	0	0	N/A	NULL	97%
#111	Screening: Pneumonia Vaccination for Patients 65 Years and Older	No	382	9	373	373	N/A	100%	98%
#113	Preventive Care and Screening: Colorectal Cancer Screening	No	336	0	336	336	N/A	100%	99%
#124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	No	375	0	375	375	N/A	100%	100%

Figure 1.14: EHR Direct Data Submission Performance Information

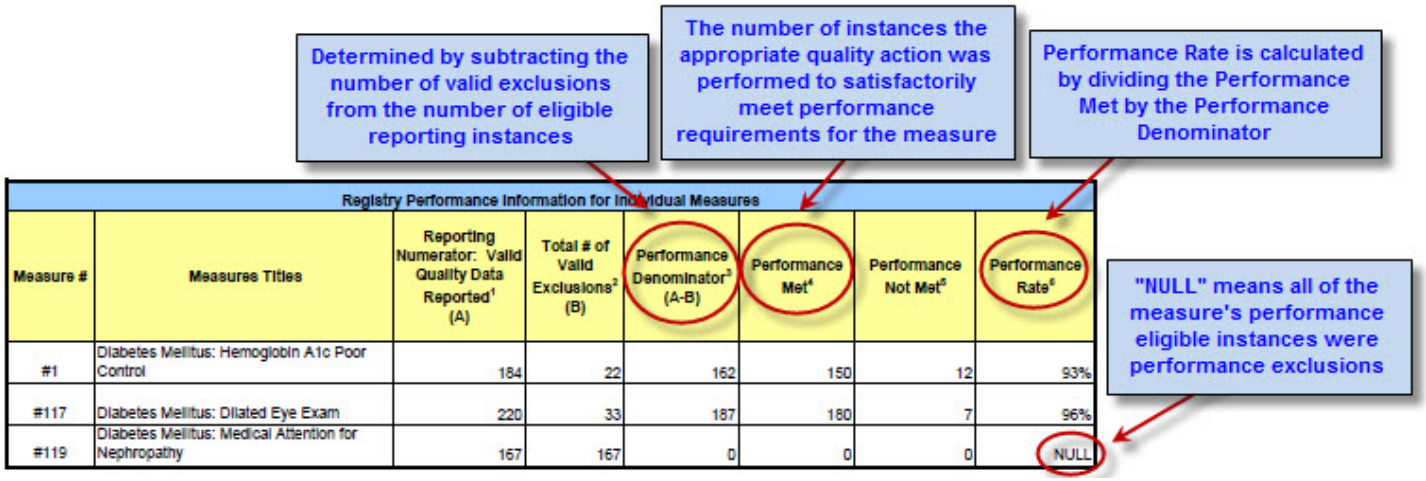


EHR Data Submission Performance Information (Based on Data Submitted by Data Submission Vendor)

Measure #	Measures Titles	Medicare EHR Incentive Program Core/Alternate Core Measure (Yes/No)[8]	Reporting Numerator: Valid Quality Data Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]	PQRS National Mean Performance Rate[7]
#47	Advance Care Plan	No	336	0	336	336	N/A	100%	99%
#128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up	Yes	0	0	0	0	0	NULL	96%
#226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Yes	30	0	30	0	30	0%	98%
#236	Hypertension (HTN): Controlling High Blood Pressure	No	451	451	0	0	N/A	NULL	97%
#237	Hypertension (HTN): Blood Pressure Management	Yes	0	0	0	0	N/A	NULL	97%
#238	Drugs to be Avoided in the Elderly	Yes	376	0	376	376	0	100%	96%
#239	Weight Assessment and Counseling for Children and Adolescents	Yes	336	0	336	336	N/A	100%	99%
#240	Childhood Immunization Status	Yes	375	0	375	375	N/A	100%	100%

Figure 1.15: EHR Data Submission Vendor Submission Performance Information

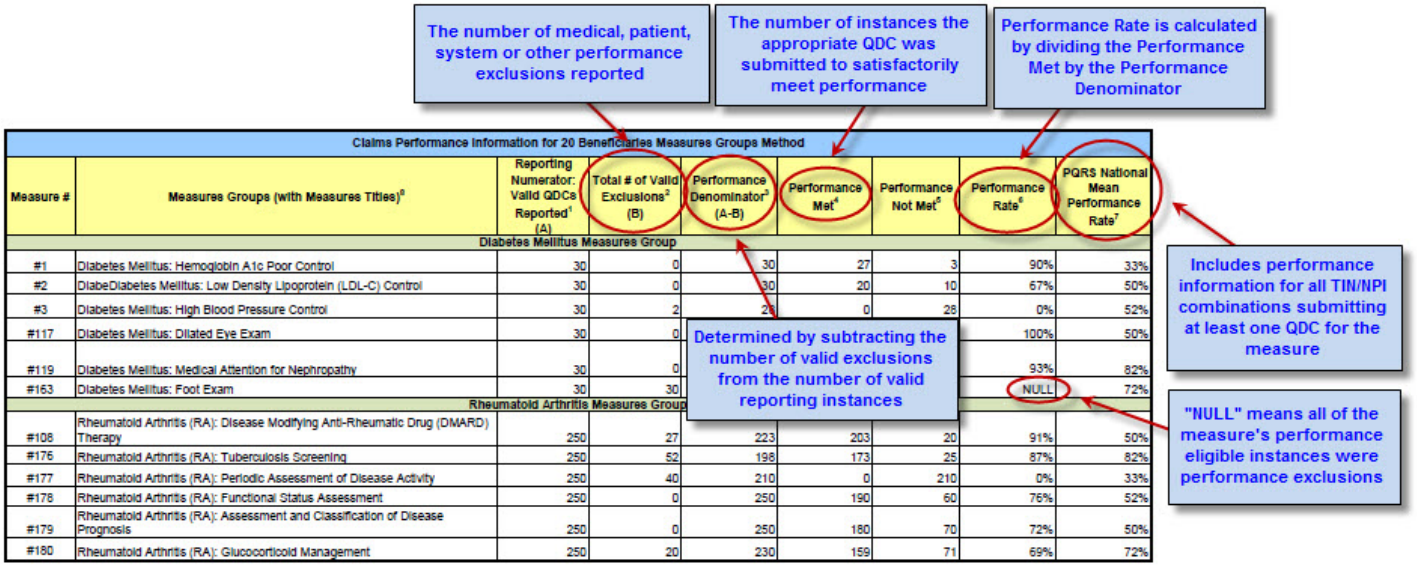
Example TIN-Level Feedback Report: Table 4 (continued)



Registry Performance Information for Individual Measures

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	Diabetes Mellitus: Hemoglobin A1c Poor Control	184	22	162	150	12	93%
#117	Diabetes Mellitus: Dilated Eye Exam	220	33	187	180	7	96%
#119	Diabetes Mellitus: Medical Attention for Nephropathy	167	167	0	0	0	NULL

Figure 1.16: Registry Performance Information for Individual Measures

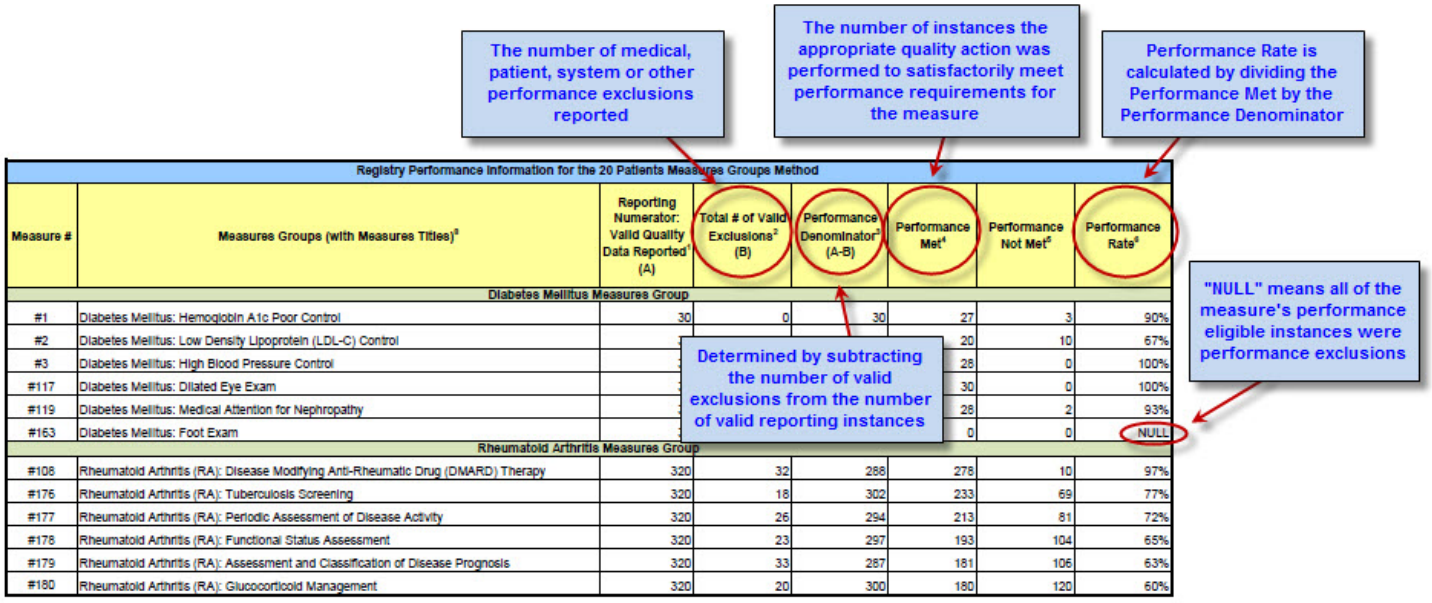


Claims Performance Information for 20 Beneficiaries Measures Groups Method

Measure #	Measures Groups (with Measures Titles)[8]	Reporting Numerator: Valid QDCs Reported[1] (A)	Total # of Valid Exclusions[2] (B)	Performance Denominator[3] (A-B)	Performance Met[4]	Performance Not Met[5]	Performance Rate[6]	PQRS National Mean Performance Rate[7]
	Diabetes Mellitus Measures Group							
#1	Diabetes Mellitus: Hemoglobin A1c Poor Control	30	0	30	27	3	90%	33%
#2	DiabeDiabetes Mellitus: Low Density Lipoprotein (LDL-C) Control	30	0	30	20	10	67%	50%
#3	Diabetes Mellitus: High Blood Pressure Control	30	2	28	0	28	0%	52%
#117	Diabetes Mellitus: Dilated Eye Exam	30	0	30	30	0	100%	50%
#119	Diabetes Mellitus: Medical Attention for Nephropathy	30	0	30	28	2	93%	82%
#163	Diabetes Mellitus: Foot Exam	30	30	0	0	0	NULL	72%
	Rheumatoid Arthritis Measures Group							
#108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	250	27	223	203	20	91%	50%
#176	Rheumatoid Arthritis (RA): Tuberculosis Screening	250	52	198	173	25	87%	82%
#177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	250	40	210	0	210	0%	33%
#178	Rheumatoid Arthritis (RA): Functional Status Assessment	250	0	250	190	60	76%	52%
#179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	250	0	250	180	70	72%	50%
#180	Rheumatoid Arthritis (RA): Glucocorticoid Management	250	20	230	159	71	69%	72%

Figure 1.17: Claims Performance Information for Measures Groups 20 Beneficiary Method

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



Registry Performance Information for the 20 Patients Measures Groups Method							
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]
Diabetes Mellitus Measures Group							
#1	Diabetes Mellitus: Hemoglobin A1c Poor Control	30	0	30	27	3	90%
#2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control				20	10	67%
#3	Diabetes Mellitus: High Blood Pressure Control				28	0	100%
#117	Diabetes Mellitus: Dilated Eye Exam				30	0	100%
#119	Diabetes Mellitus: Medical Attention for Nephropathy				28	2	93%
#163	Diabetes Mellitus: Foot Exam				0	0	NULL
Rheumatoid Arthritis Measures Group							
#108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	320	32	288	278	10	97%
#176	Rheumatoid Arthritis (RA): Tuberculosis Screening	320	18	302	233	69	77%
#177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	320	26	294	213	81	72%
#178	Rheumatoid Arthritis (RA): Functional Status Assessment	320	23	297	193	104	65%
#179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	320	33	287	181	106	63%
#180	Rheumatoid Arthritis (RA): Glucocorticoid Management	320	20	300	180	120	60%

Figure 1.18: Registry Performance Information for Measures Groups 20 Patient 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 (except for NPIs in group practices participating in GPRO). Although the incentive amount is listed separately in the *Feedback Report*, the incentive payment will be included in the lump-sum paid to the TIN.

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

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

Key Terms:

- **Maintenance of Certification Program Incentive Total Earned Incentive Amount:** The 0.5% incentive based on the total estimated allowed Medicare Part B PFS charges for services performed within the length of the reporting period for which a TIN/NPI was eligible. The additional 0.5% is awarded to those who satisfactorily reported in 2013 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 12 of this document for reference.

For definition of terms related to the 2013 Physician Quality Reporting System Feedback Report, see Appendix A. Also refer to the footnotes within each table for additional content detail.

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

Example - Maintenance of Certification Program Summary: Table 1

<insert program year> PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) INCENTIVE FEEDBACK REPORT

(MAINTENANCE OF CERTIFICATION PROGRAM INCENTIVE REPORT)

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

Table 1: Mainte
Sorted by NPI N

Tax ID Name*:
Tax ID Number

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

Total 0.5% incentive amount earned by each individual NPI

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

NPI	NPI Name*	Total Estimated Allowed Medicare Part B PFS Charges for the Reporting Period[1]	Maintenance of Certification Program Incentive Satisfactorily Reporting Participant (Yes/No)	Maintenance of Certification Program Incentive Total Earned Incentive Amount
1000000001	Tom Anderson	$80,000.00	Yes	$392.00
1000000002	Susie Smith	$100,000.00	No	N/A
1000000003	Not Available	$133,333.33	Yes	$653.33
1000000009	Steve Smithson	$125,000.00	No	N/A
1000000011	Allan Anderson	$125,000.00	No	N/A
1000000012	John Beans	$60,000.00	Yes	$294.00
1000000013	Not Available	$65,000.00	Yes	$318.50
1000000015	John Bender	$90,000.00	No	N/A
1000000016	Melissa Smith	$150,000.00	Yes	$735.00
1000000019	Not Available	$150,000.00	Yes	$735.00
			Total:	$3,127.83

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

Figure 2.1: Maintenance of Certification Program Incentive Summary

Accessing Feedback Reports

NPI-Level Reports
EPs 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 https://qualitynet.org/portal/server.pt/community/pqri_home/212 under the “Related Links” section in the upper left-hand corner of the window

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

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

The Portal is the secured entry point to access the 2013 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 a “PQRS Representative” role in order to access their 2013 feedback reports through the secure Portal. As shown in Figure 3.1, the *IACS Quick Reference Guides* provide step-by-step instructions to request an IACS account to access the Portal, if you do not already have one.

Downloadable *2013 Physician Quality Reporting System (PQRS) Feedback Reports* will be available as an Adobe® Acrobat® PDF in the fall of 2014 in the Portal. The report will also be available as a Microsoft® Excel or .csv file.

Assistance
Please see the *Portal User Guide* (https://qualitynet.org/portal/server.pt/community/pqri_home/212 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@hcqis.org. Hours of operation are Monday through Friday from 7:00 a.m. to 7:00 p.m. CST.

Note: *The* 2013 Physician Quality Reporting System Feedback Report *may contain a partial or “masked” Social Security Number/Social Security Account Number (SSN/SSAN) as part of the TIN field. Care should be taken in the handling and disposition of this report to protect the privacy of the individual practitioner with which the SSN/SSAN is potentially associated. Please ensure that these reports are handled appropriately and disposed of properly to avoid a potential Personally Identifiable Information (PII) exposure or Identity Theft risk.*

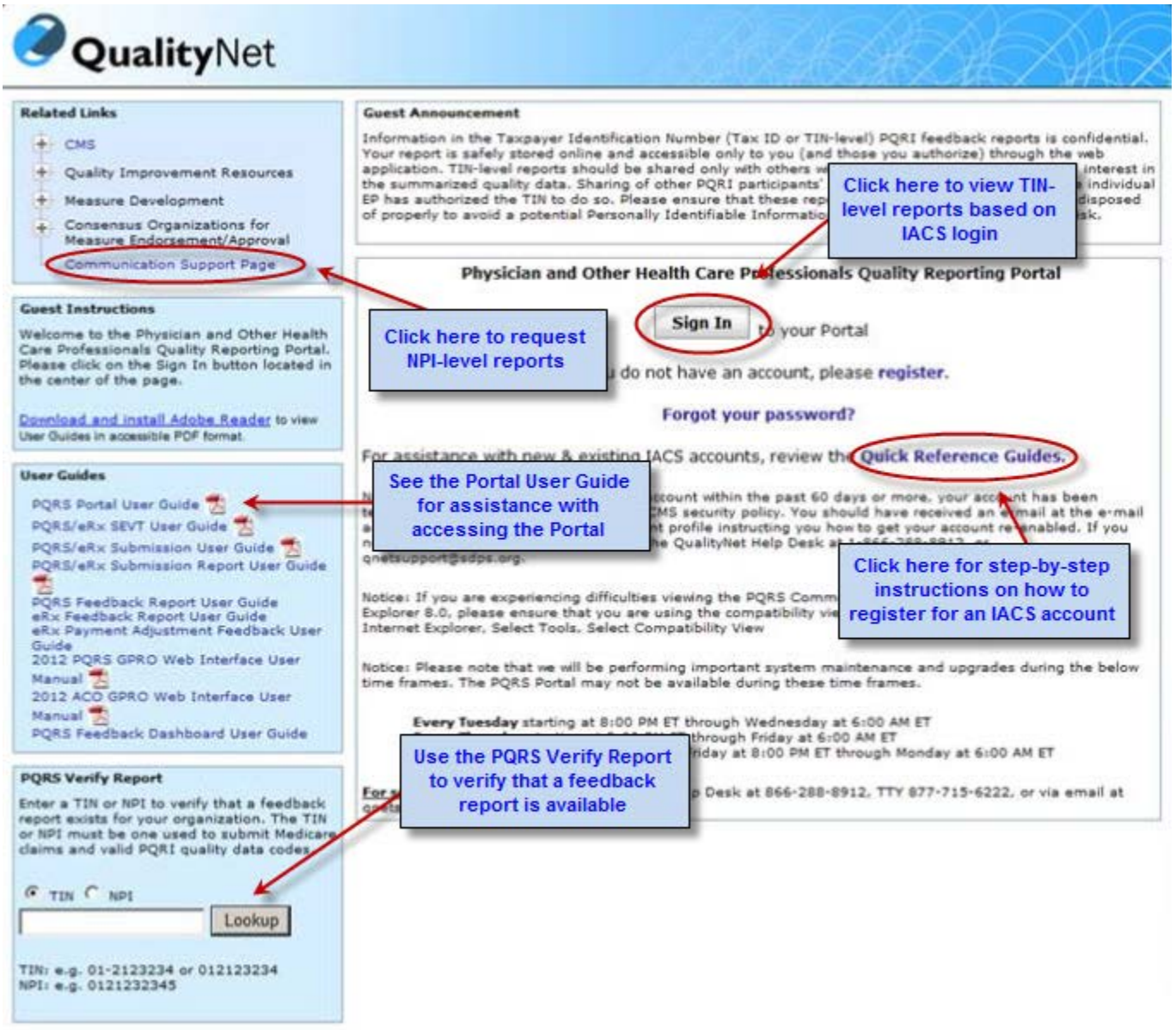


Figure 3.1 Screenshot of Physician and Other Health Care Professionals Quality Reporting Portal

Key Facts about PQRS Incentive Eligibility and Amount Calculation

Measure-Applicability Validation (MAV) and Incentive Eligibility

As required by the Tax Relief and Health Care Act of 2006 (TRHCA), 2013 PQRS included a validation process to ensure that each EP satisfactorily reported the minimum number of measures. EPs 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 group practices who participated via GPRO. For more information, refer to PQRS FAQs and the 2013 MAV documents on the CMS PQRS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Lump-Sum Incentive Payment

Payment Calculations

- The 0.5% incentive is based on CMS' estimate of all Medicare Part B PFS allowed charges for covered professional services: (1) furnished during the applicable 2013 reporting period, (2) processed by the Carrier or A/B Medicare Administrative Contractor (MAC) no later than February 28, 2014, 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 group practice eligible for the incentive is defined as a TIN who met the PQRS criteria for successful reporting through the GPRO for the 2013 PQRS program year.
- The analysis of satisfactory reporting will be performed at the individual TIN/NPI level to identify each individual EP's services and quality data. The analysis of successful reporting among EPs under group practices participating in GPRO will be performed at the TIN level to identify the group's services and quality data.
    - Incentive payments earned by individual EPs will be issued to the TIN under which he or she earned an incentive, based on the Medicare Part B PFS covered professional services claims submitted under the TIN, aggregating individual EPs' incentives to the TIN level.
    - For EPs who submit claims under multiple TINs, CMS 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 2013 PQRS program pages on the CMS website (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS), including the *Guide for Understanding 2013 Physician Quality Reporting System Incentive Payment*.
- If reporting for PQRS through another CMS program (such as the Medicare Shared Savings Program, Comprehensive Primary Care Initiative, Pioneer Accountable Care Organizations), please check the program's requirements for information on how to report quality data to earn a PQRS incentive and/or avoid the PQRS payment adjustment. Please note, although CMS has attempted to align or adopt similar reporting requirements across programs, eligible professionals should look to the respective quality program to ensure they satisfy the PQRS, EHR Incentive Program, Value-Based Payment Modifier (VBM), etc. requirements of each of these programs.

Distribution

- 2013 PQRS payments are scheduled to be issued to the TIN by the Carrier or A/B MAC in the fall of 2014 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 2013 PQRS and the 2013 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 2013 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 2013 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 (PQ13) 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.
- 2013 PQRS feedback reports are scheduled to be available in the fall of 2014.
- PQRS feedback report availability is not based on whether or not an incentive payment was earned. Feedback reports will be available for every TIN under which at least one eligible professional (identified by his or her NPI submitting Medicare Part B PFS claims) reported at least one PQRS measure a minimum of once during the reporting period.
- Feedback reports for multiple years will now be accessible via the Portal.
- If **all** of the 2013 PQRS QDCs submitted by individual EPs via claims are not denominator-eligible events for the 2013 measure, Tables 2 and 4 of the individual EP'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 EPs reporting as individuals, an individual NPI will be indicated in the feedback report as incentive eligible, but the incentive payment is determined to be zero dollars. This happens when CMS cannot find any Medicare Part B PFS allowed charges for covered professional services billed under that individual's TIN/NPI combination during the reporting period. It is important to make sure you are submitting the correct TIN/NPI number when submitting data for calculation via Registry. For EHR data submission, be sure to enter the correct TIN and NPI in the proper fields within the QRDA file. The correct TIN is the one under which the professional submitted Medicare Part B claims during 2013. The correct NPI is the professional's Individual or rendering NPI.
- The 2013 Quality and Resource Use Report (QRUR) will be available for solo practitioners and groups in late summer 2014. More information about the 2013 QRURs and how to access these reports will be made available through the Physician Feedback/Value Modifier website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html.
- The 2013 QRUR will not be available for those who participated in the Medicare Shared Savings Program (MSSP), the Pioneer Accountable Care Organization (ACO) Model, or the Comprehensive Primary Care (CPC) initiative in 2013.

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://get.adobe.com/reader/?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 Microsoft® 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 PQRS 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@hcqis.org (Monday-Friday 7:00 a.m.-7:00 p.m. CT). You may also contact them for **PQRS assistance, including accessing the Portal**.
- Contact your Carrier or A/B MAC with general payment questions. The Provider Contact Center Toll-Free Numbers Directory offers information on how to contact the appropriate provider contact center and is available for download at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNGenInfo/01_Overview.asp.

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Appendix A: 2013 PQRS Feedback Report Definitions

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

Term	Definition
Carrier or A/B MAC Identification #	Carrier and/or A/B MAC number to which the TIN bills their claims.
Tax ID Earned Incentive Amount Under Carrier or A/B MAC	The total incentive amount earned by NPIs within the Tax ID (TIN) billing to each carrier. More information regarding incentive calculations can be found on the CMS website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.
Tax ID Name	Legal business name associated with a Taxpayer Identification Number (TIN). Eligible professional's name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization's or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2013 PQRS incentive payment, only the system's ability to populate this field in the report.
Tax ID Number	The masked TIN, whether individual or corporate TIN, Employer Identification Number, or individual professional's Social Security Number.
Total Estimated Allowed Medicare Part B PFS Charges	The total estimated amount of Medicare Part B Physician Fee Schedule (PFS) allowed charges associated with services rendered during the reporting period. The PFS claims included were based on the twelve month reporting period for the method by which the NPI was incentive eligible.
TIN Total Earned Incentive Amount	The 0.5% incentive based on the total estimated Medicare Part B PFS allowed charges for services performed within the length of the reporting period for which a Tax ID was eligible. If N/A, the Tax ID was not eligible to receive an incentive. If applicable, the total incentive amount will include an additional 0.5% incentive based upon eligible professionals within the Tax ID meeting the requirements for the Maintenance of Certification Program Incentive.
Physician Quality Reporting NPI Total Earned Incentive Amount	The amount of the incentive is based on the total estimated allowed Medicare Part B PFS charges for services performed within the length of the reporting period for which a TIN/NPI was eligible. If N/A, the NPI was not eligible to receive an incentive.
Maintenance of Certification Total Earned Incentive Amount (Maintenance of Certification Only)	The 0.5% incentive based on the total estimated allowed Medicare Part B PFS charges for services performed within the length of the reporting period for which a TIN/NPI was eligible. The additional 0.5% is awarded to those who satisfactorily reported in 2013 PQRS *and* reported in the Maintenance of Certification Program.
Method of Reporting	The method of reporting attempted by the NPI. For those NPIs participating in PQRS by multiple reporting methods, the most advantageous method is displayed. For the EHR submission method, there are two submission options: 1) a qualified data submission vendor, which obtains its data from an eligible professional's EHR system, and 2) direct EHR submission, which represents submitting data directly from his or her qualified EHR system.
NPI	National Provider Identifier of the eligible professional billing under the TIN.
NPI Name	Eligible professional's name identified by matching the identifier number in the CMS national Provider Enrollment Chain and Ownership System (PECOS) database. If the organization's or professional's enrollment record or enrollment changes have not been processed and established in the national PECOS database as well as at the local Carrier or A/B MAC systems at the time this report was produced, this is indicated by "Not Available". This does not affect the organization's or professional's enrollment status or eligibility for a 2013 PQRS incentive payment, only the system's ability to populate this field in the report.

Term	Definition
NPI Total Earned Incentive Amount	The 0.5% incentive based on the total estimated Medicare Part B PFS allowed charges for services performed within the length of the reporting period for which an NPI was eligible within the Tax ID. If N/A, the NPI was not eligible to receive an incentive. If applicable, the total incentive amount will include an additional 0.5% incentive based upon the eligible professional meeting the requirements for the Maintenance of Certification Program Incentive.
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 measures reported o Insufficient # of patients and/or measures groups reported o Insufficient # of beneficiaries and/or measures groups reported o Reporting mechanism not available for incentive o Unsuccessful Pioneer ACO participant o Unsuccessful CPC participant **Eligible** o Sufficient # of measures reported o Sufficient # of patients and measures groups reported o Sufficient # of beneficiaries and measures groups reported o Successful CPC participant o Successful Pioneer ACO participant More information regarding incentive calculations can be found on the CMS website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.
Reporting Period	The 12-month time period for which an eligible professional can submit quality data for 2013 PQRS. o 12-month (January 1 – December 31, 2013)

Table 2: NPI Reporting Detail

Term	Definition
Incentive Eligible for the Reporting Method	"Yes" if satisfactorily met reporting criteria for the method of data submission and "No" if did not satisfactorily meet reporting criteria.
Reporting Method/Period Selected for Incentive Payment	The method/period of reporting deemed most advantageous will be indicated with a "Yes". If the NPI did not qualify for incentive through any reporting methods/periods, the reporting method/period that was most advantageous would be populated with "N/A". If an eligible professional is incentive eligible utilizing more than one Physician Quality Reporting System reporting method, the methods considered for incentive eligibility will be indicated according to the following hierarchy: o EHR - Direct Submission - Medicare EHR Incentive Program o EHR - Direct Submission - PQRS o EHR - Data Submission Vendor - Medicare EHR Incentive Program o EHR - Data Submission Vendor - PQRS o 20 Patient Measures Groups Registry o 20 Beneficiary Measures Groups Claims o Individual Measures Registry o Individual Measures Claims
Total # Measures Reported	The number of measures where quality-data codes (QDCs) or quality action data are submitted, but are not necessarily valid. These instances do not necessarily count towards reporting success.
Total # Measures Reported on Denominator-Eligible Instances	The number of measures for which the TIN/NPI reported a valid quality-data code (QDC) or quality action data. o **Quality-Data Code:** Specified CPT Category II codes with or without modifiers (and G-codes where CPT II codes are not yet available) used for submission of PQRS data. CMS *Physician Quality Reporting System Quality Measures Specifications* document contains all codes associated with each measure and instructions for data submission through the claims system. This document can be found on the CMS 2013 PQRS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.
Total # Measures Satisfactorily Reported	The total number of measures the TIN/NPI reported at a satisfactory rate.
Reporting Numerator: QDCs Correctly Reported or Required Quality Data Reported	The number of eligible instances for which the TIN/NPI reported a valid quality-data code (QDC) or quality action data.
No QDC Reported	The number of instances where reporting was not met due to no quality-data code (QDC) information/numerator coding existing for the measure from the TIN/NPI combination. For Measures Groups reporting, this column will be populated with "N/A" for the Measures Group Title line.
Number of Instances of QDC Reporting Errors	The number of instances where reporting was not met due to insufficient quality-data code (QDC) information/numerator coding not complete for the measure from the TIN/NPI combination (e.g. two numerator codes are necessary for the measure, only one was submitted; inappropriate CPT II modifier submitted for the measure). For Measures Groups reporting, this column will be populated with "N/A" for the Measures Group Title line.
Reporting Rate	A satisfactorily reported measure has a reporting rate of 50% or greater for claims and 80% or greater for registry and EHR.
Medicare EHR Incentive Program Core/Alternate Core Measure (EHR reporting options only)	Indicates measure is one of the three Core or three Alternate Core Measures for the Medicare EHR Incentive Program.

Table 3: NPI QDC Submission Error Detail

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

Table 4: NPI Performance Detail

Term	Definition
Reporting Numerator: Valid QDCs or Quality Data Reported	Number of valid quality-data code (QDC) submissions for a measure.
Total Number of Valid Exclusions	The number of medical, patient, system or other performance exclusions reported. • **Medical 1P:** For each measure, the number (#) of instances the TIN/NPI submitted modifier 1P. • **Patient 2P:** For each measure, the number (#) of instances the TIN/NPI submitted modifier 2P. • **System 3P:** For each measure, the number (#) of instances the TIN/NPI submitted modifier 3P. **Other:** Includes instances where a CPT II code, G-code, or 8P modifier is used as a performance exclusion for the measure.
Performance Denominator	The Performance Denominator is determined by subtracting the number of eligible instance excluded from the numerator eligible reporting instances. Valid reasons for exclusions may apply and are specific to each measure.
Performance Met	The number of instances the TIN/NPI submitted the appropriate QDC or quality action data satisfactorily meeting the performance requirements for the measure.
Performance Not Met	Includes instances where an 8P modifier, G-code, or CPT II code is used to indicate the quality action was not provided for a reason not given or otherwise specified.
Performance Rate	The Performance Rate is calculated by dividing the Performance Met by the Performance Denominator. If "NULL", all of the measure's performance eligible instances were performance exclusions.
National Mean Performance Rate	The national mean performance rate includes performance information for all TIN/NPI combinations submitting at least one quality-data code (QDC) for the measure.
Medicare EHR Incentive Program Core/Alternate Core Measure (EHR reporting options only)	Indicates measure is one of the three Core or three Alternate Core Measures for the Medicare EHR Incentive Program.