



Measurement Year 2009 – Administrative Rules

1. The PIQ program scoring method is based on data capture from medical and pharmacy claims with dates of service falling within the time frame of October 1, 2008 through September 30, 2009. There is a 31 day margin or “look-back” on the latter side of this time frame to allow for late claims that may affect a physician’s score.
2. Data capture will allow for 2 months worth of claims “run-out” after the measurement period.
3. Physicians must be a network provider with (MHP) Memorial Health Partners for a minimum of 6 months during the measurement year and must be enrolled in the MHP network on 12/31/2009.
4. Scores are based on processed claims for the applicable measurement period and incorporate data from employer sites such as labs performed for annual screenings at employee health for Gulfstream and Memorial Health.
5. Patients measured by PIQ include members covered by Gulfstream, Memorial Health, or Savannah College of Art and Design health insurance.
6. Physicians must have more than 10 patients (as defined in #5) in their direct care and management during the measurement year to be qualified for this program.
7. In the event that a physician does not have a minimum of 3 patients for a specific metric, the measurement is eliminated from the overall scoring and the remaining applicable measurements are re-proportioned with appropriate weight.
8. Primary Care/Family Practice/Internal Medicine Physicians must meet 4 of the qualifying measurements to be considered for scoring. OB/GYN Physicians must be eligible in the categories of breast cancer screening and cervical cancer screening to be considered for scoring.
9. Patients without eligibility at the end of a measurement period shall be considered excluded.
10. Due to the difficulty in obtaining Medicare data, patients who are 65 and over will be excluded. If a patient is 64 years old at the beginning of a measurement year and turns 65 during that year, they will be excluded.
11. Patients are aligned with a physician based on the following criteria (*modified 5/8/09*):
 - a. Two or more visits or
 - b. Two or more prescriptions or
 - c. Please note that hospital visits are excluded. Prescriptions given at the time of a hospital visit and filled within 5 days of the visit are also excluded.
12. If a patient is linked to a physician via rule 11 above, but the physician states that patient is no longer his/her patient then proof is required. A certified dismissal letter or dismissal letter requiring signature on delivery is acceptable. Office visits or prescriptions will not be considered “linking” events if these visits or prescriptions are within 45 days of the signed dismissal letter.

13. The following algorithm determines what is counted as one prescription and what is counted as more than one prescription.
 - a. Counts as one prescription:
 - One prescription with no refills
 - Two or more different drugs prescribed on the same date with no refills
 - b. Counts as more than one prescription:
 - One prescription with any refills
 - One drug prescribed on two or more dates
14. A member is identified as diabetic by having a diagnosis code of diabetes on two or more medical and/or pharmacy claims with different dates of services. *(modified 5/8/09)*
15. A physician cannot be linked to himself or herself. Therefore, a physician should never appear on his or her own patient list.
16. Scores are calculated based on the total number of actual points achieved, divided by the total number of points possible for that physician.
17. Scoring for the mammogram metric will be based on the following algorithm (subject to change):
 - a. 0% to 75% mammograms completed = $(\% \text{ of mammograms completed divided by } 75\%) \times \text{total possible points}$.
 - b. 76% to 100% mammograms completed = All points awarded.
18. Draft scorecards are issued for the measurement year, and physicians are given 30 calendar days to respond with any questions or requests for detailed data. Final scores for physicians are determined on or after April 1st of the year following the measurement period. *(modified 8/21/09)*
19. To obtain DQP (Distinguished Quality Physician) status, an overall minimum final score must be obtained by the physician. The minimum score for DQP status is determined each year by the PIQ Steering Committee. *(modified 8/21/09)*
20. Awards consist of certificate recognition and bonus payment from participating employers. Payment is calculated based on 20% of the allowable amount for that physician's billed E&Ms (evaluation and management CPTs 99201-99205 and 99211-99215) for the measurement time frame. The award cost to each employer is based on the actual processed claims by that employer. This 20% is in addition to previously issued claim payments, and is based on the applicable negotiated fee schedule for evaluation and management services. Bonus checks are paid on or after April 1, 2010 and before December 31, 2010. *(modified 8/21/09)*