National Provider Call:

Physician Quality Reporting System (PQRS)
and
Electronic Prescribing (eRx) Incentive Program

March 19, 2013

Medicare Learning Network

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Official CMS Information for Medicare Fee-For-Service Providers

Agenda

- CMS Updates/Announcements
- Presentation: Claims-Based Reporting Made Simple
  - 2013 Claims-Based Reporting: The Process and Coding
  - How to Report – Using the CMS-1500 (or electronic equivalent)
  - Helpful Hints
  - Resources
- Question and Answer Session

Introduction to

2013 CLAIMS-BASED REPORTING

Advantages of Claims-Based Reporting

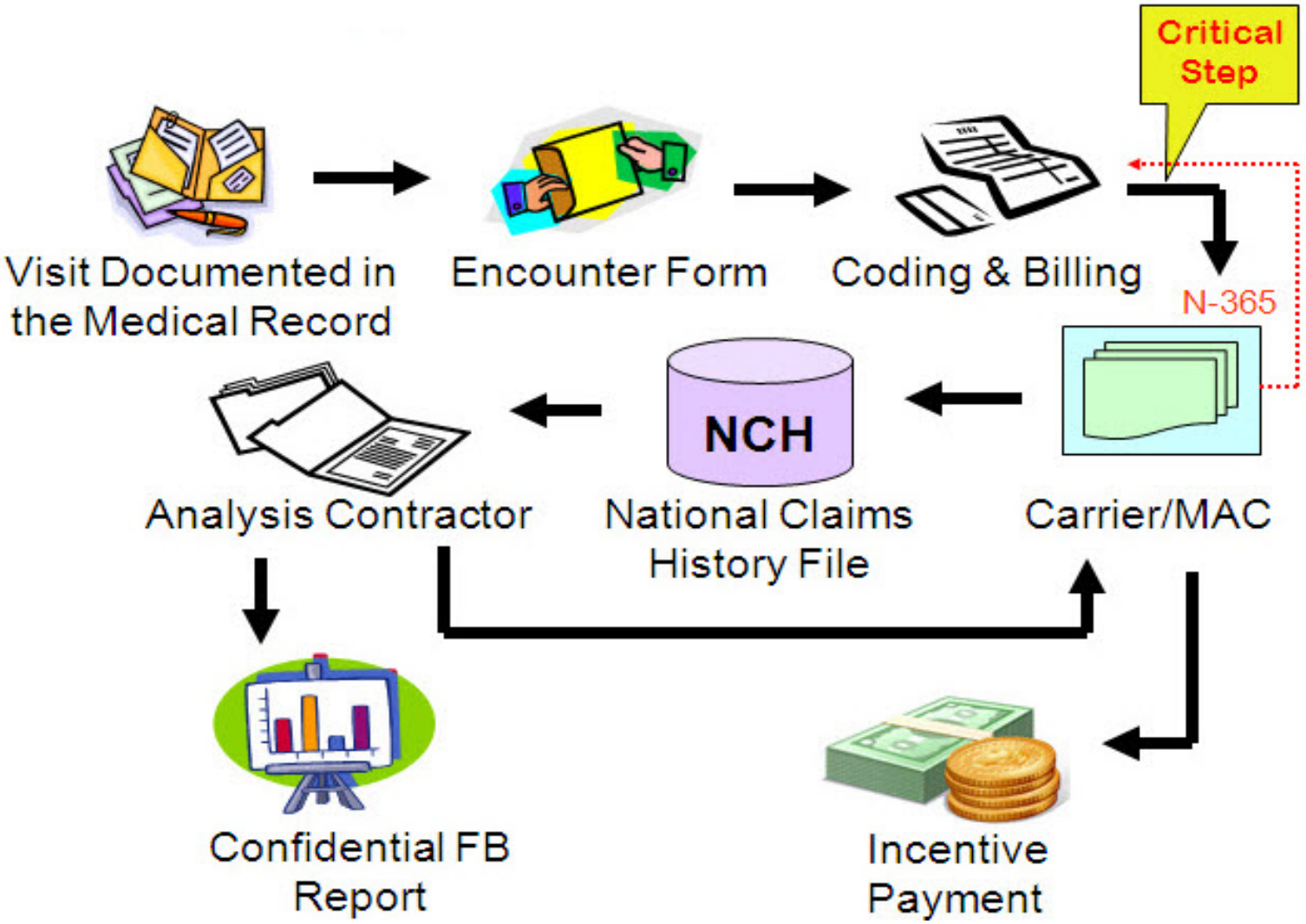
Benefits include:

- Readily accessible to all eligible professionals as it is a part of routine billing processes
- No need to contact Registry or qualified EHR vendor for submission of data
- Simple to select measures and begin reporting (add respective Quality-Data Code [QDC] to claim)

Claims-Based Reporting of Quality Data

- Medicare providers submit claims via CMS-1500 (or electronic equivalent) for reimbursement on billable services rendered to Part B beneficiaries
- Eligible professionals use their individual/rendering **National Provider Identifier (NPI)** to submit for services on Medicare Part B beneficiaries
- Claims follow a process so the information gets to the CMS National Claims History File (NCH)
- Standardized codes are found within each PQRS measure specification and within the eRx Incentive Program measure specification
  - *Be sure to reference the most current program measure specifications and supporting documents as posted on the CMS program websites*

Claims-Based Process



2013 Reporting Periods

PQRS:

- 12-month (January 1–December 31, 2013) to earn the 2013 PQRS incentive payment and avoid the 2015 PQRS payment adjustment

eRx:

- 12-month period (January 1-December 31, 2013) to earn the 2013 eRx incentive payment
  - Report the required number of denominator-eligible visits
- 6-month (January 1-June 30, 2013) to avoid 2014 payment adjustment only
  - Report on each **payable** Medicare Part B service; claims-based reporting is the only option for the 6-month eRx reporting period

Reporting Frequency

Earning the 2013 PQRS Incentive Using Claims:

- Report QDC(s) once per patient, per NPI/TIN combo per reporting period – **patient-level**
- Report QDC(s) once for each **procedure** performed
- Report QDC(s) for each acute **episode**
- Report QDC(s) for each **visit**

Avoiding the 2015 PQRS Payment Adjustment Using Claims:

- Report QDC(s) as outlined above (if avoiding 2015 payment adjustment by earning 2013 incentive)
- Report 1 valid measure or measures group on a denominator-eligible patient via claims once during the reporting period (avoids payment adjustment only)

Earning the 2013 eRx Incentive Using Claims:

- Report QDC for each denominator-eligible visit

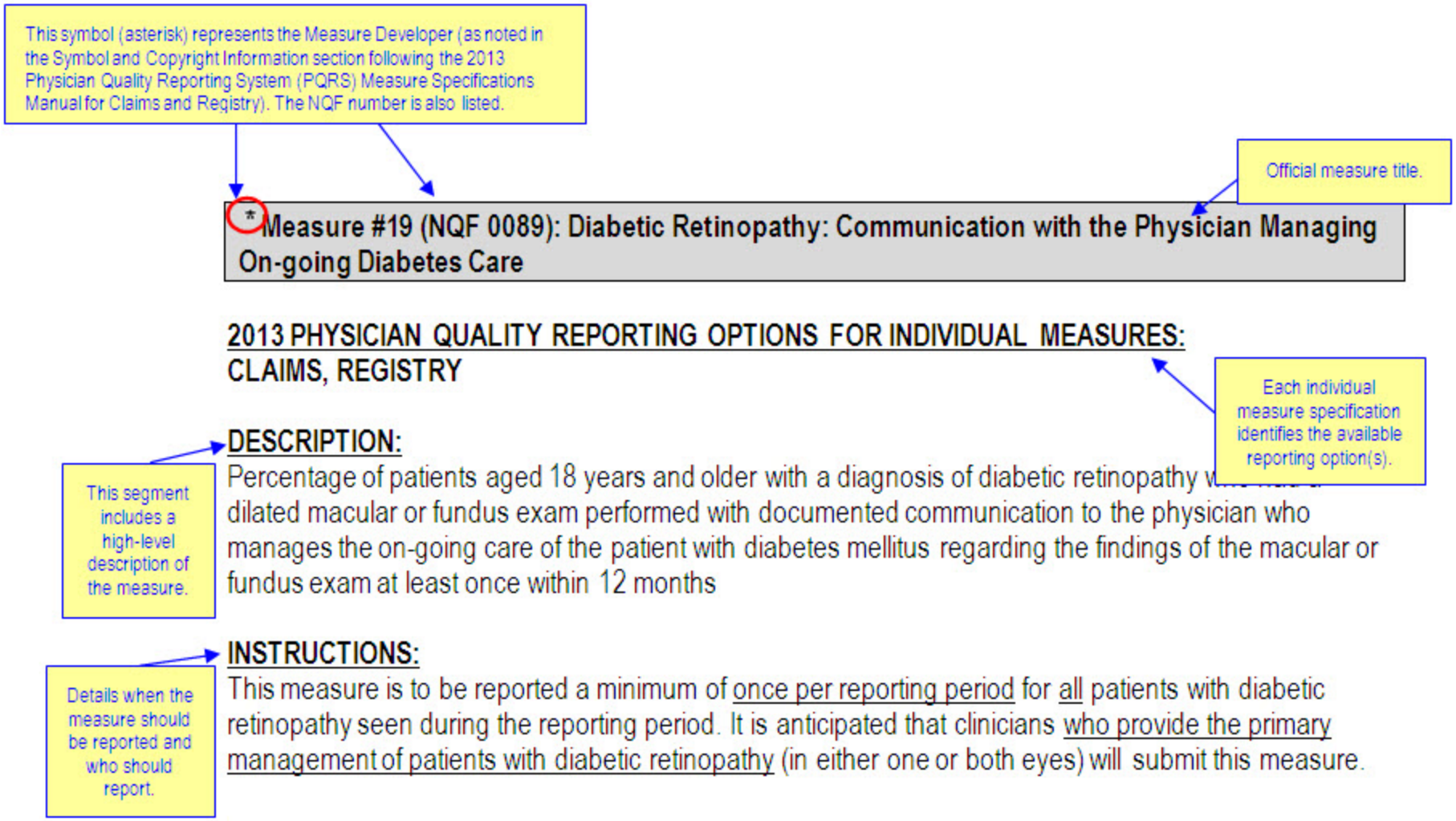
Avoiding the 2014 eRx Payment Adjustment Using Claims:

- Report QDC for each visit

PQRS and eRx Incentive Program

SAMPLE SPECIFICATION

Sample Claims/Registry Specification



Sample Claims/Registry Specification (cont.)

Measure #19 can be reported via claims and registry.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **AND/OR** G-code **OR** the CPT Category II code **with** the modifier **AND** G-code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

To ensure satisfactory reporting, submit all measure-specific coding for the beneficiary on the claim(s) representing the eligible encounter. If criteria are met, claims may be reconnected based on TIN/NPI/Beneficiary/Date of Service.

Refer to PQRS measure specification #33 to view a registry only specification.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

Sample Claims/Registry Specification (cont.)

Review patient demographics, DX, and encounter codes to determine if the patient meets denominator criteria.

Review other PQRS measures for which the patient meets denominator inclusion.

Enter the correct combination of codes on the claim.

Denominator statement describes the population evaluated by the performance measure.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for diabetic retinopathy (ICD-9-CM): 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

Patient population that may be counted as eligible to meet a measure's inclusion requirements.

Identified by ICD-9-CM, CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc), and place of service (if applicable).

ICD-10-CM codes are included in the 2013 *PQRS Measure Specifications* for reference purposes only. These codes can not be used for 2013 reporting purposes.

Diagnosis for diabetic retinopathy (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359

AND

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Sample Claims/Registry Specification (cont.)

A clinical action counted as meeting the measure's requirements (i.e., patients who received the particular service or obtained a particular outcome that is being measured).

NUMERATOR:

Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

Measures may or may not contain definitions.

Definition:

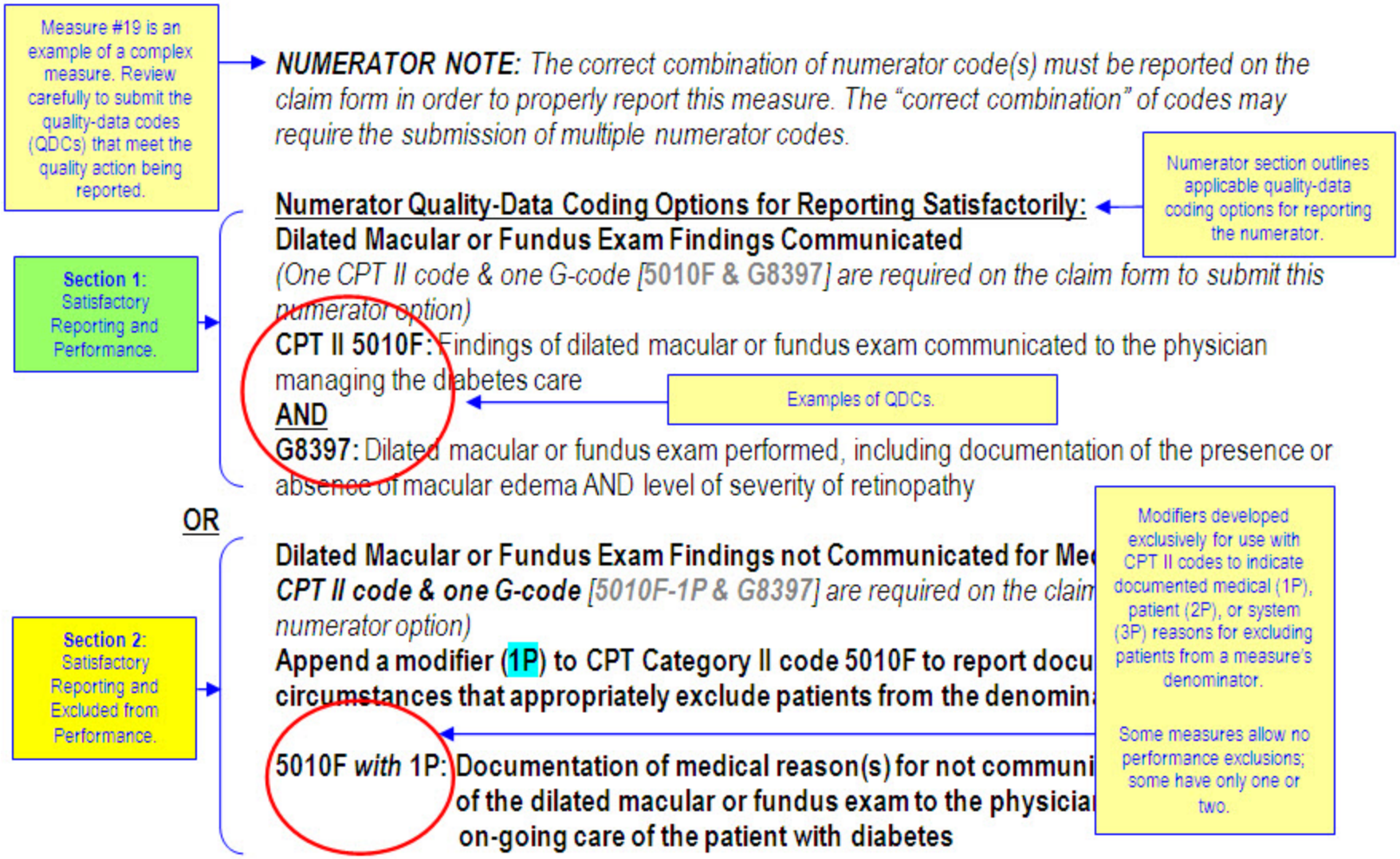
Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

Findings – Includes level of severity of retinopathy AND the presence or absence of macular edema

Measure #19 is an example of a complex measure. Review carefully to submit the quality-data codes (QDCs) that meet the quality action being reported.

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Sample Claims/Registry Specification (cont.)



Sample Claims/Registry Specification (cont.)

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

Measure #19 has two performance exclusion sections.

Section 2: Satisfactory Reporting and Excluded from Performance.

Dilated Macular or Fundus Exam Findings not Communicated for Patient Reasons

(One CPT II code & one G-code [5010F-2P & G8397] are required on the claim form to submit this numerator option)

Append a modifier (**2P**) to CPT Category II code **5010F** to report documented circumstances that appropriately exclude patients from the denominator.

5010F *with* 2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the on-going care of the patient with diabetes

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

If patient is not eligible for this measure because patient did not have dilated macular or fundus exam performed, report:

(One G-code [G8398] is required on the claim form to submit this numerator option)

G8398: Dilated macular or fundus exam not performed

Sample Claims/Registry Specification (cont.)

Section 3: Satisfactory Reporting and Performance Not Met.

Dilated Macular or Fundus Exam Findings not Communicated, Reason not Specified

(One CPT II code & one G-code [5010F-8P & G8397] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **5010F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

5010F *with* 8P: Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results.

Questions or comments regarding how the measure is constructed or suggestions for changes to a measure should be submitted to the measure's developer/owner.

RATIONALE:

The physician that manages the on-going care of the patient with diabetes should be aware of the patient's dilated eye examination and severity of retinopathy to manage the on-going diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease. (Diabetes Control and Complications Trial – DCCT, UK Prospective Diabetes Study – UKPDS)

Sample Claims/Registry Specification (cont.)

Summary of clinical recommendations based on best practices.

CLINICAL RECOMMENDATION STATEMENTS:

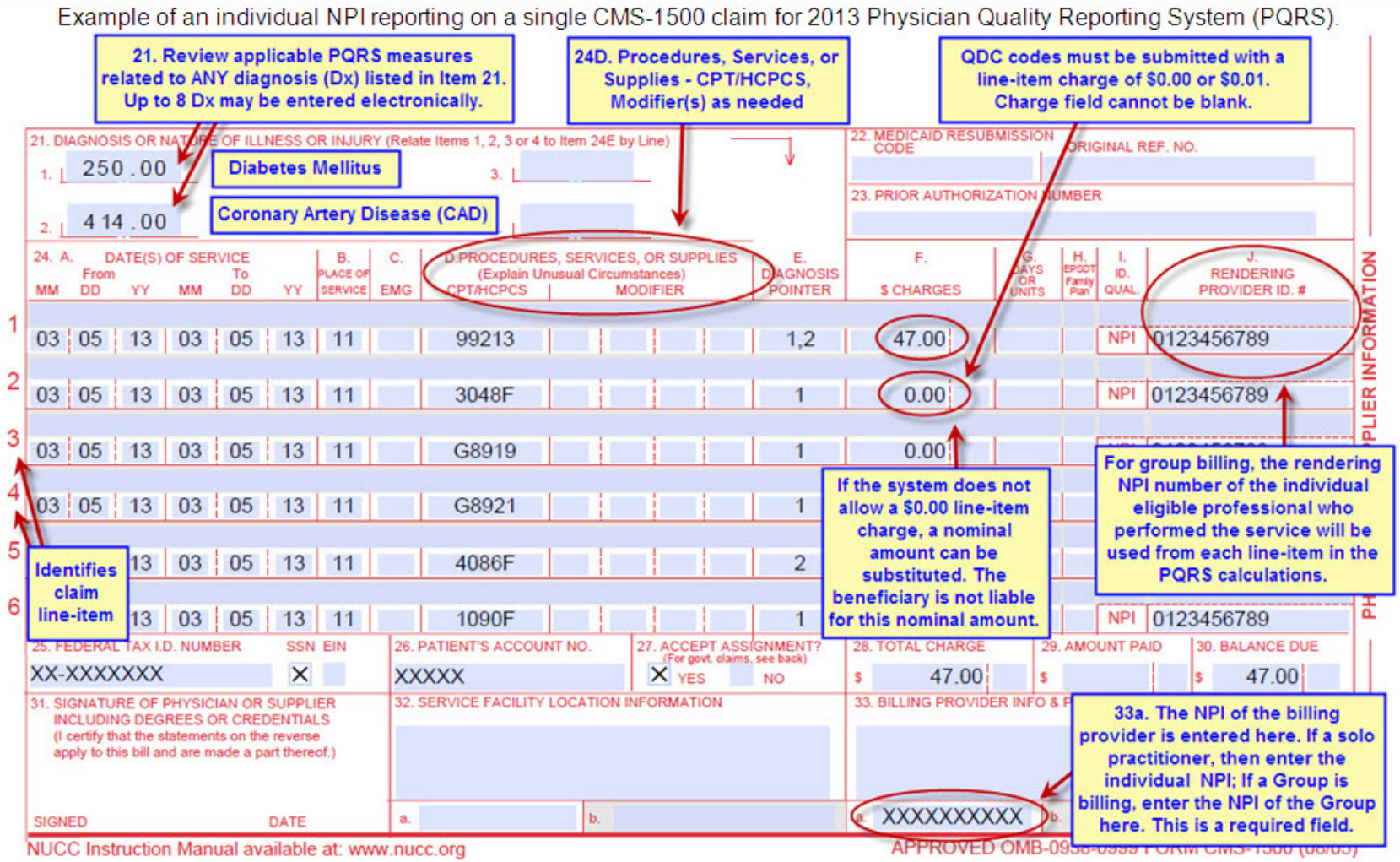
While it is clearly the responsibility of the ophthalmologist to manage eye disease, it is also the ophthalmologist's responsibility to ensure that patients with diabetes are referred for appropriate management of their systemic condition. It is the realm of the patient's family physician, internist or endocrinologist to manage the systemic diabetes. The ophthalmologist should communicate with the attending physician. (Level A: III Recommendation) (AAO, 2003)

Although the ophthalmologist will perform most of the examination and all surgery, certain aspects of data collection may be conducted by other trained individuals under the ophthalmologist's supervision and review. Because of the complexities of the diagnosis and surgery for PDR, the ophthalmologist caring for patients with this condition should be familiar with the specific recommendations of the DRS, ETDRS, UKPDS, and DCCT/EDIC (see Appendices 3 and 5).[A:III] The ophthalmologist should also have training in and experience with the management of this particular condition.[A:III] (AAO, 2008)

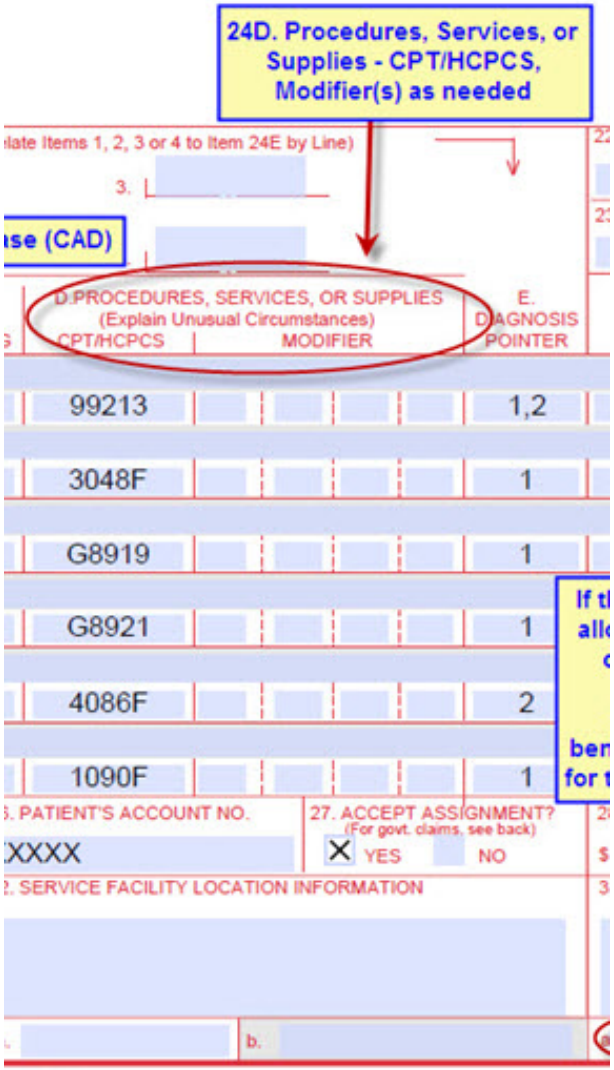
PQRS and eRx Incentive Program

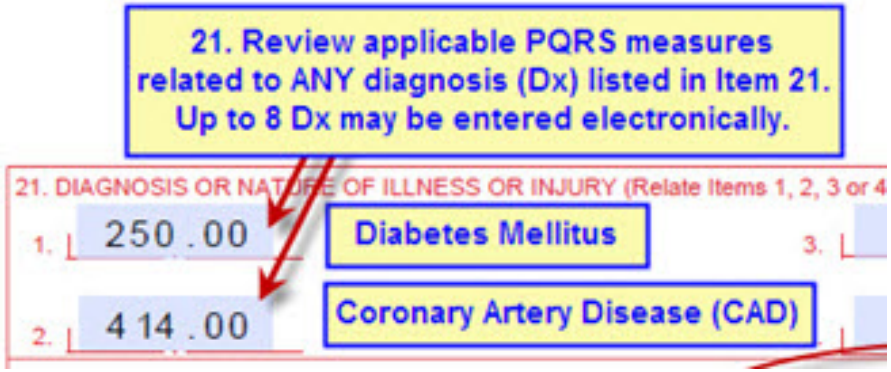
SAMPLE CMS-1500 FORM

PQRS:
Sample CMS-1500 Form

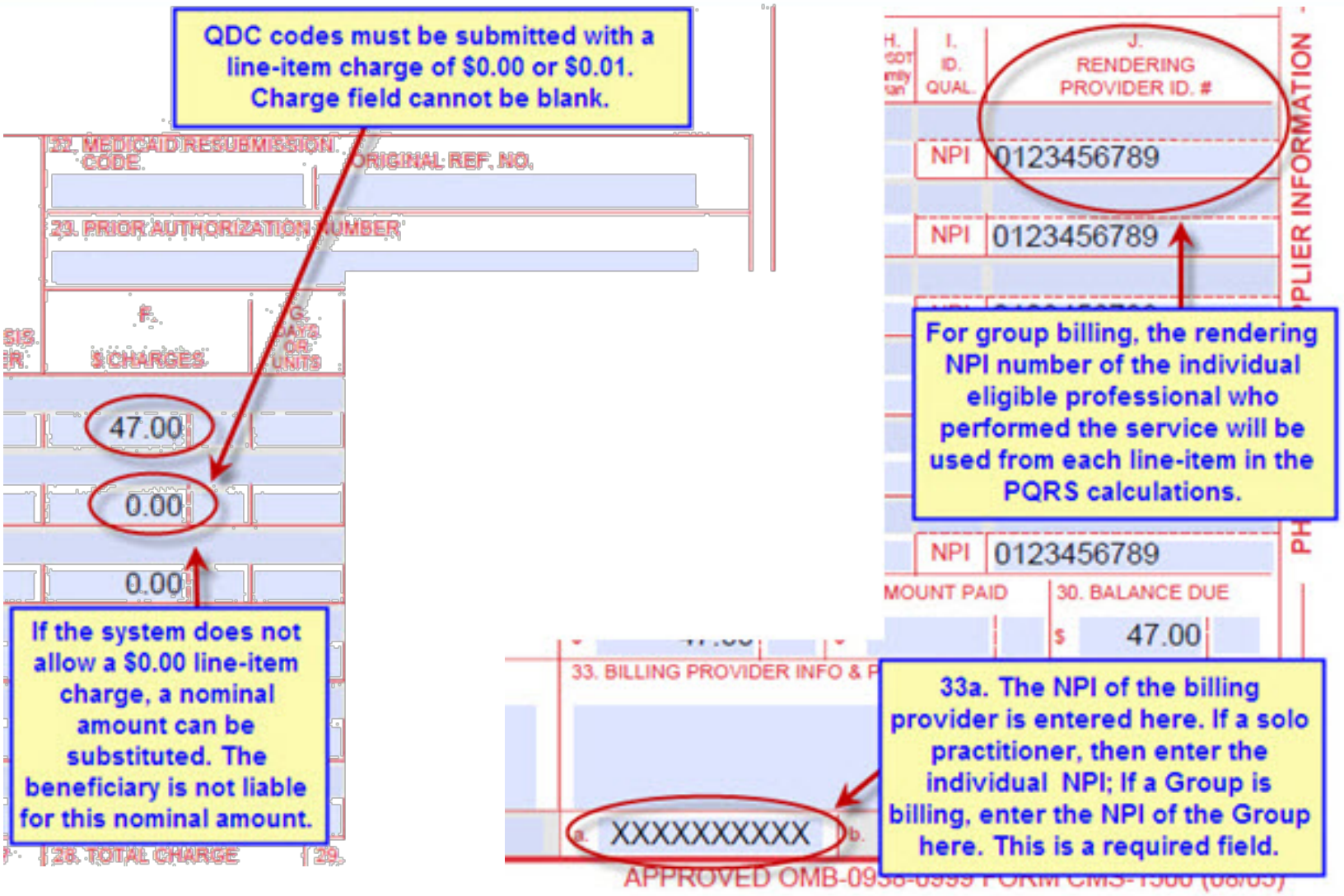


Sample CMS-1500 Form
(cont.)



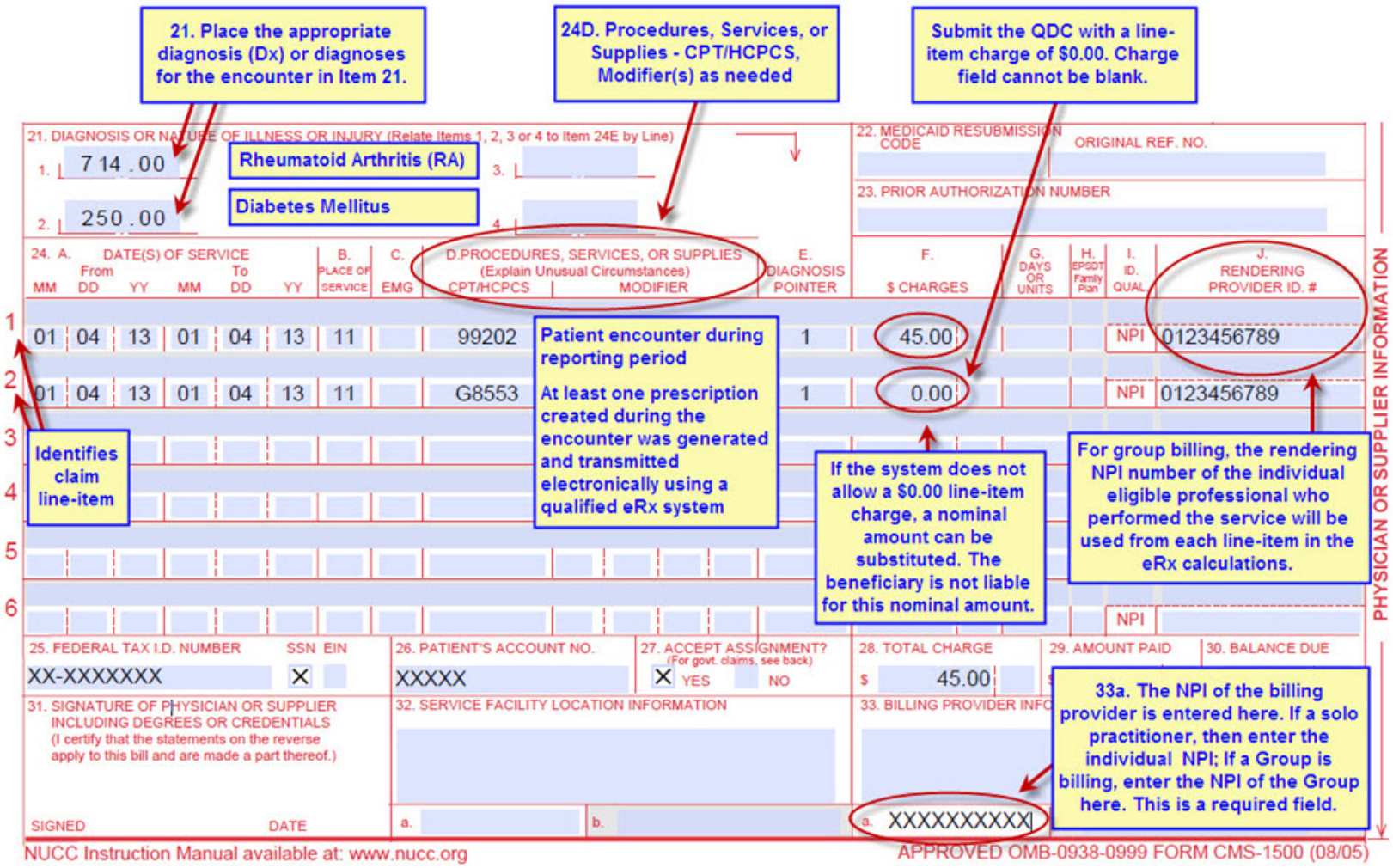


Sample CMS-1500 Form
(cont.)



eRx:
Sample CMS-1500 Form

A detailed sample of an individual NPI reporting the 2013 Electronic Prescribing (eRx) measure on a CMS-1500 claim is shown below.



How to Start Reporting Via Claims

- There is no registration required, simply start reporting the QDCs listed in the measures you have selected on applicable Medicare Part B claims
- Review the *2013 Physician Quality Reporting System (PQRS) Claims/Registry Measure Specifications Manual* for measures that are applicable to your practice

  >http://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2013_PQRS_IndClaimsRegistry_MeasureSpec_SupportingDocs_12192012.zip
- Review *2013 Physician Quality Reporting System (PQRS): Implementation Guide – Claims-Based Reporting for Incentive*

  >http://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2013_PQRS_MeasuresList_ImplementationGuide_12192012.zip

PQRS and eRx Incentive Program

HELPFUL HINTS

Helpful Hints

- Report the QDC on each eligible claim
  - Failure to submit a QDC on claims for these Medicare patients will result in a “missed” reporting opportunity that can impact incentive eligibility and payment adjustment subjectivity
- Avoid including multiple dates of service and/or multiple rendering providers on the same claim - this will help eliminate diagnosis codes associated with other services being attributed to another provider’s services
- For measures that require more than one QDC, please ensure that all codes are captured on the claim

Helpful Hints (cont.)

- If all billable services on the claim are denied for payment by the Carrier or A/B MAC, the QDCs will not be included in program analysis
  - If the denied claim is subsequently corrected and paid through an adjustment, re-opening, or the appeals process by the Carrier or A/B MAC, with accurate codes that also correspond to the measure's denominator, then any applicable QDCs that correspond to the numerator should also be included on the corrected claim
    - All claims adjustments, re-openings, or appeals processed by the Carrier or A/B MAC must reach the national Medicare claims system data warehouse (NCH file) by **February 28, 2014** to be included in analysis
  - Claims may **not** be resubmitted *solely* to add or correct QDCs
  - Claims with only QDCs on them with a zero total dollar amount may **not** be resubmitted to the Carrier or A/B MAC

Helpful Hints (cont.)

- The Remittance Advice (RA)/Explanation of Benefits (EOB) denial code **N365** is your indication that the PQRS and/or eRx codes were received into the National Claims History (NCH) file
  - N365 reads: “This procedure code is not payable. It is for reporting/information purposes only.”
  - The N365 denial code is just an indicator that the QDC codes were received, it does not guarantee the QDC is valid for the measure or that incentive quotas were met
    - When a QDC is reported satisfactorily (by the individual eligible provider), the N365 can indicate that the claim will be used for calculating incentive eligibility
  - Keep track of all cases reported so that you can verify QDCs reported against the remittance advice notice sent by the Carrier or A/B MAC
    - Each QDC line-item will be listed with the **N365 denial remark code**

PQRS:
Satisfactorily Reporting

Satisfactorily Reporting Scenario
Measure #6: Coronary Artery Disease (CAD): Antiplatelet Therapy

Mr. Jones, age 65, presents for office visit (**99213**) with Dr. Thomas

Mr. Jones, has diagnosis of CAD (414.00)

Scenario 1

Dr. Thomas prescribes aspirin or clopidogrel

4086F

Scenario 2

Dr. Thomas does not prescribe aspirin or clopidogrel for Medical, Patient or System Reasons

4086F with 1P
4086F with 2P
4086F with 3P

Scenario 3

Dr. Thomas does not prescribe aspirin or clopidogrel and does not specify the reason

4086F with 8P

Tips for Satisfactory Reporting

- Review *all* denominator codes affecting *claims-based* reporting, particularly those measures that do not have an associated diagnosis
  - You will need to report on each eligible claim as instructed in the measure specifications
- Review all diagnoses (if applicable) and CPT service (encounter) codes for denominator inclusion in PQRS/eRx (i.e., claims that are denominator-eligible)
- All denominator-eligible claims must have the appropriate QDC(s) or QDC with the allowable CPT II modifier along with the individual eligible professional's NPI
- Use the measure specifications for the current program year and report as instructed for PQRS and eRx

Key Points:

- Use the current PQRS and eRx Incentive Program information available on the CMS website
- Review the respective detailed measure specification(s) to determine the appropriate code(s) to place on the eligible claim
- QDCs must be submitted on the same claim as the billing code(s), for the same beneficiary, for the same date of service, by the same eligible professional who performed the Part B covered service provided under the PFS
- Claims may **NOT** be resubmitted *solely* to add QDCs!
- Check your RA for the N365 code to confirm receipt of QDCs into the NCH

PQRS and eRx

RESOURCES

Resources

- **CMS PQRS Website**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS
  - PQRS Claims/Registry Measure Specifications
  - PQRS Implementation Guide
  - Education Resources
- **CMS eRx Incentive Program Website**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive
  - eRx Measure Specification
  - eRx Claims-Based Reporting Principles
  - Educational Resources
- **FFS Provider Listserv**
  https://list.nih.gov/cgi-bin/wa.exe?A0=PHYSICIANS-L
- **Frequently Asked Questions (FAQs)**
  https://questions.cms.gov/

Acronyms

- **PQRS** – Physician Quality Reporting System
- **eRx** – Electronic Prescribing
- **EHR** – Electronic Health Record
- **QDC** – Quality-Data Code
- **NPI** – National Provider Identifier
- **NCH –** National Claims History
- **MAC** – Medicare Administrative Contractor
- **RA** – Remittance Advice
- **EOB** – Explanation of Benefits

Where to Call for Help

- **QualityNet Help Desk:**
  - Portal password issues
  - PQRS/eRx feedback report availability and access
  - IACS registration questions
  - IACS login issues
  - PQRS and eRx Incentive Program questions

866-288-8912 (TTY 877-715-6222)

7:00 a.m.–7:00 p.m. CST M-F or **qnetsupport@sdps.org**

You will be asked to provide basic information such as name, practice, address, phone, and e-mail

- **Provider Contact Center:**
  - Questions on status of 2012 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)
  - See *Contact Center Directory* at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

- **EHR Incentive Program Information Center:**

888-734-6433 (TTY 888-734-6563)

CMS Staff

QUESTIONS & ANSWERS

Evaluate Your Experience with Today's National Provider Call

- To ensure that the National Provider Call (NPC) Program continues to be responsive to your needs, we are providing an opportunity for you to evaluate your experience with today's NPC. Evaluations are anonymous and strictly voluntary.

- To complete the evaluation, visit http://npc.blhtech.com/ and select the title for today's call from the menu.

- All registrants will also receive a reminder email within two business days of the call. Please disregard this email if you have already completed the evaluation.

- We appreciate your feedback!

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Thank You

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- For more information about the National Provider Call Program, please visit http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html

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