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2012 Physician Quality Reporting System: Claims Reporting Made Simple

Background

The Physician Quality Reporting System (Physician Quality Reporting) is a voluntary reporting program. The program provides an incentive payment to practices with eligible professionals (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to **Medicare Part B Fee-for-Service (FFS) beneficiaries** (including Railroad Retirement Board and Medicare Secondary Payer).

Each eligible professional must satisfactorily report on at least ***50 percent*** of eligible instances when reporting through claims to qualify for the incentive.

Purpose

This document describes claims-based reporting and outlines steps that eligible professionals or practices should take prior to participating. It also provides helpful reporting tips for eligible professionals and their billing staff.

Deciding to Participate

STEP 1: Determine if you are eligible to participate in Physician Quality Reporting.

A list of eligible professionals can be found on the Physician Quality Reporting System website at http://www.cms.gov/PQRS.

STEP 2: Decide if you will report individual measures or measures groups.

- For an outline of the claims reporting options, refer to **Appendix C** in the *2012 Physician Quality Reporting Implementation Guide.* This document is available as a download on at http://www.cms.gov/PQRS/15_MeasuresCodes.asp.
- Review the *2012 Physician Quality Reporting System Measures List* at http://www.cms.gov/PQRS/15_MeasuresCodes.asp and determine which measures may apply.

Prior to a new reporting year, it is important to review the most recent measure documentation. Existing measures may have been updated or retired since the previous program year and new measures may have been added to Physician Quality Reporting. Reviewing the current program year's measure specifications allows eligible professionals to report the measure as it currently exists within the program.

Individual Measures

- For measure details, reference the *2012 Physician Quality Reporting System Measure Specifications Manual for Claims and Registry* under the *Downloads* section of the *Measures Codes* page on the CMS website at http://www.cms.gov/PQRS/15_MeasuresCodes.asp. Please note that not all individual measures are available via claims-based reporting.
- Choose at least three applicable measures for submission that will impact clinical quality within the practice.
    - If Fewer than Three Measures Apply, CMS will apply the *Measure-Applicability Validation (MAV)* process*.* Refer *to the* 2012 Physician Quality Reporting System Measure-Applicability Validation Process for

Claims-Based Reporting of Individual Measures at http://www.cms.gov/PQRS/25_AnalysisAndPayment.asp.

- Review the *2012 Physician Quality Reporting System Implementation Guide* at http://www.cms.gov/PQRS/15_MeasuresCodes.asp. This document provides guidance as to how to read and understand a measure and details how to implement claims-based reporting of measures to facilitate satisfactory reporting of quality-data codes by eligible professionals. A sample CMS-1500 form is also included in this document to assist you in reporting individual measures via claims.

Individual measures with a 0% performance rate will not be counted as satisfactorily reporting. The recommended clinical quality action must be performed on at least one patient for each individual measure reported by the eligible professional. When a lower rate indicates better performance, such as Measure #1, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting). Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

Measures Groups

- Reference the *2012 Measures Groups Specifications* at http://www.cms.gov/PQRS/15_MeasuresCodes.asp for measures group specifics. Measures groups specifications are different from those of the individual measures that form the group. Therefore, the specifications and instructions for measures group reporting are provided in a separate manual.
- Choose at least one measures group for submission to qualify for an incentive payment.
- Review *Getting Started with 2012 Physician Quality Reporting of Measures Groups at* http://www.cms.gov/PQRS/15_MeasuresCodes.asp. This document outlines the different options for reporting measures groups and serves a guide to implementing the 2012 Physician Quality Reporting System measures groups. A sample CMS-1500 form is also included in this document to assist you in reporting measures groups via claims.

If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

STEP 3: Establish an office workflow.

This will allow each chosen measure's denominator-eligible patient to be accurately identified on the Medicare Part B claim. Ensure that:

- All staff understand the measures selected for reporting
- All denominator eligible claims for the selected measure(s)/measures group(s) are identified and captured and reporting frequency of the selected measure(s) and/or measure group(s) is reviewed and understood
- All coding is represented on the claim prior to application of numerator coding

How to Start Reporting

There is no registration required to participate in individual 2012 Physician Quality Reporting. To begin, simply start reporting the Quality-Data Codes (QDCs) listed in the measures you have selected on applicable Medicare Part B claims. Below are some helpful tips to aid you in the reporting process:

- Report the QDC on **each** eligible claim that falls into the denominator. Failure to submit a QDC on claims for these Medicare patients will result in a "missed" reporting opportunity that can impact incentive eligibility.
- 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 (CPT II or G-code), please ensure that **all** codes are captured on the claim. Refer to the *2012 Quality Data Codes Categories at* http://www.cms.gov/PQRS/15_MeasuresCodes.asp. This document assists with coding claims appropriately.

For detailed instructions on claims-based reporting, refer to the *2012 Physician Quality Reporting System Coding and Reporting Principles* document under 'Related Links Inside CMS' on the CMS website at http://www.cms.gov/PQRS/30_EducationalResources.asp.

Avoiding Billing Pitfalls – Tips for Success

Below are some quick tips to help you and your office staff bill appropriately while participating in Physician Quality Reporting:

- 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 Physician Quality Reporting 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.
    - Claims may **not** be resubmitted only to add or correct QDCs, and claims with only QDCs on them with a zero total dollar amount may not be resubmitted to the Carrier or A/B MAC. Refer to the Implementation Guide for specifics for reporting via claim method.
- The Remittance Advice (RA)/Explanation of Benefits (EOB) for the denial code **N365** is your indication that the Physician Quality Reporting codes were received into the National Claims History.
    - The **N365** denial code is just an indicator that the QDC codes were received. It does not guarantee the QDC was correct or that reporting thresholds were met. However, when a QDC is reported satisfactorily (by the individual eligible provider), the **N365** can indicate that the claim will be used in calculating incentive eligibility.
- All claims adjustments, re-openings**, or** appeals processed by the Carrier or A/B MAC must reach the national Medicare claims system data warehouse (National Claims History [NCH] file) by February 22, 2013 to be included in the 2012 Physician Quality Reporting analysis.

For specific instructions on how to bill appropriately, contact your Carrier or A/B MAC.

Additional Information

- For more information on what's new for 2012 Physician Quality Reporting, go to http://www.cms.gov/PQRS/30_EducationalResources.asp on the CMS website.
- For more information on reporting measures groups, see *2012 Physician Quality Reporting System Fact Sheet: Physician Quality Reporting System Made Simple For Reporting Preventive Care Measures Group* found here: http://www.cms.gov/PQRS/30_EducationalResources.asp
- To find answers to frequently asked questions, go to https://questions.cms.hhs.gov/app/home.