

2013 Physician Quality Reporting System (PQRS): Claims Reporting Made Simple

Background

The Physician Quality Reporting System (PQRS) 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).

When using the claims-based reporting option, each eligible professional must satisfactorily report on at least 50 percent of eligible instances when reporting individual measures **OR** at least 20 patients when reporting a measures group via claims to qualify for the incentive.

Beginning in 2015, the program also applies a payment adjustment to eligible professionals who do not satisfactorily report data on quality measures for covered professional services. This article covers information on earning the **2013 PQRS incentive payment only**. For complete information on the 2015 PQRS payment adjustment (including information on reporting via administrative claims), see the Centers for Medicare & Medicaid Services (CMS) PQRS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>.

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 PQRS.

A list of eligible professionals can be found on the PQRS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/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 *2013 Physician Quality Reporting System (PQRS) Implementation Guide*. This document is available as a download at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>.
- Review the *2013 Physician Quality Reporting System Measures List* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> > Downloads 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 PQRS. 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 *2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry* on the CMS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> > Related Links. 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 *2013 Physician Quality Reporting System (PQRS) Measure-Applicability Validation Process for Claims-Based Reporting of Individual Measures* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html> > Downloads.
- Review the *2013 Physician Quality Reporting System (PQRS) Implementation Guide* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> > Downloads. 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 during the reporting period. 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 only performance exclusion quality-data codes, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

Measures Groups

- Reference the *2013 Physician Quality Reporting System (PQRS) Measures Groups Specifications* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> > Related Links for measures group specifics. Measures groups specifications are different from individual measures. Therefore, the specifications and instructions for measures group reporting are provided in a separate manual. Please note that not all measures groups are available via claims-based reporting.
- Choose at least one measures group for submission to qualify for an incentive payment.
- Review *Getting Started with 2013 Physician Quality Reporting System (PQRS) Reporting of Measures Groups* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> > Related Links. This document outlines the different options for reporting measures groups and serves a guide to implementing the 2013 PQRS 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 supporting 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 denominator coding is represented on the claim form prior to application of numerator coding.

How to Start Reporting

Simply start reporting the quality-data codes (QDCs) listed in the individual measures/measures groups 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, please ensure that **all** codes are captured on the claim. Refer to the *2013 Physician Quality Reporting System (PQRS) Quality-Data Codes Categories* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> > Related Links. This document assists with coding claims appropriately.

For detailed instructions on claims-based reporting, refer to the *2013 Physician Quality Reporting System (PQRS) Coding and Reporting Principles* document on the CMS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html> > Related Links.

Avoiding Billing Pitfalls – Tips for Success

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

- 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 PQRS 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. 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 PQRS 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 28, 2014** to be included in the 2013 PQRS 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 2013 PQRS, go to <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html> .
- For more information on reporting measures groups, see *2013 Physician Quality Reporting System (PQRS) Fact Sheet: PQRS Made Simple For Reporting Preventive Care Measures Group* found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html>.
- To find answers to frequently asked questions, go to <https://questions.cms.gov/faq.php?id=5005&rtopic=1893>.