

National Provider Call:
Physician Quality Reporting System
(Physician Quality Reporting)
and
Electronic Prescribing (eRx)
Incentive Program

February 21, 2012

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Agenda



- ◆ CMS Updates/Announcements
- ◆ Presentation
 - ◆ Claims-Based Reporting: The Process and Coding
 - ◆ How to Report – Using the CMS-1500
 - ◆ Helpful Hints
 - ◆ Resources
- ◆ Question and Answer Session

Introduction to

CLAIMS-BASED REPORTING

Advantages of Claims-Based Reporting



Benefits include:

- ◆ Readily accessible to all eligible professional as it is a part of routine billing processes
- ◆ No need to contact Registry or EHR 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) for reimbursement on billable services rendered to Part B beneficiaries
- ◆ Eligible professionals use their individual **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 or NCH
- ◆ **Standardized codes** are found within each Physician Quality Reporting measure specification and within the eRx measure specification

What Do These Codes Mean?



Understanding the Measure Specification Construct

NUMERATOR

CPT II Code or Temporary G-code
(Describes **clinical action** required for performance)



DENOMINATOR

ICD-9-CM (future ICD-10-CM)
& CPT Category I Codes
(**Eligible cases** for the eligible patient population)

Reporting Frequency



Physician Quality Reporting:

- ◆ Report one-time per patient, per NPI/TIN combo per reporting period – **patient-level**
- ◆ Report once for each **procedure** performed
- ◆ Report for each acute **episode**
- ◆ Report for each **visit**

eRx:

- ◆ 12-month (to earn the 2012 incentive payment and avoid the 2014 eRx payment adjustment)
 - ◆ Report the required number of denominator-eligible visits
- ◆ 6-month (to avoid 2013 payment adjustment only)
 - ◆ Report on each **billable** Medicare Part B service, claims-based reporting is the only option for the 6-month eRx reporting period

How to Start Reporting



- ◆ There is no registration required, simply start reporting the 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, please ensure that all codes are captured on the claim

Physician Quality Reporting and eRx

SAMPLE CMS-1500 FORM

Physician Quality Reporting: Sample CMS-1500 Form



21. Review applicable Physician Quality Reporting measures related to ANY diagnosis (Dx) listed in Item 21. Up to 8 Dx may be entered electronically.

24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier(s) as needed

QDC codes must be submitted with a line-item charge of \$0.00 or \$0.01. Charge field cannot be blank.

For group billing, the rendering NPI number of the individual Eligible Professional who performed the service will be used from each line-item in Physician Quality Reporting calculations.

Identifies claim line-item

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by line)													22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.											
24. A. DATE(S) OF SERVICE													D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OF SERVICE		H. ICD-9-CM		I. RENDERING PROVIDER ID. #			
B. PLACE OF SERVICE													C. EMG		CPT/HCPCS		MODIFIER				UNITS		FAMILY PLAN		RENDERING PROVIDER ID. #	
1	07	09	12	07	09	12	11						99213			1,2	47.00				NPI	0123456789				
2	07	09	12	07	09	12	11						3048F			1	0.00				NPI	0123456789				
3	07	09	12	07	09	12	11						3074F			1	0.00				NPI	0123456789				
4	07	09	12	07	09	12	11						3078F			1	0.00				NPI	0123456789				
5	07	09	12	07	09	12	11						4011F			2	0.00				NPI	0123456789				
6	07	09	12	07	09	12	11						1090F			1	0.00				NPI	0123456789				

25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE		29. AMOUNT PAID BY PATIENT	
XX-XXXXXXX		X		XXXXX		X YES NO		\$ 47.00		\$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH			
SIGNED				DATE				XXXXXXXXXX			

The NPI of the billing provider is entered here. If a solo practitioner, then enter the individual NPI; if a Group is billing, enter the NPI of the group here. This is a required field.

Sample CMS-1500 Form

(cont.)



24D. Procedures, Services, or Supplies –
CPT/HCPCS, Modifier(s) as needed

Items 1, 2, 3 or 4 to Item 24E by Line

litus

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGE
99213		1,2	47.00
3048F		1	0.00
3074F		1	0.00
3078F		1	0.00
4011F		2	0.00
1090F		1	0.00

PATIENT'S ACCOUNT NO. XXXX

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
 YES NO

28. TOTAL CHARGE \$ 47

21. Review applicable Physician Quality Reporting measures related to ANY diagnosis (Dx) listed in Item 21. Up to 8 Dx may be entered electronically.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20)

1.	250.00	Diabetes Mellitus
2.	414.00	CAD

24. A. DATE(S) OF SERVICE B. C. D. PROC.

Sample CMS-1500 Form

(cont.)



Submit the QDC with a line-item charge of \$0.00. Charge field cannot be blank.

22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.			
23. PRIOR AUTHORIZATION NUMBER					
E. ICD-9-CM DIAGNOSIS CENTER	F. \$ CHARGES	G. DAYS OF UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER ID. #
1	45.00			NPI	0123456789
1	0.00			NPI	0123456789
				NPI	
NT7 (k)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE		
	\$ 45.00	\$	\$ 45.00		

PHYSICIAN OR SUPPLIER INFORMATION

If the system does not allow a \$0.00 line-item charge, a nominal amount can be substituted. The beneficiary is not liable for this nominal amount.

Sample CMS-1500 Form

(cont.)



Charge here cannot be blank.

22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.		
23. PRIOR AUTHORIZATION NUMBER				
F. \$ CHARGES	G. DAYS OR UNITS	H. EPISODE Family Plan	I. CL. ICD-9-CM	J. RENDERING PROVIDER ID. #
47.00				NPI 0123456789
0.00				NPI 0123456789
0.00				NPI 0123456789
0.00				NPI 0123456789
0.00				NPI 0123456789
0.00				NPI 0123456789
28. TOTAL CHARGE	29. AMOUNT			
\$ 47.00	\$			
33. BILLING PROVIDER INFO & PH				
XXXXXXXXXX				

PHYSICIAN OR SUPPLIER INFORMATION

For group billing, the rendering NPI number of the individual Eligible Professional who performed the service will be used from each line-item in Physician Quality Reporting calculations.

The NPI of the billing provider is entered here. If a solo practitioner, then enter the individual NPI; if a Group is billing, enter the NPI of the group here. This is a required field.

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

eRx: Sample CMS-1500 Form

21. Place the appropriate diagnosis (Dx) or diagnoses for the encounter in Item 21.

24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier(s) as needed

Submit the QDC with a line-item charge of \$0.00. Charge field cannot be blank.

Identifies claim line-item

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.					
1. 7 14 .00 Rheumatoid Arthritis (RA)																	
2. 250 .00 Diabetes Mellitus																	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM I. D. QUAL J. RENDERING PROVIDER ID. #																	
1	01	10	12	01	10	12	11		99202	1	45.00		NPI	0123456789			
2	01	10	12	01	10	12	11		G8553	1	0.00		NPI	0123456789			
3													NPI				
4													NPI				
5													NPI				
6													NPI				
25. FEDERAL TAX I.D. NUMBER				SSN/EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For gov. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE		
XX-XXXXXXX				X		XXXXXX			X YES NO		\$ 45.00		\$		\$ 45.00		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH # ()					
SIGNED						a.						b. XXXXXXXXXXXX					

Patient encounter during reporting period
At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system

If the system does not allow a \$0.00 line-item charge, a nominal amount can be substituted. The beneficiary is not liable for this nominal amount.

Solo practitioner - Enter individual NPI here

For group billing, the rendering NPI number of the individual eligible professional who performed the service will be used from each line-item in the eRx calculations.

Physician Quality Reporting and eRx

HELPFUL HINTS

Helpful Hints



- ◆ 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
 - ◆ 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 analysis
 - ◆ 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

Helpful Hints (cont.)

- ◆ The Remittance Advice (RA)/Explanation of Benefits (EOB) denial code **N365** is your indication that the Physician Quality Reporting and/or eRx codes were received into the National Claims History
 - ◆ 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 was correct 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**

Tips for Satisfactory Reporting



- ◆ Review *all* denominator codes affecting *claims-based* reporting, particularly those measures that do not have an associated diagnosis (for example, #110 Influenza Immunization, #154 Falls Risk Assessment, #47 Advance Care Plan, #125 Adoption/Use of Electronic Prescribing, etc.)
 - ◆ 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 Physician Quality Reporting/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 Physician Quality Reporting and eRx

Physician Quality Reporting and eRx

RESOURCES

Resources



The **CMS Physician Quality Reporting and eRx Incentive Program websites** are the official sources for all program materials.

Educational Resources

- ◆ *2012 Physician Quality Reporting System: Claims-Based Coding and Reporting Principles*
> http://www.cms.gov/PQRS/Downloads/2012PQRS_CodingRpgPrinc_PMBR_01-30-2012_508_2.pdf
- ◆ *Claims-Based Reporting Principles for 2012 Electronic Prescribing Incentive Program*
 - ◇ This document can be found on the E-Prescribing page of the Electronic Prescribing Incentive Program website at
https://www.cms.gov/ERxIncentive/06_E-Prescribing_Measure.asp > Downloads
- ◆ *2012 Physician Quality Reporting System: Claims Reporting Made Simple*
> http://www.cms.gov/PQRS/Downloads/2012PQRS_SatisfRprtng-Claims_Final508_1-13-2012.pdf

Resources (cont.)



◆ QualityNet Help Desk:

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

Key Points to Remember:



- ◆ Use the current Physician Quality Reporting 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 National Claims History

Thank You



- Questions?