



# 2016 Physician Quality Reporting System (PQRS): Claims Reporting Made Simple

January 2016

## Background

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The Physician Quality Reporting System (PQRS) is a voluntary quality reporting program that applies a negative payment adjustment to promote the reporting of quality information by individual eligible professionals (EPs) and group practices. The program applies a negative payment adjustment to practices with EPs identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN), or group practices participating via the group practice reporting option (GPRO), referred to as PQRS group practices, who **do not** satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (MPFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Those who report satisfactorily for the 2016 program year will avoid the 2018 PQRS negative payment adjustment.

For more information on PQRS or the payment adjustment, visit [the PQRS webpage](#).

*This document applies only to claims reporting for PQRS. It **does not** provide guidance for other Medicare or Medicaid incentive programs, such as the [Electronic Health Record \(EHR\) Incentive Program](#), or the [Value-Based Payment Modifier](#).*

## Purpose

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This document describes claims-based reporting and outlines steps that EPs should take prior to participating in 2016 PQRS. It also provides helpful reporting tips for EPs and their billing staff.

Please see the Decision Trees for reporting mechanism criteria in the “2016 PQRS Implementation Guide”, found in the [PQRS How to Get Started webpage](#).

## Overview

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Claims-based reporting is readily accessible to EPs as it is a part of routine billing processes. However, it is not an option for PQRS group practices. There is no need to contact a registry or qualified EHR vendor to submit data, and it's simple to select measures and begin reporting (by adding the respective quality-data code [QDC] to the claim). Medicare providers submit claims via the [CMS-1500 form](#) or [CMS-1450](#) (or electronic equivalent) for reimbursement on billable

services rendered to Part B FFS beneficiaries. EPs use their individual/rendering National Provider Identifier (NPI) to submit for services on Medicare Part B FFS beneficiaries.

Quality data reported to CMS through Part B MPFS claims (containing QDC line items for each EP’s NPI) are processed to final action by the Medicare Administrative Contractor (MAC) and subsequently transferred to the National Claims History (NCH) where it is available for PQRS analysis. See the *2016 PQRS Implementation Guide* for a flow diagram of the PQRS claims-based process. Quality measures data reported on claims denied for payment are not included in PQRS analysis. QDC line items from claims are analyzed according to the measure specifications, including coding instructions, reporting frequency, and performance timeframes.

An example of a claim in CMS-1500 format that illustrates how to report several PQRS measures is provided. See the *2016 PQRS Implementation Guide* for the current CMS-1500 claim form (version 02/12).

**For additional information on the measures, see the “2016 Physician Quality Reporting System (PQRS) Measure Specifications for Claims and Registry Reporting of Individual Measures,” available on the [PQRS Measures Codes webpage](#).**

## How to Get Started

Step	Description
<p><b>Step 1:</b> Determine if you are eligible to participate in PQRS</p>	<p>A list of professionals who are eligible to participate in PQRS is available <a href="#">on the CMS PQRS website</a>. Read this list carefully, as not all are considered EPs.</p> <p><b>IMPORTANT:</b> The PQRS definition of an EP differs from the Medicare EHR Incentive Program’s definition. Find information on who is eligible to participate within the <a href="#">Medicare EHR Incentive Program</a>.</p>
<p><b>Step 2:</b> Decide which individual measures you will report</p>	<p>For an outline of the claims reporting options and measures details, refer to the “2016 Physician Quality Reporting System (PQRS) Implementation Guide”. This document is available on the <a href="#">PQRS Measures Codes webpage</a>.</p> <p>Please note that not all individual measures are available via claims-based reporting. Review the “2016 Physician Quality Reporting System (PQRS) Measures List” on the <a href="#">PQRS Measures Codes webpage</a> and determine which measures may apply.</p> <p>Individual EPs and PQRS group practices can use the new <a href="#">PQRS Web-Based Measure Search Tool</a> to easily identify applicable PQRS measures. Users can search and filter important measure-related information such as measure number, reporting mechanisms, NQS domain, cross-cutting measures and measure steward. The tool also allows users to view the individual claims and registry measure specifications for 2016.</p>

Step	Description
(Step 2 continued)	<p>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 EPs to report the measure as it currently exists within the program. Please see the "2016 Physician Quality Reporting System (PQRS) Measure Specifications for Claims and Registry Reporting of Individual Measures" on the <a href="#">PQRS Measures Codes webpage</a>.</p>
<p><b>Step 3:</b> Identify eligible cases</p>	<p>Ensure that the practice identifies and reports on all denominator-eligible cases for the measures selected by the practice. Consider implementing an edit on the billing software that will flag each claim every time a combination of codes listed in a measure's denominator is billed so the entry QDCs is required prior to final claim submission. Additional PQRS educational resources are available as downloads on the <a href="#">CMS PQRS website</a>.</p>
<p><b>Step 4:</b> Satisfactorily report</p>	<p>EPs may satisfactorily report in 2016 PQRS by meeting the following criteria:</p> <ul style="list-style-type: none"> <li>• Report on at least 9 measures, covering at least 3 of the National Quality Strategy (NQS) domains AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. <ul style="list-style-type: none"> <li>○ EPs who satisfactorily report only 1 to 8 PQRS measures or fewer than 3 NQS domains will be subject to <a href="#">Measure-Applicability Validation (MAV)</a> to determine if additional measure or NQS domains could have been reported.</li> <li>○ Measures with a 0% performance rate will not be counted.</li> <li>○ An EP who sees 1 Medicare patient in a face-to-face encounter must also report on 1 cross-cutting measure (counts as 1 measure). <ul style="list-style-type: none"> <li>▪ For broadly applicable measures that are defined as cross-cutting, reference the "2016 PQRS List of Face-To-Face Encounter Codes" on the <a href="#">PQRS Measures Codes webpage</a>.</li> </ul> </li> </ul> </li> </ul>

Step	Description
<p><b>Step 5: Establish an office workflow</b></p>	<p>Establishing an office workflow will allow each chosen measure's denominator-eligible patient to be accurately identified on the Medicare Part B claim. Ensure that:</p> <ul style="list-style-type: none"> <li>• All supporting staff understand the measures selected for reporting.</li> <li>• All denominator-eligible claims for the selected measure(s) are identified and captured and reporting frequency of the selected measure(s) is reviewed and understood.</li> <li>• All denominator coding is represented on the claim form prior to application of numerator coding.</li> </ul>

## 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 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 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 or \$0.01 total dollar amount may not be resubmitted to the MAC. Refer to the "2016 PQRS Claims-Based Coding and Reporting Principles" in the [PQRS Educational Resources webpage](#) for specifics for reporting via claims.

### Remittance Advice (RA)/Explanation of Benefits (EOB)

The RA/EOB denial code **N620** is your indication that the PQRS codes are valid for the 2016 PQRS reporting year.

- The **N620** denial code is just an indicator that the QDC codes are valid for 2016 PQRS. It does not guarantee the QDC was correct or that reporting thresholds were met. However, when a QDC is reported satisfactorily (by the individual EP), the **N620** can indicate that the claim will be used in calculating satisfactory reporting.
- EPs who bill on a \$0.00 QDC line item will receive the N620 code. EPs who bill on a \$0.01 QDC line item will receive the **CO 246 N620** code.
- All submitted QDCs on fully processed claims are forwarded to the CMS warehouse for analysis by the CMS quality reporting program, so providers will first want to be sure they do see the QDC's line item on the RA/EOB, regardless of whether the RA **N620** code appears.
- Keep track of all cases reported so that you can verify QDCs reported against the remittance advice notice sent by the MAC. Each QDC line-item will be listed with the **N620** denial remark code.

### Claim Adjustment Reason Code (CARC) for QDCs with \$0.01

The **CARC 246** with Group Code CO or PR and with RARC **N620** indicates that this procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.

- In addition to **N620**, the remittance advice will show Claim Adjustment Reason Code (**CARC**) **CO or PR 246**. (This non-payable code is for required reporting only.)
- **CARC 246** reads: *This non-payable code is for required reporting only.*
- EPs who bill with a charge of \$0.01 on a QDC item will receive **CO 246 N620** on the EOB.

### Remittance Advice Remark Code (RARC) for QDCs with \$0.00

The new RARC code **N620** is your indication that the PQRS codes were received into the CMS National Claims History (NCH) database.

- EPs who bill with \$0.00 charge on a QDC line item will receive an **N620** code on the EOB.
- **N620** reads: *This procedure code is for quality reporting/informational purposes only.*

### CMS 1450 Claim Form

For the 2016 PQRS program year, EPs in Critical Access Hospital Method II (CAH II) may participate in the PQRS using all reporting mechanisms, including the claims-based reporting mechanism via the CMS-1450 form. Regardless of the reporting mechanism, CAH II providers will need to continue to add their NPI to the CMS-1450 claim form for analysis of PQRS reporting at the NPI level.

The [CMS-1450 form](#) (UB-04 at present) can be used by an institutional provider to bill a Medicare fiscal intermediary when a provider qualifies for a waiver from the Administrative Simplification Compliance Act requirement for electronic submission of claims. It is also used for billing of institutional charges to most Medicaid State Agencies. Please contact your Medicaid State Agency for more details on their requirements for this paper form.

### Timeliness of Quality Data Submission

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Claims processed by the MAC (including claims adjustments, re-openings, or appeals) must reach the national Medicare claims system data warehouse (National Claims History file) by **February 24, 2017** to be included in analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. For specific instructions on how to bill appropriately, contact your MAC.

## Additional Information

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- For more information on reporting individual measures via claims, please see the following resources available on the [PQRS Measures Codes webpage](#).
  - *2016 Physician Quality Reporting System (PQRS) Individual Measure Specifications for Claims and Registry Reporting and/or Release Notes*
  - *2016 Physician Quality Reporting System (PQRS) Individual Measure Specifications and Measures Flow Guide for Claims and Registry Reporting*
  - *2016 Physician Quality Reporting System (PQRS) Measures List*
  - *2016 Physician Quality Reporting System (PQRS) Implementation Guide*
- For more information related to the 2016 PQRS payment adjustment, please refer to the [PQRS Payment Adjustment Information webpage](#) on the CMS website.
- For more information on what's new for 2016 PQRS, visit the [PQRS Educational Resources webpage](#).
- To find answers to frequently asked questions, visit the [CMS FAQ webpage](#).

## Questions?

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Contact the **QualityNet Help Desk** at **1-866-288-8912** (TTY 1-877-715-6222), available 7 a.m. to 7 p.m. Central Time Monday through Friday, or via e-mail at [gnetsupport@hcqis.org](mailto:gnetsupport@hcqis.org). To avoid security violations, **do not** include personal identifying information, such as Social Security Number or TIN, in email inquiries to the QualityNet Help Desk.