DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – REVISED product from the Medicare Learning Network® (MLN)

"Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC," Booklet, ICN 006973, Downloadable

MLN Matters® Number: SE1207

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

2012 Physician Quality Reporting System Claims-Based Coding and Reporting Principles

Provider Types Affected

This article is intended for physicians and other providers who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting System reporting and incentive program.

What Providers Need to Know

This article describes claims-based coding and reporting, and outlines steps that eligible professionals or practices should take prior to participating in 2012 Physician Quality Reporting.

For guidance on reporting the electronic prescribing (eRx) measure, please reference the *Claims-Based Reporting Principles for 2012 Electronic Prescribing Incentive Program* at http://www.cms.gov/ERxIncentive.asp, under the eRx "Downloads" section of the CMS website.

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 Medicare Physician Fee Schedule

(MPFS) services furnished to Medicare Part B Fee-For-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer).

Key Points

How to Get Started

STEP 1: Fill Out Claim(s) with Codes for Reimbursement

STEP 2: Reference Measure Specifications

To ensure accurate application of Physician Quality Reporting denominator and numerator codes, reference the *2012 Physician Quality Reporting System Measure Specifications* available as a download at http://www.cms.gov/PQRS/15_MeasuresCodes.asp on the CMS website.

STEP 3: Do a Double Check

CMS encourages eligible professionals to review their claims for accuracy prior to submission for reimbursement and reporting purposes.

STEP 4: Review your Remittance Advice (RA)/Explanation of Benefits (EOB)

Review your RA/EOB for denial code N365. This code indicates that the Physician Quality Reporting codes were received into the National Claims History.

Coding and Reporting Principles—tips when reporting via claims

Claims-Based Reporting Principles

Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim.

- Only one diagnosis can be linked to each line item.
- Physician Quality Reporting analyzes claims data using ALL diagnoses from the base claim (Item 21 of the CMS-1500 or electronic equivalent) and service codes for each individual eligible professional (identified by individual NPI).
- Eligible professionals should review ALL diagnosis and encounter codes listed on the claim to make sure they are capturing ALL chosen measures applicable to that patient's care.

All diagnoses reported on the base claim will be included in Physician Quality Reporting analysis, as some measures require reporting more than one diagnosis on a claim.

- For line items containing a Quality-Data Code (QDC), only one diagnosis from the base claim should be referenced in the diagnosis pointer field.
- To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis

pointer field, all diagnoses on the claim(s) are considered in the Physician Quality Reporting analysis.

If your billing software limits the number of line items available on a claim, you may add a nominal amount such as a penny to one of the line items on that second claim for a total charge of one penny.

- Physician Quality Reporting analysis will subsequently join claims based on the same beneficiary for the same date-of-service, for the same Taxpayer Identification Number/National Provider Identifier (TIN/NPI), and analyze as one claim.
- Providers should work with their billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses, QDCs, or nominal charge amounts are not dropped.

A sample CMS-1500 form can be found in Appendix D of the *2012 Physician Quality Reporting System Implementation Guide* at http://www.cms.gov/PQRS/15_MeasuresCodes.asp, under the "Downloads" section of Physician Quality Reporting on the CMS website.

Submitting Quality-Data Codes (QDCs)

QDCs are specified Current Procedural Terminology II (CPT-II) codes (with or without modifiers) and G-codes used for submission of Physician Quality Reporting data. QDCs can be submitted to carriers or A/B Medicare Administrative Coordinators (MACs) either through:

1. Electronic-based submission (using the ASC X 12N Health Care Claim Transaction [version 5010]); OR,
2. Paper-based submission using the CMS-1500 claim form (version 08-05).

Principles for Reporting QDCs

The following principles apply for claims-based reporting of Physician Quality Reporting measures:

1. QDCs must be reported:
   - On the claim(s) with the denominator billing code(s) that represents the eligible Medicare Part B MPFS encounter;
   - For the same beneficiary;
   - For the same date of service (DOS); and
   - By the same eligible professional (individual NPI) who performed the covered service, applying the appropriate encounter codes (ICD-9-CM, CPT Category I or HCPCS codes). These codes are used to identify the measure's denominator.

2. QDCs must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed.
   - The submitted charge field cannot be blank.
   - The line item charge should be $0.00.
   - If a 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.
   - Entire claims with a zero ($0.00) charge will be rejected.

- Whether a $0.00 charge or a nominal amount is submitted to the carrier or A/B MAC, the Physician Quality Reporting code line will be denied but will be tracked in the National Claims History (NCH) for analysis.

3. When a group bills, the group NPI is submitted at the claim level, therefore, the individual rendering/performing physician's NPI must be placed on each line item, including all allowed charges and quality-data line items. Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field (#33a on the CMS-1500 form or the electronic equivalent).

Note: Claims may NOT be resubmitted for the sole purpose of adding or correcting QDCs.

Remittance Advice/Explanation of Benefits

The RA/EOB denial code N365 is your indication that the Physician Quality Reporting 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. However, 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.

Timeliness of Quality Data Submission

Claims processed by the carrier or A/B MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 22, 2013, to be included in analysis. Claims for services furnished toward the end of the reporting period should be filed promptly.

Additional Information

For more information on reporting individual measures via claims, please see the following resources available as downloads on the Physician Quality Reporting website at http://www.cms.gov/PQRS/15_MeasuresCodes.asp on the CMS website:

- 2012 Physician Quality Reporting System Measure Specifications Manual and Release Notes;
- 2012 Physician Quality Reporting System Measures List;
- 2012 Physician Quality Reporting QDC Categories; and
- 2012 Physician Quality Reporting System Implementation Guide

For more information on reporting measures groups via claims, please see the following resources available as downloads on the Physician Quality Reporting website at http://www.cms.gov/PQRS/15_MeasuresCodes.asp on the CMS website.

- 2012 Physician Quality Reporting System Measures Groups Specifications Manual;
- Getting Started with 2012 Physician Quality Reporting of Measures Groups; and
- 2012 Physician Quality Reporting System Fact Sheet: Physician Quality Reporting Made Simple – Reporting the Preventive Care Measures Group.

News Flash - **It's Not too Late to Give and Get the Flu Vaccine.** Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. **Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug.** For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit 2011-2012 Provider Seasonal Flu Resources and Immunizations. For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp on the Centers for Medicare & Medicaid Services (CMS) website.