

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



2013 Physician Quality Reporting System (PQRS): Claims-Based Coding and Reporting Principles

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 beneficiaries).

The Centers for Medicare & Medicaid Services (CMS) suggests eligible professionals periodically review posted PQRS-related materials at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS> on the CMS website. You can also visit this page by scanning the Quick Response (QR) code on the right with your mobile device.



Purpose

This fact sheet describes claims-based coding and reporting and outlines steps that eligible professionals or practices should take prior to participating in the 2013 PQRS. For more information about reporting the PQRS quality measures, visit <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> on the CMS website.

How to Get Started

STEP 1: Complete claim(s) with codes for reimbursement.

STEP 2: Reference measure specifications.

To ensure accurate application of PQRS denominator and numerator codes, refer to the “2013 Physician Quality Reporting System (PQRS) Measures List” and the “2013 Physician Quality Reporting System (PQRS) Implementation Guide – Claims-Based Reporting” available in the zip file titled “2013 PQRS Measure

List Implementation Guide” located at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> 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 the PQRS codes were received into the National Claims History (NCH).

Coding and Reporting Principles

Below are some helpful tips for reporting via claims.

Claims-Based Reporting Principles

- You can report up to four diagnoses in the header on the Form CMS-1500 paper claim and up to eight diagnoses in the header on the electronic equivalent.
 - Only one diagnosis can be linked to each line item.
 - The PQRS analyzes claims data using **ALL** diagnoses from the base claim (Item 21 of Form 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** measures chosen to report and that are applicable to the patient’s care.
- All diagnoses reported on the base claim will be included in PQRS analysis, as some measures require reporting more than one diagnosis on a claim.
 - For line-items containing a Quality-Data Code (QDC), reference only one diagnosis from the base claim in the diagnosis pointer field.
 - To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number that corresponds to one of the measure’s diagnoses listed on the base claim in the diagnosis pointer field. Regardless of the reference number in the diagnosis pointer field, all diagnoses on the claim(s) are considered in the PQRS 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.
 - The PQRS analysis will subsequently join claims based on the same beneficiary for the same date-of-service, for the same TIN/NPI and analyze as one claim.
 - Providers should work with their billing software vendor or clearinghouse regarding line limitations for claims to ensure that diagnoses, QDCs, or nominal charge amounts are not dropped.

For a sample Form CMS-1500 paper claim form, refer to Appendix D of the “2013 Physician Quality Reporting System (PQRS) Implementation Guide – Claims-Based Reporting” document in the zip file titled “2013 PQRS Measure List Implementation Guide” at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> on the CMS website.

Submitting QDCs

QDCs are specified Current Procedural Terminology (CPT) Category II codes (with or without modifiers) and Healthcare Common Procedure Coding System (HCPCS) G-codes used for submission of PQRS data. You can submit QDCs to carriers or A/B Medicare Administrative Contractors (MACs) through:

- Electronic-based submission (using the ASC X12N 837 Health Care Claim Transaction),
- OR**
- Paper-based submission (using Form CMS-1500).

Principles for Reporting QDCs

The following principles apply for claims-based reporting of PQRS measures:

1. QDCs must be reported:
 - On the claim(s) with the denominator billing code(s) that represents the eligible Medicare Part B PFS 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 (International Classification of Diseases, 9th Revision, Clinical Modification [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; and
 - Entire claims with a zero (\$0.00) charge will be rejected.
3. Whether a \$0.00 charge or a nominal amount is submitted to the carrier or A/B MAC, the PQRS code line will be denied but will be tracked in the NCH for analysis.



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

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

RA/EOB

The RA/EOB denial code **N365** is your indication that the PQRS codes were received in the NCH.

- **N365** reads: “This procedure code is not payable. It is for reporting/information purposes only.”
- The **N365** denial code is 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, 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 RA sent by your 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 carriers or A/B MACs must reach the NCH file by **February 28, 2014**, to be included in the 2013 PQRS analysis. Claims for services furnished toward the end of the reporting period should be filed promptly.

Resources

For more information on reporting individual measures via claims, refer to the following documents at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> on the CMS website:

- “2013 Physician Quality Reporting System (PQRS) Claims/Registry Measure Specifications Manual and/or Release Notes,”
- “2013 Physician Quality Reporting System (PQRS) Measures List,”
- “2013 Physician Quality Reporting System (PQRS) Quality-Data Code (QDC) Categories,” and
- “2013 Physician Quality Reporting System (PQRS) Implementation Guide – Claims-Based Reporting.”

For more information on reporting measures groups via claims, refer to the following documents at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> on the CMS website:

- “2013 Physician Quality Reporting System (PQRS) Measures Groups Specifications Manual,” and
- “2013 Physician Quality Reporting System (PQRS) Getting Started with Measures Groups.”

The Medicare Learning Network® (MLN) Educational Web Guides MLN Guided Pathways to Medicare Resources help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information applicable to you, refer to the section about your provider type in the “MLN Guided Pathways to Medicare Resources Provider Specific” booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website. For all other “Guided Pathways” resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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