November 2014

2014 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 (EPs, 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).

Beginning in 2015, the program will apply a payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services. Those that report satisfactorily for the 2014 program year and receive an incentive will also avoid the 2016 PQRS payment adjustment.

For more information on PQRS or the payment adjustment, visit http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.

Purpose

This document describes claims-based coding and reporting and outlines steps that EPs or practices should take prior to participating in 2014 PQRS.

How to Get Started

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

EPs must include a $0.01 line-item charge for the quality-data code (QDC). This is a new requirement for quality reporting via claims to CMS.

STEP 2: Reference Measure Specifications

To ensure accurate application of PQRS denominator and numerator codes, reference the *2014 Physician Quality Reporting System (PQRS) Measure Specifications* available on the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

STEP 3: Do a Double Check

CMS encourages EPs 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 (N620 or N572 after 4/1/2014). This code indicates the PQRS codes are valid for the 2014 PQRS reporting year.

Coding and Reporting Principles

Below are some helpful tips when reporting via claims.

Claims-Based Reporting Principles

- **The *2014 Physician Quality Reporting System (PQRS) Measure Specifications* contain ICD-9-CM coding and ICD-10-CM coding. Beginning 10/01/2015, the PQRS system will only accept ICD-10-CM codes for analysis.**

- A new CMS-1500 claim form (02/12) is available for use to accommodate the new ICD-10-CM coding. CMS will continue to accept the old CMS-1500 claim form (08/05) through March 31, 2014. However, on April 1, 2014, CMS will receive claims on only the revised CMS-1500 claim form (02/12). Claims sent on the old CMS-1500 claim form (08/05) will not be accepted.
- Up to twelve diagnoses can be reported in item 21 on the CMS-1500 paper claim (02/12) (see the *2014 PQRS Implementation Guide*) and up to twelve diagnoses can be reported in the header on the electronic claim.
    - Only one diagnosis can be linked to each line item.
    - PQRS 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 EP (identified by individual NPI).
    - **EPs 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 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 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 PQRS analysis.
- If your billing software limits the number of line items available on a claim, you must add a $0.01 nominal amount to one of the line items on that second claim for a total charge of one penny.
    - PQRS 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.**
    - In an effort to streamline reporting of QDCs across multiple CMS quality reporting programs, **CMS strongly encourages all EPs and practices to begin billing 2014 QDCs with a $0.01 charge. EPs should pursue updating their billing software to accept the $0.01 charge prior to implementing 2014 PQRS.** EPs and practices will need to work with their billing software or EHR vendor to ensure this capability is activated.

A sample CMS-1500 form can be found in the *2014 Physician Quality Reporting System (PQRS) Implementation Guide*, available as a download on the PQRS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

Submitting Quality-Data Codes (QDCs)

QDCs are specified CPT II codes (with or without modifiers) and G-codes used for submission of PQRS data. QDCs can be submitted to Carriers or A/B Medicare Administrative Contractors (MACs) either through:

- Electronic-based submission (using the ASC X 12N Health Care Claim Transaction [version 5010]); **OR**,
- Paper-based submission using the CMS-1500 claim form (version 08-05 until 3/31/2014 then use version 02-12)

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).
   - by the same EP (individual NPI) who performed the covered service, applying the appropriate encounter codes (ICD-9-CM/ICD-10-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 $0.01 at the time the associated covered service is performed.
   - The submitted charge field cannot be blank.
   - The line item charge should be $0.01 – the beneficiary is not liable for this nominal amount.
   - Entire claims with a $0.01 charge will be rejected.
   - The $0.01 charge is submitted to the Carrier or A/B MAC and then the PQRS 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 (field 24J), 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 (RA) /Explanation of Benefits (EOB)

The RA/EOB denial code **N365** is your indication that the PQRS codes are valid for the 2014 PQRS reporting year.

- The **N365** denial code is just an indicator that the QDC codes are valid for 2014 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 **N365** can indicate that the claim will be used in calculating incentive eligibility.
  - **Important:** In an effort to streamline reporting of QDCs across multiple CMS quality reporting programs, **CMS strongly encourages all EPs and practices to begin billing 2014 QDCs with a $0.01 charge. EPs should pursue updating their billing software to accept the $0.01 charge prior to implementing 2014 PQRS.** EPs and practices will need to work with their billing software or EHR vendor to ensure this capability is activated.
  - **Please Note:** Effective on 4/1/2014, EPs who bill on a $0.00 QDC line item will receive the **N620** code. It replaces the current **N365**, which will be deactivated effective 7/1/2014. EPs who bill on a $0.01 QDC line item will receive the **CO 246 N572** 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 new 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 Carrier or A/B MAC. Each QDC line-item will be listed with the **N365** denial remark code.

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 see **N620** instead of N365.
- EPs will receive code **N620** on the claim EOB form beginning 4/1/2014.
- **N620** reads: *This procedure code is for quality reporting/informational purposes only.*
- EPs who bill with a $0.00 charge on a QDC line item will receive an **N620** code on the EOB and may or may not receive any Group Code or CARC

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

The new **CARC 246** with Group Code CO or PR and with RARC **N572** indicates that this procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.

- In addition to **N572,** 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 N572** on the EOB.

Addendum

Effective on 4/1/2014, EPs who bill on a $0.00 or $0.01 QDC line item will receive the **N620** code. It replaces **N365**, which is deactivated effective 7/1/2014.

The new remittance advice reason code (**RARC**) **N620** is your indication that the PQRS codes were received into the CMS National Claims History (NCH) database. The accompanying message is “Alert: This procedure code is for quality reporting/informational purposes only.” RARC N620 is used for processing claims with a $0.00 QDC line-item charge, and will not show a group code or CARC.

Claims with a QDC line-item charge of $0.01 or more will also generate new claim adjustment reason code (**CARC**) **246**. The accompanying message is “This non-payable code is for required reporting only.” CARC 246 must be used with Group Code CO and with RARC **N620**.

In summary: Eligible professionals will receive RARC N620 if they bill $0.00 on QDCs, or RARC N620 CO246 if they bill $0.01.

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 27, 2015** 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 PQRS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

- *2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual* and/or *Release Notes*
- *2014 Physician Quality Reporting System (PQRS) Measures List*
- *2014 Physician Quality Reporting System (PQRS) QDC Categories*
- *2014 Physician Quality Reporting System (PQRS) Implementation Guide*

Appendix A: Summary of Revisions

Page 1: Updated ICD-9/ICD-10 information in bullet 1 under “Claims-Based Reporting Principles” (11/2014)

Page 4: Added additional information on RA codes in new section “Addendum” (11/2014)