CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-22 Medicare Quality Reporting Incentive Programs	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 31	**Date: August 29, 2014**
	Change Request 8787

SUBJECT: Language-Only Changes for Updating ICD-10 and ASC X12 Language in Pub 100-22, Chapters 1 and 2

I. SUMMARY OF CHANGES: This Change Request (CR) contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-22, Chapters 01 & 02. Additionally, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: ASC X12: January 1, 2012; ICD-10: Upon Implementation of ICD-10
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: September 30, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/50.1.1/ Coding and Reporting Principles for Claims-Based Reporting
R	2/50.1.1/ Coding and Reporting Principles for Claims-Based Reporting

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-22	Transmittal: 31	Date: August 29, 2014	Change Request: 8787

SUBJECT: Language-Only Changes for Updating ICD-10 and ASC X12 Language in Pub 100-22, Chapters 1 and 2

EFFECTIVE DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: September 30, 2014

I. GENERAL INFORMATION

A. Background: This Change Request (CR) contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-22, Chapters 01 and 02. Additionally, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

B. Policy: This Change Request (CR) contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-22, Chapters 01 and 02. Additionally, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8787.1	A/B MACs shall be aware of the updated language for ICD-10 and ASC X12 in Pub. 100-22, Chapters 01& 02.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Diane Stern, Diane.Stern@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR)

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Quality Reporting Incentive Programs Manual

Chapter 1 – The Physician Quality Reporting System

50.1.1 – Coding and Reporting Principles for Claims-*B*ased Reporting

(Rev. 31, Issued: 08-29-14, Effective: ASC 12X: January 1, 2012; ICD – 10: Upon Implementation of ICD – 10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 09 -30-14)

The following principles apply to the reporting of QDCs for Physician Quality Reporting System measures:

- The CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:
    - on the same claim(s) as the denominator billing code(s) for the same date of service (DOS)
    - for the same beneficiary
    - for the same date of service (DOS)
    - by the same eligible professional (individual NPI) who performed the covered service as the payment codes, usually ICD *diagnosis* , CPT Category I or HCPCS codes, which supply the denominator.

- All diagnoses reported on the claim will be included in Physician Quality Reporting System analysis, as some Physician Quality Reporting System measures require reporting more than one diagnosis on a claim. For line items containing a QDC, only a single reference number in the diagnosis pointer field will pass into the NCH file. 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, both primary and all secondary diagnoses (base claim diagnoses) are considered in Physician Quality Reporting System analysis.

- Up to *twelve* diagnoses can be reported in the header on the *Form* CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically. The Physician Quality Reporting System analyzes claims data using ALL diagnoses from the base claim *(the ASC X12 837 professional claim format or* Item 21 of the *Form* CMS-1500) and service codes for each individual professional identified by his or her rendering individual NPI. In other words, base claim diagnoses apply to all rendering TIN/NPIs on the claim. Eligible professionals should review ALL diagnosis and encounter codes listed on the claim to make sure they are capturing ALL reported measures applicable to that patient's care.

- If the eligible professionals' billing software limits the number of line items available on a claim, an eligible professional 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. CMS will look across all claims data for common occurrences of *A/B MAC (B)* claim control numbers, equated beneficiary claim numbers (HIC), and *A/B MAC (B)* numbers.

Only final action claims will be analyzed for Physician Quality Reporting System. For Physician Quality Reporting System measure calculation purposes, claims will be combined based on the same beneficiary for the same date-of-service, for the same TIN/NPI and analyzed as one claim. Providers should work with their billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses or QDCs are not dropped.

- QDCs must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered professional service is performed.
    - The submitted charge field cannot be blank.
    - The line item charge should be $0.00.
    - If an eligible professional's billing software does not allow a $0.00 line-item charge, a nominal amount can be substituted such as 1 penny ($0.01) – the beneficiary is not liable for this nominal amount.
    - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)
    - Whether a $0.00 charge or a nominal amount is submitted to the *A/B MAC (B)*, the Physician Quality Reporting System QDC code line is denied and tracked.

- QDC line items will be denied for payment, but are then passed through the claims processing system for Physician Quality Reporting System analysis. Eligible professionals will receive a Remittance Advice (RA) associated with the claim which will contain the Physician Quality Reporting System quality-data code line-item and will include a standard remark code (N365) and a message that confirms that the QDCs passed into the NCH file. N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report.
    - Keep track of all Physician Quality Reporting System cases reported so that the eligible professionals can verify QDCs reported against the remittance advice notice sent by the *A/B MAC (B)*. Each QDC line-item will be listed with the N365 denial remark code.

- Multiple eligible professionals' QDCs can be reported on the same claim using their individual NPI. Therefore, when a group is billing, the group should follow its normal billing practice of placing the NPI of the individual eligible professional who rendered the service on each line item on the claim including the QDC line(s).

- Some measures require the submission of more than one QDC in order to properly report the measure. Eligible professionals may report each QDC as a separate line item, referencing one diagnosis and including the rendering provider NPI.

- Use of CPT II modifiers (1P, 2P, 3P, 8P) is unique to CPT II codes and may not be used with other types of CPT codes. Only CPT II modifiers may be appended to CPT II codes. Do not append CPT I modifiers to CPT II codes or vice versa.

- Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, *(on the ASC X12 837 professional claim format or item* 33*b* on the *Form* CMS-1500).

- Eligible professionals may submit multiple codes for more than one measure on a single claim.

- Multiple CPT Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim.

- If a denied claim is subsequently corrected through the appeals process to the A/B MAC *(B)*, with accurate codes that also correspond to the measure's denominator, then QDCs that correspond to the numerator should also be included on the resubmitted claim as instructed in the measure specifications.

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

- Eligible Professionals should use the 8P reporting modifier judiciously for applicable measures they have selected to report. The 8P modifier may not be used indiscriminately in an attempt to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

Submission through *A/B MACs (B)*

QDCs shall be submitted to *A/B MACs (B)* either through:

Electronic submission, which is accomplished using the current version of the **ASC *X12 837 professional claim format*.**

CPT Category II and/or temporary G-codes should be submitted in the **SV101-2** "Product/Service ID" Data Element on the **SV1** "Professional Service" Segment of the **2400 "Service Line" Loop**.

- It is also necessary to identify in this segment that a HCPCS code (HC) is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.

- Diagnosis codes are submitted at the claim level, **Loop 2300, in data element HI01**, and if there are multiple diagnosis codes, in **HI02 through HI12** as needed with a single reference number in the diagnosis pointer.

- In general for group billing, report the NPI for the rendering provider in **Loop 2310B** (Rendering Provider Name, claim level) or **2420A** (Rendering Provider Name, line level), using data elements **NM109 (NM108=XX)**.

OR

Paper-based submission, which is accomplished by using the *Form* **CMS-1500 claim (version *02-12*)**. Relevant diagnosis codes are entered in **Field 21. Service codes** (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in **Field 24D** with a single reference *letter* in the diagnosis pointer **Field 24E** that corresponds with the diagnosis *letter* in Field 21.

- For group billing, the **National Provider Identifier (NPI)** of the rendering provider is entered in **Field 24J**.

- The **Tax Identification Number (TIN)** of the employer is entered in **Field 25**.

Group NPI Submission
When a group bills, the group's NPI is submitted at the claim level, therefore, the individual rendering physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.

Individual NPI Submission
The individual NPI of the solo practitioner must be included on the claim line as is the normal billing process for submitting Medicare claims. For the Physician Quality Reporting System, the QDC must be

included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in Physician Quality Reporting System analysis.

Form **CMS-1500 Claim Example**

An example of a claim in CMS-1500 format that illustrates how to report several Physician Quality Reporting System measures is available in the Physician Quality Reporting System Implementation Guide, a downloadable document that is updated for each program year and posted on the CMS Physician Quality Reporting System website http://www.cms.hhs.gov/PQRS.

Satisfactorily Reporting Measures

Physician Quality Reporting System participants should also refer to the "How to Get Started" section of the Physician Quality Reporting System website, available at http://www.cms.gov/PQRS. This section provides helpful information on how to get started with reporting quality measures for the Physician Quality Reporting System.

Timeliness of Quality Data Submission

Claims processed by the *A/B MAC (B)* must reach the National Claims History (NCH) file by no later than 2 months after the end of the reporting period to be included in the analysis. For the 2010 Physician Quality Reporting System, for example, claims processed by the *A/B MAC (B)* must reach the NCH file by no later than February 28, 2011 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis for Physician Quality Reporting System.

Medicare Quality Reporting Incentive Programs Manual

Chapter 2 – The Electronic Prescribing (eRx) Incentive Program

50.1.1 - Coding and Reporting Principles for Claims-*B*ased Reporting

(Rev. 31, Issued: 08-29-14, Effective: ASC 12X: January 1, 2012; ICD – 10: Upon Implementation of ICD – 10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 09 -30-14)

The following principles apply for claims-based reporting of the eRx measure:

For the eRx measure used for the reporting period that occurred during calendar year 2009, report one of the three eRx codes listed below as the claim numerator, when applicable:

- G8443 - "All prescriptions created during the encounter were generated using a qualified eRx system."
- G8445 - "No prescriptions were generated during the encounter."
- G8446 - "Provider does have access to a qualified eRx system and some or all of the prescriptions generated during the encounter were printed or phoned in as required by the State or Federal Law or regulations, patient request or pharmacy system being unable to receive electronic transmission; or because they were for narcotics or other controlled substances."

One of these codes must be reported on at least 50% of patients who meet the denominator criteria of the measure.

For the eRx measure used for the reporting period that occurred during calendar year 2010 the eRx measure's numerator includes only 1 G-code (CMS eliminated the 3 numerator G-codes used for the 2009 reporting period). To report the eRx measure for the 2010 reporting period, report the following eRx numerator G-code, when applicable:

- G8553 – At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.

For the eRx measure for reporting periods that occurred during calendar year 2011, the eRx measure's numerator is the same G-code used in the 2010 reporting period. To report the eRx measure for 2011 reporting periods, report the following eRx numerator G-code, when applicable:

- G8553 – "At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system."

For the eRx measure used for reporting periods that occur during the 2012 or 2013 calendar year, the eRx measure's numerator code is the same G-code used in 2010 and 2011 reporting periods. To report the eRx measure for the 2012 or 2013 reporting periods, report the following eRx numerator G-code, when applicable:

- G8553 – "At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system (faxes do not count)."

The eRx G-code, which supplies the numerator, must be reported for the applicable amount of unique visits (for services in the denominator) to successfully report for incentive payment purposes:

- on the claim(s) with the denominator billing code(s) that represent the eligible encounter for the 2012 eRx incentive payment; **OR** on the claim(s) with any billing code(s) that represent the encounter to avoid the 2013 eRx payment adjustment,
- for the same beneficiary,
- for the same date of service (DOS), and
- by the same eligible professional (individual NPI) who performed the covered service as the payment codes, CPT Category I or

The eRx G-code 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 an eligible professional's billing software does not allow a $0.00 line-item charge, a nominal amount, such as $0.01, can be substituted - the beneficiary is not liable for this nominal amount.
- Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)
- Whether a $0.00 charge or a nominal amount is submitted to the Medicare Administrative Contractor (MAC) *(B)*, the eRx G-code line is denied and tracked.

ERx line items will be denied for payment, but are passed through the claims processing system to the NCH database and used for eRx claims analysis. Eligible professionals will receive a Remittance Advice (RA) which includes a standard remark code (N365). N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does NOT indicate whether the eRx G-code is accurate for that claim or for the measure the eligible professional is attempting to report. N365 only indicates that the eRx G-code passed into NCH.

When a group bills, the group NPI is submitted at the claim level, 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, (*on the ASC X12 837 professional claim format or item* 33 on the *Form* CMS-1500).

Claims may **NOT** be resubmitted for the sole purpose of adding or correcting an eRx code.

Submission Through *A/B MACs (B)*

ERx G-codes shall be submitted to *A/B MACs (B)* either through: Electronic submission using the *current version of the* ASC X12 837 *professional claim*, or via paper-based submission, using the *Form* CMS-1500 claim.

Electronic-based Submission:

Physician Quality Reporting QDCs are submitted on the claim just like any other code; however, QDCs will have a $0.00 (or nominal) charge. Electronic submission, which is accomplished using the ASC *X12 837 professional claim format*, should follow the current HIPAA standard version of the ASC *X12 837* technical report 3.

Paper-based Submission:

Paper-based submissions are accomplished using the *Form* CMS-1500 claim (version 02-12). Relevant diagnosis codes are entered in Field 21. Service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in Field 24D with a single reference *letter* in the diagnosis pointer Field 24E that corresponds with the diagnosis *letter* in Field 21.

For group billing, the NPI of the rendering/performing provider is entered in Field 24J and the TIN of the employer is entered in Field 25.

Timeliness of Quality Data Submission

Claims processed by the must reach the National Claims History (NCH) file by no later than 2 months after the end of the reporting period to be included in the analysis. For the 2011 eRx Incentive Program, for example, claims processed by the *A/B MAC (B)* must reach the NCH file by no later than February 28, 2011 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.