2015 Physician Quality Reporting System (PQRS)
Claims Reporting Made Simple
January 2015

Background

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 eligible professionals (EPs). 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). Beginning in 2015, the program will apply a negative payment adjustment to EPs and PQRS group practices who did not satisfactorily report data on quality measures for covered professional services in 2013. Those who report satisfactorily for the 2015 program year will avoid the 2017 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 Modifier.*

Purpose

This document describes claims-based reporting and outlines steps that EPs should take prior to participating in 2015 PQRS. It also provides helpful reporting tips for EPs and their billing staff.

How to Get Started

Step 1: Determine if you are eligible to participate in PQRS	A list of professionals who are eligible to participate in PQRS is available on the CMS website. Read this list carefully, as not all are considered EPs. **IMPORTANT:** 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 Medicare EHR Incentive Program.

Step 2: Decide which individual measures you will report	For an outline of the claims reporting options and measures details, refer to the *2015 Physician Quality Reporting System (PQRS) Implementation Guide.* This document is available on the Measures Codes page of the CMS PQRS website. Please note that not all individual measures are available via claims-based reporting. Review the *2015 Physician Quality Reporting System (PQRS) Measures List* on the CMS Measures Codes webpage and determine which measures may apply. 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 *2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures* on the CMS Measures Codes webpage.
Step 3: Satisfactorily report	EPs may satisfactorily report in 2015 PQRS by meeting the following criteria: - Report on at least 9 measures across 3 NQS domains for at least 50% of the EP's Medicare Part B FFS patients. - EPs who see 1 Medicare patient in a face-to-face encounter must also report on 1 cross-cutting measure. **OR** - EPs who submit quality data for **only 1 to 8** PQRS measures for at least 50% of their patients or encounters eligible for each measure, **OR** that submit data for **9 or more** PQRS measures across **less than 3 domains** for at least 50% of their patients or encounters eligible for each measure will be subject to Measure-Applicability Validation (MAV). - EPs who see 1 Medicare patient (face-to-face encounter), but do not report on 1 cross-cutting measure will be subject to MAV. (See the Analysis and Payment webpage for more information on MAV). *Note: Measures with a 0% performance rate will not be counted for either of the options.*
Step 4: Establish an office workflow	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: - All supporting staff understand the measures selected for reporting. - 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. **All denominator coding is represented on the claim form prior to application of numerator coding.**

Helpful Reporting Tips

To get started, simply start reporting the quality-data codes (QDCs) listed in the individual measures you have selected on applicable Medicare Part B claims. Below are some helpful tips to aid you in the reporting process:

- Report the QDC on **each** eligible claim that falls into the denominator (eligible patient) population. Failure to submit a QDC on claims for these Medicare patients will result in a "missed" reporting opportunity that can impact your payment adjustment status. Read more about denominators at the PQRS Measure Selection Considerations section of the *2015 PQRS Implementation Guide*.
- Avoid including multiple dates of service and/or multiple rendering providers on the same claim. This will help eliminate diagnosis codes associated with other services being attributed to another provider's services.
- For measures that require more than one QDC, please ensure that **all** codes are captured on the claim. Refer to the *2015 Physician Quality Reporting System (PQRS) Quality-Data Codes Categories* on the CMS Measures Codes webpage.

For detailed instructions on claims-based reporting, refer to the *2015 Physician Quality Reporting System (PQRS) Coding and Reporting Principles* document on the PQRS Educational Resources webpage.

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 Medicare Administrative Contractors (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 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 *2015 PQRS Implementation Guide* 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 2015 PQRS reporting year.

- The **N620** denial code is just an indicator that the QDC codes are valid for 2015 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

New for the 2015 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

- 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 26, 2016** 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

- For more information on reporting individual measures via claims, please see the following resources available on the PQRS Measures Codes webpage.
    - *2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual* and/or *Release Notes*
    - *2015 Physician Quality Reporting System (PQRS) Measures List*
    - *2015 Physician Quality Reporting System (PQRS) QDC Categories*
    - *2015 Physician Quality Reporting System (PQRS) Implementation Guide*
- For more information related to the 2015 PQRS payment adjustment, please refer to the PQRS webpage on the CMS website.
- For more information on what's new for 2015 PQRS, visit the PQRS Educational Resources webpage.
- To find answers to frequently asked questions, visit the CMS FAQ webpage.

Questions?

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 qnetsupport@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.