

2014 Physician Quality Reporting System (PQRS): Claims Reporting Made Simple

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).

When using the claims-based reporting option, each eligible professional (EP) must satisfactorily report on at least **50 percent** of eligible instances to qualify for the incentive.

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. This article covers information on earning the **2014 PQRS incentive payment only**.

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 reporting and outlines steps that EPs or practices should take prior to participating. It also provides helpful reporting tips for EPs and their billing staff.

Deciding to Participate

STEP 1: Determine if you are eligible to participate in PQRS.

A list of EPs can be found on the PQRS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>.

STEP 2: Decide which individual measures you will report.

- For an outline of the claims reporting options, refer to the *2014 Physician Quality Reporting System (PQRS) Implementation Guide*. This document is available as a download at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>.
- Review the *2014 Physician Quality Reporting System (PQRS) Measures List* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html> > Downloads, 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. 2014 measure documentation will be available on the CMS PQRS website by December 31, 2013.

The *2014 Physician Quality Reporting System (PQRS) Measure Specifications* contain ICD-9-CM coding and ICD-10-CM coding. When applicable, ICD-9-CM codes should be used between 1/1/2014 and 9/30/2014. Beginning 10/1/2013, the PQRS system will *only* accept ICD-10-CM codes for analysis.

Individual Measures

- For measure details, reference the *2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry* on the CMS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>. Please note that not all individual measures are available via claims-based reporting.
- Review the *2014 Physician Quality Reporting System (PQRS) Implementation Guide* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>. This document provides guidance on how to implement measures reporting to satisfactorily meet reporting criteria. A sample CMS-1500 form is also included in this document to assist you in reporting individual measures via claims. Choose at least **9** applicable measures across **3** National Quality Strategy (NQS) domains for submission that will impact clinical quality within the practice.
- To qualify for the 2014 PQRS incentive payment if reporting **individual measures** via claims, report at least 9 measures, covering at least 3 of the NQS domains, **AND** Report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
 - If less than 9 measures apply to the EP, then the eligible professional must report 1-8 measures for which there is Medicare patient data **AND** report each measure for at least 50 percent of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. The EP would also be subject to Claims-based Measure-Applicability Validation (MAV).
- For those EPs who satisfactorily submit quality-data codes (QDCs) for fewer than **9** PQRS measures across **3 domains**, a Claims-Based MAV process will determine whether they should have submitted additional measures or domains. For payment adjustment considerations for those EPs who satisfactorily submit QDCs for fewer than **3** PQRS measures, the MAV process will determine whether an EP should have submitted for additional measures.
 - Refer to the 2014 Physician Quality Reporting System (PQRS) Measure-Applicability Validation Process for Claims-Based Reporting of Individual Measures at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html>.

*Individual measures with a 0% performance rate will not be counted as satisfactorily reporting. The recommended clinical quality action must be performed on at least one patient for each individual measure reported by the EP during the reporting period. When a lower rate indicates better performance, such as Measure #1, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting). Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits only performance exclusion quality-data codes, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting. See the **2014 PQRS Quality-Data Code (QDC) Categories**, "Performance Not Met" column in relation to 0% performance.*

STEP 3: Establish an office workflow.

This 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)/measures group(s) are identified and captured and reporting frequency of the selected measure(s) and/or measure group(s) is reviewed and understood.
- All denominator coding is represented on the claim form prior to application of numerator coding.

How to Start Reporting

Simply start reporting the 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. Failure to submit a QDC on claims for these Medicare patients will result in a “missed” reporting opportunity that can impact incentive eligibility.
- 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 *2014 Physician Quality Reporting System (PQRS) Quality-Data Codes Categories* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>. This document assists with coding claims appropriately.

For detailed instructions on claims-based reporting, refer to the *2014 Physician Quality Reporting System (PQRS) Coding and Reporting Principles* document on the CMS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html>.

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 the Carrier or Part A/B 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 the Carrier or A/B 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 total dollar amount may not be resubmitted to the Carrier or A/B MAC. Refer to the *Implementation Guide* for specifics for reporting via the claims method.
- The Remittance Advice (RA)/Explanation of Benefits (EOB) for the 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 group 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.

- **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 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.
 - **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.

- All claims adjustments, re-openings, **or** appeals processed by the Carrier or A/B MAC must reach the national Medicare claims system data warehouse (National Claims History [NCH] file) by **February 27, 2015** to be included in the 2014 PQRS analysis.

- For specific instructions on how to bill appropriately, contact your Carrier or A/B MAC.

Additional Information

- For more information on what's new for 2014 PQRS, go to <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html>.
- To find answers to frequently asked questions, go to <http://questions.cms.hhs.gov/>.