2015 Physician Quality Reporting System (PQRS)
Claims-Based Coding and Reporting Principles

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-based coding 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 coding and reporting, and outlines steps that EPs should take prior to participating in 2015 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 2015 Physician Quality Reporting System (PQRS) Measure Specifications available on the PQRS Measures Codes webpage.
Step 3: Double check claims	CMS encourages EPs to review their claims for accuracy prior to submission for reimbursement and reporting purposes.
Step 4: Review remittance advice explanation of benefits (EOB)	Review your Remittance Advice (RA)/Explanation of Benefits (EOB) for denial code N620. This code indicates the PQRS codes are valid for the 2015 PQRS reporting year.

Coding and Reporting Principles

Below are some helpful tips when reporting via claims.

Claims-Based Reporting Principles

- The *2015 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 1/1/2015 and 9/30/2015. Beginning 10/1/2015, the PQRS system will only accept ICD-10-CM codes for analysis. For more information, see the ICD-10 National Provider Call presentation.
- 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, 2015. However, on April 1, 2015, 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.
- 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.
- 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.

- Diagnoses should be reported in form locator field (FL) 66-67 a-q on the CMS-1450 claim form. Up to 12 diagnoses can be reported in item 21 on the CMS-1500 paper claim (02/12) (see the *2015 PQRS Implementation Guide*) and up to 12 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 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 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. (See *2015 PQRS Implementation Guide*)

- 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 the claims 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, 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 2015 QDCs with a $0.01 charge. EPs should pursue updating their billing software to accept the $0.01 charge prior to implementing 2015 PQRS. EPs and practices need to work with their billing software or EHR vendor to ensure that this capability is activated.

A sample CMS-1500 form can also be found in the *2015 PQRS Implementation Guide* on the PQRS Measures Codes webpage.

Submitting Quality-Data Codes (QDCs)

QDCs are specified Current Procedure Terminology (CPT) II codes (with or without modifiers) and G-codes used for submission of PQRS data. QDCs can be submitted to 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 3/31/2015 then use version 02-12) or CMS-1450 claim form.

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.

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 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 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 **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.

Remittance Advice Remark Code (RARC) for QDCs with $0.00

The 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.*
- 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 **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.

Timeliness of Quality Data Submission

Claims processed by the MAC must reach the national Medicare claims system data warehouse (NCH 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.

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.