Quality Reporting Round Up!

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Course Disclaimer

The information presented in this course complies with accepted coding practices and guidelines as defined in the ICD-9-CM and ICD-10-CM coding books. It is the responsibility of the physician or other healthcare provider to produce accurate and complete documentation and clinical rationale, which describes the encounter with the patient and the medical services rendered, to properly support the use of the most appropriate ICD-9-CM and ICD-10-CM code(s) according to the guidelines. If the clinical information in the medical record does not support a given code, that code cannot be used.
Objectives

- To have a better understanding of:
  - HEDIS
  - Domains of Care
  - PQRS
  - Methodologies
  - Tools

What Does HEDIS Stand for?

- Healthcare
- Effectiveness
- Data &
- Information
- Set

System for establishing standardized performance measures used in managed care industry
System for establishing accountability in health care
**HEDIS Origination**

- The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used set of health care performance measures in the United States.

- The term “HEDIS” originated in the late 1980s as the product of a group of forward-thinking employers and quality experts, and was entrusted to NCQA in the early 1990s.

- NCQA has expanded the size and scope of HEDIS to include measures for physicians, PPOs and other organizations.

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**HEDIS Measures Life Cycle**

Selection → Development → Public Comment → First Year → Public Reporting → Evaluation → Retirement
What Does HEDIS Measure?

For 2014 HEDIS contains 80 measures across 5 domains of care:

**Domains of Care**
- Effectiveness of Care (Screenings, Tests & Vaccines)
- Access/Availability
- Experience of Care
- Utilization and Relative Resource Use
- Health Plan Descriptive Information


How Does HEDIS Measure?

3 Data Sources

- Administrative Data (claims encounters)
- Hybrid Data (medical record data)
- Surveys
Domain 1: Effectiveness of Care

Staying Healthy: Screenings, Tests and Vaccines

- This domain is driven by the early recognition of certain disease entities in the elderly through evaluation tools, HEDIS®, HOS and CAHPS® which measure the effectiveness in the Staying Healthy domain.

<table>
<thead>
<tr>
<th>SAMPLE DOMAIN I MEASURE: BREAST CANCER SCREENING</th>
<th>1 Star</th>
<th>2 Stars</th>
<th>3-Star Threshold</th>
<th>3 Stars</th>
<th>4-Star Threshold</th>
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<tr>
<td>&lt; 59%</td>
<td>&gt; 59% and &lt; 69%</td>
<td>&gt; or = to 69%</td>
<td>&gt; 69% and &lt; 74%</td>
<td>&gt; 74%</td>
<td>&gt; 74% and &lt; 82%</td>
<td>&gt; = 82%</td>
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Staying Healthy: Screenings, Tests and Vaccines

- Breast Cancer Screening
- Colorectal Cancer Screening
- Cardiovascular Care – Cholesterol Screening
- Diabetes Care – Cholesterol Screening
- Glaucoma Testing
- Annual Flu Vaccine
- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health
- Monitoring Physical Activity
- Adult BMI Assessment
### What is a HEDIS Measure?

<table>
<thead>
<tr>
<th>HEDIS Measures</th>
<th>Standard Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Immunizations</td>
<td>CIS</td>
</tr>
<tr>
<td>Lead Screening in Children</td>
<td>LSC</td>
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<tr>
<td>Immunizations for Adolescents</td>
<td>IMA</td>
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<tr>
<td>Prenatal &amp; Postpartum Care</td>
<td>PPC</td>
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<tr>
<td>Frequency of Prenatal Care</td>
<td>FPC</td>
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<tr>
<td>Comprehensive Diabetes Care</td>
<td>CDC</td>
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<tr>
<td>Cervical Cancer Screening</td>
<td>CCS</td>
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<tr>
<td>Controlling High Blood Pressure</td>
<td>CBP</td>
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<tr>
<td>Cholesterol Management</td>
<td>CMC</td>
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<tr>
<td>Colorectal Cancer Screening</td>
<td>COL</td>
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<tr>
<td>Adult BMI</td>
<td>ABA</td>
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<tr>
<td>Weight Assessment/ Counseling for Nutrition/ Physical Activity for Children/Adolescents</td>
<td>WCC</td>
</tr>
<tr>
<td>Medication Reconciliation Post-Discharge</td>
<td>MRP</td>
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<tr>
<td>Care of Older Adults</td>
<td>COA</td>
</tr>
</tbody>
</table>

### HEDIS Measures

**Adult BMI Assessment (ABA) Every 2 Years**

- **BMI:** date and result
- **Weight:** date and result

Adult BMI Assessment (ABA)

Medicare Health Plan Rating Measure

• 18-74 year old members
• BMI documented during the measurement year or the year prior to the measurement year:
  ICD-9-CM: V85.0-V85.5

• Codes To Identify Outpatient Visits:
  • CPT®: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456
  • HCPCS: G0402, G0438, G0439
  • UB Revenue: 051x, 0520-0523, 0526-0529, 0982, 0983

Documentation Tip

• **Body Mass Index (BMI)**
  • Recording the actual BMI on a progress note and properly coding it now are essential HEDIS/Stars healthcare quality measures, mandated by the Centers for Medicare and Medicaid Services (CMS).
  • BMI provides the most useful population-level measure of overweight and obesity
  • While BMI may be coded from the dietician’s or other caregiver’s documentation, the diagnosis of being overweight or obese must also be documented and coded from the provider’s chart notes because the BMI code alone does not capture the abnormal weight condition
When Coding Obesity

- Use additional code to identify Body Mass Index (BMI), if known:
  - V85.0 – V85.45 for Adults over 20 years old
- For members with a BMI of 40 and over:
  - V85.41 BMI 40.0-44.9, adult
  - V85.42 BMI 45.0-49.9, adult
  - V85.43 BMI 50.0-59.9, adult
  - V85.44 BMI 60.0-69.9, adult
  - V85.45 BMI 70 and over, adult
- Obesity due to a specified cause, such as thyroid disorder (240-246), is coded to the underlying condition.

ICD-9-CM Codes

- 278.00 Obesity Unspecified
- 278.01 Morbid Obesity
- 278.02 Overweight
- 278.03 Obesity Hypoventilation Syndrome
- V85.41 Body Mass Index 40.0-44.9 Adult
- V85.42 Body Mass Index 45.0-49.9 Adult
- V85.43 Body Mass Index 50.0-59.9 Adult
- V85.44 Body Mass Index 60.0-69.9 Adult
- V85.45 Body Mass Index 70 and Over Adult
Breast Cancer Screening (BCS) – Every 2 Years

- Mammogram
- X-ray of breast to screen for abnormal growth of tissue
- Early detection of breast cancer

HEDIS Measures


Breast Cancer Screening (BCS)

Medicare Health Plan Rating Measure

- 50-74 year old women
- One or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

- CPT®: 77055-77057
- ICD-9-CM: 87.36, 87.37
- HCPCS: G0202, G0204, G0206
- UB Revenue: 0401, 0403

- Exclusion: Bilateral Mastectomy
HEDIS Measures

Colorectal Cancer Screening (COL)

**Annually - Fecal occult blood test (FOBT)**
- Tiny sample of stool on a special card
- The lab uses chemicals to find blood that can’t be seen with the naked eye
- This test should be performed every year after the age of 50

**Every 5 Years - Sigmoidoscopy**
- Inspection of the lower part of the large intestine using a lighted viewing scope
- Remove small growths and collect tissue samples (biopsy)
- About half of all colon tumors and polyps can be found using sigmoidoscopy

**Every 10 Years - Colonoscopy**
- Allows visual inspection of the entire intestine
- Used to diagnose unexplained changes in bowel habits
- Also used to look for early signs of cancer in the colon and rectum

[Links to HEDIS Measures]

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**Colorectal Cancer Screening (COL)**

Medicare Health Plan Rating Measure
- 50-75 year old members
- Documentation (date and result) of one or more of these screenings:
  - Colonoscopy during measurement year or 9 years prior;
  - FOBT during measurement year;
  - Flexible Sigmoidoscopy during measurement year or 4 years prior or Diagnosis of colorectal cancer

[Links to Medicare Health Plan Rating Measure]
Colorectal Cancer Screening (COL) Cont’d

Fecal Occult Blood Test (FOBT)
- CPT®: 82270, 82274 HCPCS: G0328

Flexible Sigmoidoscopy
- CPT®: 45330-45335, 45337-45342, 45345; HCPCS: G0104
  ICD-9-CM: 45.24

Colonoscopy
- CPT®: 44388-44394, 44397, 45355, 45378-45387, 45391, 45392 HCPCS: G0105, G0121; ICD-9-CM: 45.22, 45.23, 45.25, 45.42, 45.43
  - Exclusion: Diagnosis of colorectal cancer or total colectomy.

HEDIS Measures

Comprehensive Diabetes Care (CDC)
Yearly screening of the following:
- HbA1c testing
- HbA1c result > 9.0 = poor control
- HbA1c result < 8.0 = good control
- LDL-C
- LDL-C result < 100
- Retinal eye exam
- Nephropathy screening test or evidence of nephropathy
- Blood pressure collected as 2 measures
  < 140/90
  < 140/80

Comprehensive Diabetes Care (CDC)

Medicare Health Plan Rating Measure

• 18-75 year old members with type 1 or type 2 diabetes
• HbA1c testing and result*
• LDL C screening and result*
• Blood Pressure*
• Medical attention to nephropathy (micro/macro urine, ACE/ARB medication therapy) in measurement year
• Retinal eye exam performed by an eye care professional in measurement year or year prior

*Date and result of last screening in the measurement year

Exclusions: Polycystic ovaries, steroid-induced diabetes or gestational diabetes.

Comprehensive Diabetes Care (CDC) Cont’d

• **Diabetes Diagnosis:** ICD-9-CM: 250, 250.0-250.9, 357.2, 362.0, 362.01-362.07, 366.41, 648.0
• **HbA1c Screen CPT®:** 83036 and 83037; CPT® Cat II: 3044F, 3045F, 3046F
• **Eye Exams CPT®:** 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 CPT® Cat II: 2022F, 2024F, 2026F, 3072F HCPCS: S0620, S0621, S0625, S3000
• **LDL C Screen CPT®:** 80061, 83700, 83701, 83704, 83721 CPT® Cat II: 3048F, 3049F, 3050F
• **Nephropathy Screen CPT®:** 82042, 82043, 82044 and 84156 CPT® Cat II: 3060F, 3061F
Adolescent Well Child Visit  age 12–21 years

• One Well Child Visit with a PCP or OB/GYN during the measurement year
• All three components of an Adolescent Well Care Visit must be included:
  – Health and Development History (physical and mental)
  – Physical Examination
  – Health Education/Anticipatory Guidance

Well Child Visit  age 3–6 years

• One Well Child Visit with a PCP during the measurement year.
• All three components of a Well Child Visit must be included:
  – Health and Development History (physical and mental)
  – Physical Examination
  – Health Education/Anticipatory Guidance
Domain 2: Managing Chronic (Long-Term) Conditions

Access & Availability

• HEDIS® survey methodologies:

The grouping of HEDIS® measures in the Managing Chronic (Long-Term) Conditions category concerns clinical pathways for treatment and outcomes. For example, the diabetic HEDIS® measure determines if a clinical pathway was followed obtaining a HbA1c for monitoring and an outcome of the last value being less than 9%.

Managing Chronic (Long Term) Conditions

• Care for Older Adults – Medication Review
• Care for Older Adults – Functional Status Assessment
• Care for Older Adults – Pain Screening
• Osteoporosis Management in Women who had a Fracture
• Diabetes Care – Eye Exam
• Diabetes Care – Kidney Disease Monitoring
• Diabetes Care – Blood Sugar Controlled
• Diabetes Care – Cholesterol Controlled
• Controlling Blood Pressure
• Rheumatoid Arthritis Management
• Improving Bladder Control
• Reducing the Risk of Falling
• Plan All-Cause Readmissions
Domain 3: Ratings of Health Plan Responsiveness and Care

Experience of Care

- This domain evaluates the interaction between the member and provider based on CAHPS® survey measures. These questions measure the member’s experience communicating with their provider as well as accessing care with their provider or a specialist, if necessary.

Member Experience with Health Plan

- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Rating of Health Care Quality
- Rating of Health Plan
- Care Coordination
Domains 4 & 5: Health Plan Focused Domains

Utilization & Relative Resource Use
Health Plan Descriptive Information

- Domain IV, Member Complaints, Problems Getting Services and Choosing to Leave the Plan
- Domain V, Health Plan Customer Service, are mostly related to health plan operations and may not directly impact providers.

Member Complaints, Problems Getting Services, and Improvement in the Health Plan’s Performance

- Complaints about the Health Plan
- Beneficiary Access and Performance Problems
- Members Choosing to Leave the Plan
- Health Plan Quality Improvement
Health Plan Customer Service

- Plan Makes Timely Decisions about Appeals
- Reviewing Appeals Decisions
- Call Center – Foreign Language Interpreter and TTY Availability

Surveys

CAHPS® Survey (Consumer Assessment of Healthcare Providers and Systems)
- Measures member’s satisfaction with their care
- Areas include: claims processing, customer service, and getting needed care quickly

HOS survey (Health Outcomes Survey)
- First patient-reported outcomes measure

Additional Opportunities

• New opportunities exist for the primary care provider when counseling patients regarding obesity (G0447, Face to Face Behavioral Counseling for Obesity, 15 minutes). This HCPCS code (G0447) enables the primary care provider to evaluate and counsel the patient during multiple visits and must be billed with one of the ICD-9-CM codes for a BMI 30.0 and over (V85.30-V85.39, V85.41-V85.45).

• For more information on the 5As approach and reporting requirements for G0447, please see:

Documentation Tips

Commonly seen chart deficiencies

• Incomplete information from consultants in the PCP charts

• Incomplete information related to yearly lab testing and results

** It is very important to work with your EMR team to ensure that documents are “linked”, “pulled in” or “attached” to the encounter correctly.**
Sources for Quality Ratings

1. The Healthcare Effectiveness Data and Information Set (HEDIS®)
2. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
3. The Health Outcomes Survey (HOS)
4. CMS administrative data, which includes information about member satisfaction and disenrollment, as well as plans’ appeals processes, audit results and customer service

Significance of Star Rating

A contract may receive a high performing icon as a result of its performance on the Part C and D measures. The high performing icon is assigned to an MA-only contract for achieving a 5-star Part C summary rating, a PDP contract for a 5-star Part D summary ratings and an MA-PD contract for a 5-star overall rating.

Physician Quality Reporting System (PQRS)

- Created by CMS

- Reporting program that uses a combination of incentive payments and payment adjustments to promote quality.
  - Program provides an incentive payment to practices with eligible providers who satisfactorily report data on quality measures covered by the Medicare Physician Fee Schedule for services furnished to Medicare Part B Fee-for-Service beneficiaries.

- Commencing in 2015, the program also applies a payment reduction adjustment to eligible providers who do not satisfactorily report data on quality measures.

Measurement Selection

- Consider the following when selecting measures for 2014 reporting:
  - Clinical conditions you treat most often
  - Type(s) of care you typically provide – e.g., preventive, chronic, acute
  - Setting(s) where you usually deliver care – e.g., office, emergency department, surgical suite
  - Quality improvement goals you have planned for 2014
  - Additional quality reporting programs you are using or considering

PQRS 2014

- Beginning in 2014, most PQRS reporting options require an EP or group practice to report 9 or more measures covering at least 3 National Quality Strategy (NQS) domains for incentive purposes. The domains associated with the measures are as follows:
  - Patient Safety
  - Person and Caregiver-Centered Experience and Outcomes
  - Communication and Care Coordination
  - Effective Clinical Care
  - Community/Population Health
  - Efficiency and Cost Reduction

Example of Measures

<table>
<thead>
<tr>
<th>#</th>
<th>NQF #</th>
<th>Measure Title &amp; Description*</th>
<th>Measure Developer</th>
<th>Reporting Options/Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0069</td>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%</td>
<td>NQGA</td>
<td>Claims, Registry*, EHR**, DM Measures Group (C/R), GPRO**</td>
</tr>
<tr>
<td>2</td>
<td>0064</td>
<td>Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL)</td>
<td>NQGA</td>
<td>Claims, Registry*, EHR**, DM Measures Group (C/R), GPRO**, Cardiovascular Prevention Measures Group (C/R)</td>
</tr>
<tr>
<td>3</td>
<td>0061</td>
<td>Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg)</td>
<td>NQGA</td>
<td>Claims, Registry*, EHR**, DM Measures Group (C/R), GPRO**</td>
</tr>
<tr>
<td>4</td>
<td>0081</td>
<td>Heart Failure: Angiotensin-Converting Enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) &lt; 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at each hospital discharge</td>
<td>AMA-PCPI/ACCF/AHA</td>
<td>Registry**, EHR**, HF Measures Group (R), GPRO**</td>
</tr>
<tr>
<td>6</td>
<td>0067</td>
<td>Coronary Artery Disease (CAD): Antiplatelet Therapy Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who were prescribed aspirin or clopidogrel</td>
<td>AMA-PCPI/ACCF/AHA</td>
<td>Claims, Registry*, EHR**, CAD Measures Group (N), GPRO**</td>
</tr>
<tr>
<td>7</td>
<td>0070</td>
<td>Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF &lt; 40%) Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI or a current or prior LVEF &lt; 40% who were prescribed beta-blocker therapy</td>
<td>AMA-PCPI/ACCF/AHA</td>
<td>Registry**, EHR**</td>
</tr>
</tbody>
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PQRS Denominators and Numerators

Measures consist of two major components:

1) A denominator that describes the eligible cases for a measure
   - The eligible patient population associated with a measure’s numerator

2) A numerator that describes the clinical action required by the measure for reporting and performance

- Each component is defined by specific clinical codes described in each measure specification along with reporting instructions
Individual Eligible Providers (EPs)
To satisfactorily report or to satisfactorily participate in the 2014 PQRS program, individual EPs may choose to report quality data via:

1. EHR Direct Product that is Certified Electronic Health Record Technology (CEHRT)
2. EHR data submission vendor that is CEHRT
3. A qualified PQRS registry
4. Participation through a Qualified Clinical Data Registry (QCDR)
5. Medicare Part B claims submitted to CMS

Group Practice Reporting Option (GPRO)
- GPRO was introduced in 2010 as a reporting method for group practices to qualify to earn a PQRS incentive. PQRS defines a group practice as a single Tax Identification Number (TIN) with 2 or more individual EPs (as identified by Individual National Provider Identifier [NPI]) that have reassigned their billing rights to the TIN.
- Group practices may choose to report PQRS quality data via:
  1. GPRO Web Interface
  2. Qualified PQRS Registry
  3. EHR Direct Product that is CEHRT
  4. EHR data submission vendor that is CERT
  5. CMS-certified survey vendor
- Group practices reporting via GPRO must register for their selected reporting method by September 30, 2014
Participation via Qualified Clinical Data Registry (QCDR) - New for 2014

- The (QCDR) provides a new standard for individual EPs to satisfy PQRS requirements based on satisfactory participation. A QCDR is a CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients. The data submitted to CMS via QCDR covers quality measures across multiple payers and is not limited to Medicare. Reporting via QCDR is one of three reporting methods (Qualified Registry, EHR, and QCDR) that provides calculated reporting and performance rates to CMS.
- A list of CMS-designated QCDRs will be available on the CMS PQRS website in the fall of 2014.
- **Note:** The measures that may be submitted to a QCDR are not limited to the measures found in the PQRS measure set but are limited to submitting no more than 20 non-PQRS measures.

Quality-Data Codes

- QDCs are non-payable Healthcare Common Procedure Coding System (HCPCS) codes comprised of specified CPT Category II codes and/or G-codes that describe the clinical action required by a measure’s numerator. Clinical actions can apply to more than one condition and, therefore, can also apply to more than one measure. Where necessary, to avoid shared CPT Category II codes, G-codes are used to distinguish clinical actions across measures. Some measures require more than one clinical action and, therefore, have more than one CPT Category II code, G-code, or a combination associated with them.

**CPT Category II Codes**

- Serve to encode the clinical action(s) described in a measure’s numerator. CPT II codes consist of five alphanumeric characters in a string ending with the letter “F.” CPT II codes are not modified or updated during the reporting period and remain valid for the entire program year as published in the measure specifications manuals and related documents for PQRS.
Claims-Based Reporting Principles

• Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim.

• Only one diagnosis can be linked to each line item, although for PQRS all diagnosis codes will be taken into consideration for analysis.

• 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 eligible professional (identified by individual NPI).

• Eligible professionals should review ALL diagnosis and encounter codes listed on the claim to make sure they are capturing ALL chosen measures applicable to that patient’s care.

Claims-Based Reporting Principles

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 eligible professional (individual rendering NPI) that performed the covered service, applying the appropriate encounter codes (ICD-9-CM, CPT Category I or HCPCS codes). These codes are used to identify the measure's denominator.

• QDCs must be submitted with a line-item charge of one penny ($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
When the $0.01 nominal amount is submitted to the Carrier or A/B Medicare Administrative Contractor (MAC), the PQRS code line will be denied but will be tracked in the National Claims History (NCH) for analysis.

**Please note:** Effective 4/1/2014, PQRS issued different Remittance Advice (RA) codes for providers that bill on claims using $0.01 vs. $0.00. Eligible professionals may want to pursue updating their claims software to accept the $0.01 charge prior to implementing 2014 PQRS.

**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. Entering the nominal charge of $0.01 on claims will help ensure the QDCs are processed into the CMS claims database.

**Note:** Claims may **NOT** be resubmitted for the sole purpose of adding or correcting QDCs. If a denied claim is subsequently corrected through the appeals process to the Carrier or A/B MAC, 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.
Remittance Advice (RA) / Explanation of Benefits (EOB)

- The RA/EOB denial code N365 is your indication that the PQRS codes were received into the CMS National Claims History (NCH) database. 
  - N365 reads: “This procedure code is not payable. It is for reporting/information purposes only.”

- The N365 denial code is just an indicator that the QDC codes were received. It does not guarantee the QDC was correct or that incentive quotas were met. However, when a QDC is reported satisfactorily by the individual eligible professional, the N365 can indicate that the claim will be used for calculating incentive eligibility.

- **Please note:** Watch for additional information from CMS about new RA codes becoming effective on 4/1/2014. EPs that bill on a $0.00 QDC line item will see a different RA code.

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 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.
Sample Claims Reporting Scenario

Satisfactorily Reporting Scenario
Measure #6: Coronary Artery Disease (CAD): Antiplatelet Therapy

Mr. Jones, age 65, presents for office visit (99213) with Dr. Thomas

Mr. Jones, has diagnosis of CAD (414.00)

Scenario 1
Dr. Thomas prescribes aspirin or clopidogrel
4086F

Scenario 2
Dr. Thomas does not prescribe aspirin or clopidogrel for Medical Patient or System Reasons
4086F with 1P
4086F with 2P
4086F with 3P

Scenario 3
Dr. Thomas does not prescribe aspirin or clopidogrel and does not specify the reason
4086F with 8P

How It Works

PQRS Claims-Based Process

Visit Documented in the Medical Record

Encounter Form

Coding & Billing

Critical Step

N-365

Critical Advice (DA)

Analysis Contractor

National Claims History File

Carrier/MAC

Confidential Report

Incentive Payment
Any Questions?

• Feel free to email me at

michellerichards@aapc.com