One patient, one measure, no penalty

A step-by-step guide to avoiding Medicare payment penalties

The Medicare Quality Payment Program (QPP) is designed to potentially reward physicians for providing quality, high-value care to Medicare patients.

Reporting on one patient on one measure with CMS before the end of this year is all you need to do to avoid a negative 4% payment adjustment in 2019 under the Merit-based Incentive Payment System (MIPS).

Just follow these directions:

Step 1 Fill out a 1500 billing form as you normally would in boxes 1 through 20.

Step 2 Enter the patient's diagnoses and procedure codes in box 21, as usual.

Step 3 Visit **qpp.cms.gov/measures/quality** to find the Quality Measure search tool. Search for the measure you're reporting and note its three-digit quality ID number.

Step 4 Go to **https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html** to find a ZIP file named "Quality Measure Specifications." Download this file and unzip it on your computer.

Step 5 In the file you unzipped, open the "**QPP_quality_measure_specifications**" folder. Use the quality ID code to find the claims document for the measure you're reporting. In this document, find the Quality Data Code (QDC), for that measure.

Step 6 Go back to your 1500 billing form and enter the QDC code in box 24D.

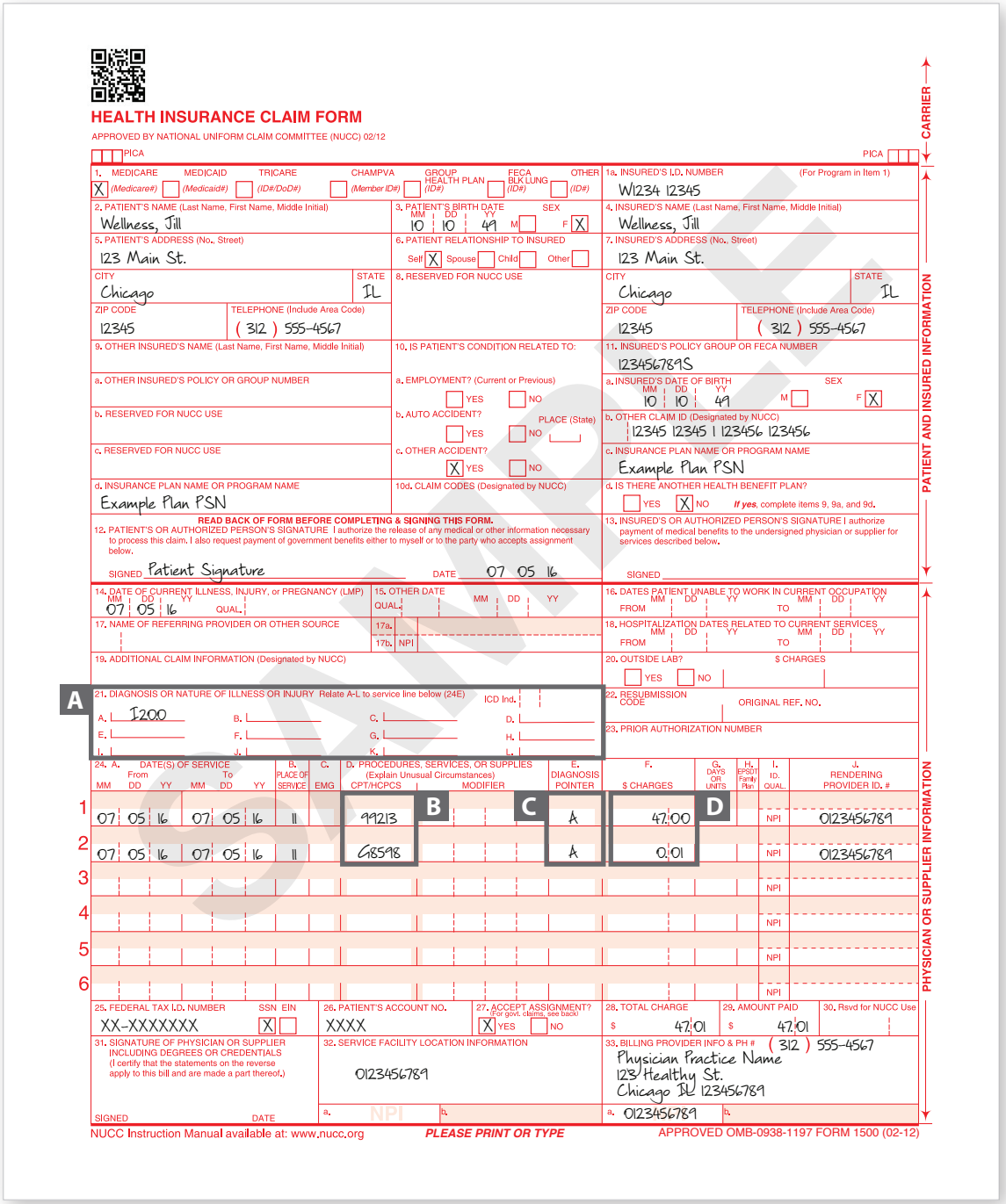
Step 7 In box 24F, list a line-item charge of one cent ($0.01) for the QDC codes you entered in box 24D.

Step 8 Finish entering the information requested in boxes 25 through 33.

Step 9 Submit your 1500 billing form to your Medicare Administrative Contractor.

You can see an example of a completed form on the next page and direct links to all of these CMS tools at **ama-assn.org/qpp-reporting**.

Completed 1500 billing form example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): W1234 12345

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Wellness, Jill

3. PATIENT'S BIRTH DATE MM DD YY: 10 10 49 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Wellness, Jill

5. PATIENT'S ADDRESS (No., Street): 123 Main St.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 Main St.

CITY: Chicago STATE: IL

8. RESERVED FOR NUCC USE

CITY: Chicago STATE: IL

ZIP CODE: 12345 TELEPHONE (Include Area Code): (312) 555-4567

ZIP CODE: 12345 TELEPHONE (Include Area Code): (312) 555-4567

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 123456789S

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 10 49 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC): 12345 12345 | 123456 123456

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Example Plan PSN

d. INSURANCE PLAN NAME OR PROGRAM NAME: Example Plan PSN

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Patient Signature DATE 07 05 16

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 05 16 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

A

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. I200 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 05 16	07 05 16	11		99213	B	C A	47.00	D		NPI	0123456789
2 07 05 16	07 05 16	11		G8598		A	0.01			NPI	0123456789
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: XX-XXXXXXX [X]

26. PATIENT'S ACCOUNT NO.: XXXX

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 47.01

29. AMOUNT PAID $ 47.01

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: 0123456789

a. NPI b.

33. BILLING PROVIDER INFO & PH # (312) 555-4567
Physician Practice Name
123 Healthy St.
Chicago IL 123456789

a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

A Box 21: Enter the applicable ICD-10 code for each diagnosis on its own line.

B Box 24D: Enter QDC codes for appropriate measures.

C Box 24E: Enter the diagnosis that is applicable to each service using the letter lines of the corresponding diagnosis in box 21.

D Box 24F: QDC codes from box 24D must be accompanied by a line-item charge of $0.01 in box 24F.