

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 qpp.cms.gov/resources/education 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

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



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

1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (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 SEX 10 10 49 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 123 Main St. CITY: Chicago STATE: IL		7. INSURED'S ADDRESS (No., Street) 123 Main St. CITY: Chicago STATE: IL	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER 123456789S	
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 QUAL: 07 05 16		15. OTHER DATE MM DD YY QUAL: _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI: _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY _____	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO _____	
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 E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OFF UNITS H. EPOCH PAY #/YR I. ID. QUAL. J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For 90% claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE 29. AMOUNT PAID 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.) _____		32. SERVICE FACILITY LOCATION INFORMATION 0123456789	
33. BILLING PROVIDER INFO & PH # (312) 555-4567 Physician Practice Name 123 Healthy St. Chicago IL 123456789		34. SIGNATURE OF PHYSICIAN OR SUPPLIER DATE 35. NPI 36. DATE	

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

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.