MIPS Quality Example to Avoid Medicare Payment Penalties

Here is an example of an individual NPI reporting on a single CMS-1500 claim a quality measure on one patient encounter. Otherwise, follow normal coding rules for filing a claim.

The patient was seen for an office visit (99213). The physician is reporting a measure related to ischemic vascular disease (IVD):

- **Measure # 204 (IVD) with QDC G8598 + unstable angina diagnosis (24E points to DX I20.0 in Item 21).**
- **The QDC code must be submitted with a line-item charge of $0.01.**
- **If transmission of your Quality Data Code (QDC) was successful to your Medicare Administrative Contractor (MAC) you will receive Remittance Advice Remark Code (RARC) code N620 or CO 246.**

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): X123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe, Jan	02 02 1945 M F X	Doe, Jan
5. PATIENT'S ADDRESS (No., Street): 1234 Healthy Lane	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse X Child Other	7. INSURED'S ADDRESS (No., Street): 1234 Healthy Lane
CITY: Small Town / STATE: PA	8. RESERVED FOR NUCC USE	CITY: Small Town / STATE: PA
ZIP CODE: 16875 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 16875 / TELEPHONE (Include Area Code): ( )
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 X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 01 23 1945 M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicare
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *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 SOF DATE

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 SOF

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 05 2017 QUAL. 431		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. I20.0 B. C. D. / E. F. G. H. / I. J. K. L.		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 17	07 05 17	11		99213		A	47 00	1		NPI	9876543210
2 07 05 17	07 05 17	11		G8598		A	0 01			NPI	9876543210
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
111222444333 X	555666	X YES NO	$ 47 00	$ 00 00	

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	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. NPI b.	Physician Practice Inc. 789 Healthcare Street Doctor Town, IL 60605 a. 12345678 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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