

Practice Management Center

MIPS quality reporting: Claims-based example

STEP 1:

Select a claims-based quality measure you would like to report on.

Visit www.aad.org/FindMeasures to find a measure reportable through claims.

1

STEP 2:

Review the selected measure specification to verify that you have met the performance requirements and to determine applicable quality data code(s) (QDC).

2

STEP 3:

Complete the form following steps 4, 5, 6, and 7. *This example is not intended to be used for official reporting.*

3

STEP 4:

Complete this part of the claim form with patient demographics and insurance information:

- Name
- Address
- ID Number
- Secondary insurance information
- Etc.

4

STEP 5:

Enter patient's diagnosis code(s) in section 21.

5

STEP 6:

- A. Enter date of service.
- B. Enter place of service.
- C. Leave blank
- D. Enter appropriate CPT code (with modifier if appropriate) and G-code for selected measure.
- E. Link corresponding letter(s) from diagnosis box in section 21.
- F. Codes from box 24D must be accompanied by a line-item charge of \$0.01 in box 24F.

6

STEP 7:

Complete this part of the claim form as usual.

7

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HEALTH INSURANCE CLAIM FORM

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

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1. MEDICARE (Medicare #)		2. MEDICAID (Medicaid #)		3. TRICARE (TRICARE #)		4. CHAMPVA (Member ID#)		5. GROUP HEALTH PLAN (ID#)		6. FECA BLK LUNG (ID#)		7. OTHER (ID#)		8. INSURED'S ID NUMBER (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)								3. PATIENT'S BIRTH DATE MM DD YY				SEX M F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)								6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other				7. INSURED'S ADDRESS (No., Street)					
CITY STATE ZIP CODE TELEPHONE (Include Area Code)								8. RESERVED FOR NUCC USE				9. CITY STATE ZIP CODE 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					
a. OTHER INSURED'S POLICY OR GROUP NUMBER								a. EMPLOYMENT? (Current or Previous) YES NO				a. INSURED'S DATE OF BIRTH MM DD YY					
b. RESERVED FOR NUCC USE								b. AUTO ACCIDENT? YES NO				b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE								c. OTHER ACCIDENT? YES NO				c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME								10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO					
<p>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.</p> <p>SIGNED _____ DATE _____</p> <p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNED _____ DATE _____</p>																	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY																	
15. OTHER DATE MM DD YY																	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE																	
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? YES NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. L20.8 B. C. D. E. F. G. H. I. J. K. L.																	
22. RE submission CODE																	
23. PRIOR AUTHORIZATION NUMBER																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS E. DIAGNOSIS POINTER F. \$ CHARGES G. DTS OF UNITS H. I. Q. QUAL. J. RENDERING PROVIDER ID. #																	
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NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

For more information, contact the Academy's Practice Management Center:
EMAIL: MACRA@aad.org • WEBSITE: aad.org/practicecenter

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