

2017 Merit-based Incentive Payment System (MIPS) Quality Performance Category: Claims Data Submission Fact Sheet

The Merit-based Incentive Payment System (MIPS) is 1 of 2 tracks of the [Quality Payment Program](#). MIPS combines aspects of 3 Medicare “legacy” programs – the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals – into a single, improved program.

Under MIPS, there are 4 performance categories that will affect your Medicare payments:

1. Quality
2. Improvement activities
3. Advancing care information
4. Cost

For the transition year, if you’re [eligible for MIPS](#), you have to submit data for the quality, improvement activities, and advancing care information performance categories by March 31, 2018 to avoid a negative payment adjustment and possibly earn a positive payment adjustment. Please note that for the transition year of MIPS, data submission is not required for the cost performance category.

This fact sheet:

- Tells you how to submit data through your claims for the quality performance category and
- Gives you and your billing staff helpful data collection and submission tips

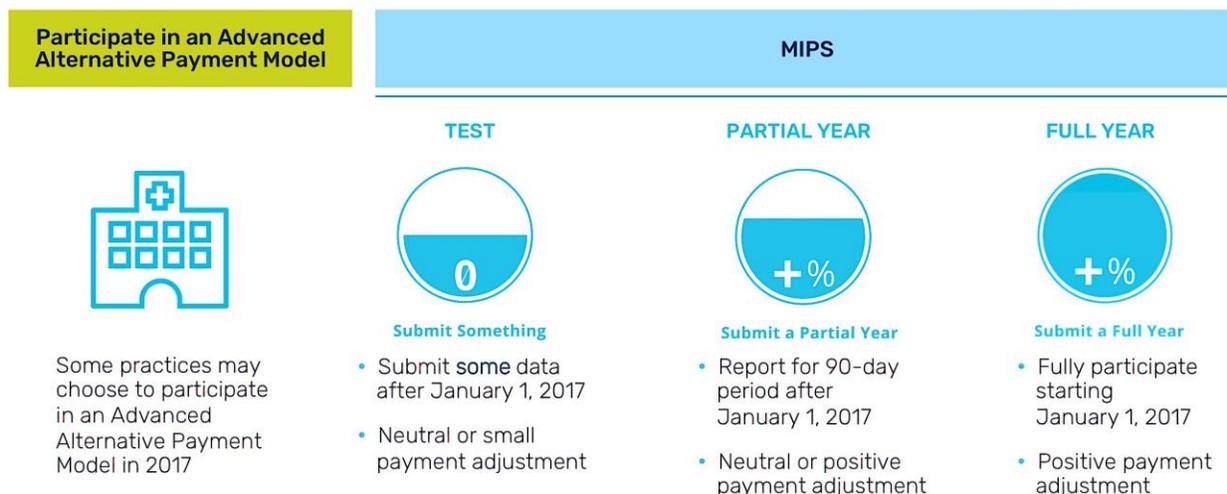
MIPS Quality Performance Category

Under MIPS, there are 74 quality measures that can be submitted through claims. The quality performance category is worth 60% of your overall MIPS final score. For the transition year, you’ll automatically get a minimum of 3 points for submitting at least 1 quality measure. If you participate beyond 1 quality measure and submit up to 6 measures or a specialty measure set, it’s likely that you can be scored on all the measures. Quality measures that can’t be reliably scored against a benchmark, or quality measures without a benchmark, will automatically receive 3 points as long as you have met the data completeness and case minimum requirements.

For the 2017 transition year, you’ll be able to pick how much data to submit, known as “pick your pace.”



Pick your pace gives you 3 levels of participation to choose from:



Note: Clinicians do not need to tell CMS which option they intend to pursue.

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

Test: If you choose the test option, you'll submit the minimally required data: at least 1 quality measure, for 1 patient for 1 day. This will let you get familiar with the program while making sure you avoid the negative payment adjustment.

Partial: If you choose to partially participate, you'll submit at least 6 quality measures, including at least 1 outcome measure, for 90 consecutive days, up to a full year. Under partial participation, we'll look at your performance data and you'll have the chance to earn a modest positive payment adjustment.

Full: If you choose to fully participate, you'll have to submit data for the full year (Jan 1-Dec 31, 2017). Participating fully gives you more of a chance to earn a higher positive payment adjustment.

MIPS Claims-based Data Submission

You can only use claims-based data submission if you're an individual MIPS eligible clinician submitting quality data. It's not an option if you're participating in MIPS as a [group](#).

To submit quality data through your claims, you have to:

- Pick the appropriate MIPS quality measures
- Report the measures through your regular billing

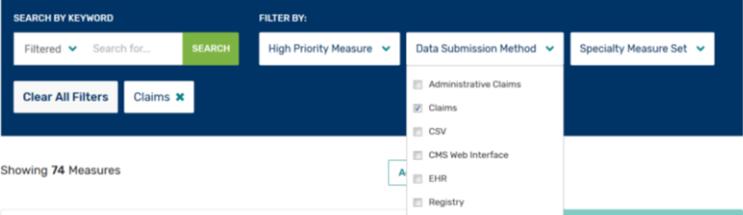
If you choose to submit your data through your claims, you'll add Quality Data Codes (QDCs) to denominator eligible claims to show that the required quality action or exclusion happened. QDCs are specified Current Procedure Terminology (CPT) II codes (with or without modifiers) and G-codes used for submission of quality data for MIPS. When these codes are including on your claims form, it identifies your selected quality measures for CMS. You'll also need to apply encounter codes, including ICD-10-CM, CPT Category I, or Healthcare Common Procedure Coding System (HCPCS) codes. These codes show which patients should be added toward the denominator/numerator of the quality measure.

As a Medicare provider, you submit claims through the [CMS-1500 form](#) or [CMS-1450](#) (or the electronic version) to be paid for billable services given to Part B Fee-for-Service (FFS) beneficiaries that you'll bill for using your individual/rendering National Provider Identifier (NPI).

When you report your quality data to CMS through your claims (claims will have QDC line items for each clinician's NPI), they'll be processed to final action by the Medicare Administrative Contractor (MAC) and then sent to the National Claims History (NCH) for MIPS analysis.

5 Steps for Claims-based Data Submission

STEP	DESCRIPTION
<p>Step 1: Figure out if you're required to participate in MIPS</p>	<p>For 2017, you're required to participate in MIPS if you:</p> <ul style="list-style-type: none"> • Are 1 of these types of clinicians: <ul style="list-style-type: none"> o Physicians (including doctors of medicine, doctors of osteopathy, osteopathic practitioners, doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors) o Physician's assistants o Nurse practitioners o Clinical nurse specialists o Certified registered nurse anesthetists o Groups that include the clinicians in this list <p>Unless, during the applicable determination periods, you:</p> <ul style="list-style-type: none"> • Bill less than or equal to \$30,000 in Medicare Part B allowed charges or • Have 100 or fewer Part B-enrolled Medicare beneficiaries <p>You can check your MIPS participation status by entering your NPI in the participation Look Up Tool on qpp.cms.gov.</p>

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<p>Step 2: Choose your quality measures</p>	<p>Visit the Quality section of the Quality Payment Program website to:</p> <ul style="list-style-type: none"> • See which quality measures work best for you • Learn if you can submit the measures through claims • Review the measure specifications for the QDC that goes with the measures you picked <p>Use the measures tool at the bottom of the Quality webpage to see if the measures can be submitted through claims. You'll pick "claims" from the data submission drop-down menu.</p> <p>Select Measures</p> 
<p>Step 3: Find your eligible cases</p>	<p>Make sure that your practice finds all denominator- eligible cases for the measures you picked. Think about using a billing software edit that will flag claims every time the combination of codes in a measure's denominator is billed so the entry QDCs is required before the final claims are submitted.</p> <p>To find denominator-eligible cases, see the Quality Measure Specifications Supporting Documents.</p>
<p>Step 4: Submit your 2017 data for the MIPS quality performance category by March 1, 2018</p>	<p>You can submit your quality data for MIPS through your claims by appending a QDC to your claims form throughout the year – but not later than March 1, 2018.</p> <p>Claims processed by the MAC (including claims adjustments, re-openings, or appeals) must get to the national Medicare claims system data warehouse (National Claims History file) by March 1, 2018 to be analyzed. You should be sure to file claims for services given toward the end of the performance year in time. Your MAC can give you specific instructions on how to bill.</p> <p>For the 2017 transition year, you can meet the minimum MIPS program requirement if you submit 1 quality measure for at least 1 patient for at least 1 day. This is the "test" participation option</p>

STEP	DESCRIPTION
	<p>of Pick Your Pace and guarantees that you'll avoid the negative payment adjustment.</p> <p>To learn more, see the What to Report section of the Quality Payment Program website.</p>
<p>Step 5: Establish an office workflow</p>	<p>Setting up an office workflow will let the denominator-eligible patient for each of the measures you've picked to be accurately identified on your Medicare Part B claims. Make sure that:</p> <ul style="list-style-type: none"> • All of your supporting staff (including billing services) understand the measures you've picked for submission. • All denominator-eligible claims for the measure(s) you've picked are found and noted; and how often the measures you've picked have to be reported is known and understood. • All denominator coding is shown on the claim form before the numerators are coded.

QDC Verification

Remittance Advice (RA)/Explanation of Benefits (EOB)

The RA/EOB denial code N620 tells you that the QDC codes are valid for the 2017 MIPS performance period. The N620 denial code tells you that the QDC codes are valid for the 2017 MIPS performance period, but doesn't mean the QDC was right or that you met the measure requirements.

If you bill on a \$0.00 QDC line item, you'll get the N620 code. If you bill on a \$0.01 QDC line item, you'll get the CO 246 N620 code. All of your submitted QDCs on fully processed claims get sent to our warehouse for analysis, so you'll want to be sure you see the QDCs' line items on the RA/EOB, whether or not you get the RAN620 code. Remember to keep track of all cases you've submitted to prove QDCs reported against the remittance advice notice were sent by the MAC. Each QDC line-item will be listed with the N620 denial remark code.

Claim Adjustment Reason Code (CARC) for QDCs with a charge \$0.01

The CARC 246 with Group Code CO or PR and with the Remittance Advice Remark Code (RARC) N620 shows that a procedure isn't payable unless non-payable reporting codes and the right modifiers are submitted.

- CARC 246 shows this is a non-payable code for reporting only.
- If you bill with a charge of \$0.01 on a QDC item, you'll get CO 246 N620 on the EOB.

RARC code for QDCs with \$0.00

The new RARC code N620 shows you that the QDC codes got to our National Claims History (NCH) database.

- If you bill with \$0.00 charge on a QDC line item you'll get an N620 code on the EOB.
- The N620 will say: This procedure code is for quality reporting/informational purposes only.

Clinicians at Critical Access Hospitals (CAHs)

For the 2017 performance period, if you're a clinician in a Critical Access Hospital Method II (CAH II), you can participate in MIPS using the claims-based reporting through the CMS-1450 form. No matter which way you submit data, if you're a CAH II clinician, you'll have to keep adding your NPI to the [CMS-1450 claim form](#) so we can analyze your MIPS reporting at the NPI level.

If you're an institutional provider and you qualify for a waiver from the Administrative Simplification Compliance Act requirement to submit your claims electronically, you can use the [CMS-1450 form](#) to bill a Medicare fiscal intermediary. You can also use this form to bill for institutional charges to most Medicaid State Agencies. You should contact your Medicaid State Agency for more details about how to use this paper form.

Technical Assistance for Small, Underserved, and Rural Practices

We give you flexible options and help if you're in a small practice, including if you're in a rural location, a health professional shortage area, or a medically underserved area. You can find more about these options on the Quality Payment Program [webpage](#).

Tips for Successful Participation in MIPS

1. If your MAC denies payment for all the billable services on your claim, the QDCs won't be included in the MIPS analysis, so your data won't count towards your MIPS participation.
2. If you correct a denied claim and it gets paid through an adjustment, re-opening, or the appeals process by the MAC with accurate codes that go with the measure's denominator, then any of the QDCs that apply and go with the numerator should also be included on the corrected claim.
3. As long as an originally submitted claim contains a QDC for the performance period, eligible clinicians can resubmit that claim to correct or add the line item charge (i.e. \$0.00 or \$0.01) associated with that QDC.
4. You can only submit claims-based data for the quality performance category. To fully participate in MIPS for the transition year, you should use your certified EHR technology to submit your advancing care information data and attest to your practice improvement activities, unless you chose the minimum requirement for the transition year (also referred to as Test under pick your pace).
5. To submit at least 90 days of quality data through claims, you should start appending QDCs to your claims no later than October 2, 2017.



Resources

- For questions, contact the Quality Payment Program Service Center at 1-866-288-8292 (TTY 1-877-715- 6222), available Monday through Friday 8:00 AM-8:00 PM Eastern Time, or by e-mail at QPP@cms.hhs.gov