

2018 Merit-based Incentive Payment System (MIPS) Quality Performance Category: Claims Data Submission Fact Sheet

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:

- Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advanced APMs)

Under MIPS, there are four performance categories that may affect your 2018 final score, and the MIPS payment adjustment that applies to Medicare payments in the 2020 payment year:

1. Quality
2. Improvement Activities
3. Promoting Interoperability
4. Cost

If you're [eligible for MIPS in 2018](#), you generally have to submit data for the Quality, Improvement Activities, and Promoting Interoperability performance categories by March 31, 2019. **If you are participating in MIPS as an individual clinician and you choose to use claims to submit Quality performance category data, you will attach quality data codes to your claims throughout the 2018 performance year. The last day for submitting 2018 claims with quality data codes for the 2018 performance period is determined by your [Medicare Administrative Contractor \(MAC\)](#) but must be processed 60 days after the close of the performance period. Please check with your MAC for this guidance.** (Please note that data submission is not required for the Cost performance category; CMS will calculate your cost measures using administrative claims data.) Your performance in these 4 categories will result in a final score, which in turn will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.

For those MIPS eligible clinicians who choose to submit Quality performance category data via claims-based reporting, 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

Starting in 2018, there's a 12-month Quality performance period (January 1 – December 31, 2018). In Year 2 of the Quality Payment Program, the Quality performance category is 50% of your overall MIPS final score.

Clinicians, groups, and Virtual Groups should report the measures that are most meaningful to their practice and choose the submission mechanism that best meets their needs; not all quality measures can be reported through all submission mechanisms.

Under MIPS, there are 73 quality measures that can be submitted through claims. To fulfill the Quality performance category requirements via claims, a clinician must submit:

- Six quality measures (or specialty measure set) for the 12-month performance period
- At least one outcome measure, or another high priority measure in the absence of an applicable outcome measure.

Quality measures that meet case minimum requirements (20 cases) and data completeness requirements (60% in Year 2) are eligible for scoring against a benchmark and will earn 3 – 10 points based on performance as compared to the related benchmark. Please note that quality measures submitted via claims are not eligible for the end-to-end electronic reporting bonus. For additional information on MIPS scoring, please refer to the 2018 MIPS Scoring 101 Guide.

MIPS Claims-based Data Submission

Clinicians participating in MIPS as individuals can submit their quality measures through claims. This submission mechanism is not an option when participating in MIPS as a [group or Virtual Group](#).

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

- Select the MIPS claims quality measures most meaningful to your practice
- Submit the measures through your regular billing processes by adding certain billing codes to denominator eligible claims

If you choose to submit your quality measure data through claims-based submission, you must first code your claim form for reimbursement. If the claim meets the denominator criteria for the quality measure chosen to submit, you will apply the corresponding Quality Data Codes (QDCs) found within the numerator of that quality measure. The denominator of claims-based quality measures includes ICD-10-CM, CPT Category I, and/or Healthcare Common Procedure Coding System (HCPCS) codes. These codes show which encounters should be included in the denominator of the quality measure. Each quality measure specification (found in the [2018 Resource Library](#)) includes the code sets to identify denominator eligible encounters.

Note: CMS is establishing an annual review process to assess claims quality measures impacted by ICD-10 code changes during the performance year. Significantly impacted measures will be assessed only on the first nine months (1/1-9/30) of the 2018 performance period because ICD-10 code changes are effective 10/1 of the 2018 performance period.

Each QDC(s) corresponds to a quality action that could have occurred during the denominator eligible encounter. Choose the most appropriate quality option for that denominator eligible encounter and apply that QDC(s) to your claim form. QDCs may include Current Procedure Terminology (CPT) II codes (with or without modifiers) and/or G-codes for submission of quality data in MIPS. The QDC(s) included on your claim form identify for CMS which claims-based quality measure(s) you are submitting.

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).

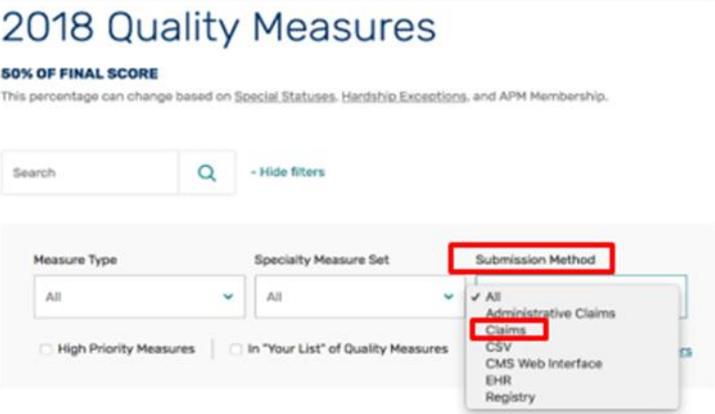
When you submit your quality data to CMS through your claims (claims will have QDC line items for each clinician's NPI), they'll be processed to final action by the Medicare Administrative Contractor (MAC). All claims reimbursed are sent to the National Claims History (NCH). This is the data source that MIPS will use for measure analysis.

Please keep in mind that claims can only be used for submitting measures in the Quality performance category; clinicians submitting quality measures via claims need to select a different submission mechanism to submit their Promoting Interoperability data and Improvement Activities.

5 Steps for Claims-based Quality Measure Submission

<p>Step 1:</p> <p>Figure out if you're required to participate in MIPS</p>	<p>For 2018, 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"> ○ 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) ○ Physician Assistants ○ Nurse Practitioners ○ Clinical Nurse Specialists ○ Certified Registered Nurse Anesthetists ○ 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 \$90,000 in Medicare Part B allowed charges for covered professional services under the PFS; OR • Have 200 or fewer Part B-enrolled Medicare Fee for Service (FFS) beneficiaries <p>You can check your MIPS participation status by entering your NPI in the QPP Participation Status Tool on gpp.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 claims measure specifications that correspond with the measures you selected <p>Helpful hint: You can filter measures on the Quality section of the Quality Payment Program website by submission mechanism to see if the measures can be submitted through claims. You'll pick "claims" from the data submission drop-down menu.</p> 
<p>Step 3: Find your eligible cases</p>	<p>Make sure that your practice finds all denominator- eligible cases for the measures you selected. Think about using a billing software that will flag claims every time the combination of codes in a measure's denominator is billed so that QDC entry is required before the final claims are submitted.</p> <p>To find denominator-eligible cases, see the Quality Measure Specifications Supporting Documents.</p> <p>There is a 60% data completeness requirement in 2018, which means that you must submit performance on at least 60% of your denominator-eligible instances per measure.</p>
<p>Step 4: Submit your 2018 claims data for the MIPS Quality performance category</p>	<p>Submit your quality data for MIPS through your claims by appending a QDC to your claims form with dates of service during the performance period– January 1, 2018 through December 31, 2018.</p> <p>Claims are processed by the MACs (including claims adjustments, re-openings, or appeals) and must get to the national Medicare claims</p>



	<p>system data warehouse (National Claims History file) no later than 60 days following the close of the performance period to be analyzed.</p> <p>You should be sure to file claims for services given toward the end of the performance year in time. Please work with your MAC for specific instructions on how to bill.</p>
<p>Step 5: Establish an office workflow</p>	<p>Set up an office workflow that will let the denominator-eligible patients for each of the measures you've selected be accurately identified on your Medicare Part B claims. To do, make sure that:</p> <ul style="list-style-type: none"> • All of your supporting staff (including billing services) understand the measures you've selected for submission. • All of your supporting staff (including billing services) can identify all denominator-eligible claims for the measure(s) you've selected. • All of your supporting staff (including billing services) understand how often the measures you've selected have to be submitted.

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 2018 MIPS performance period. The N620 denial code tells you that the QDC codes are valid for the 2018 MIPS performance period, but it doesn't mean the QDC was reported correctly for the intended measure 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 2018 performance period, if you're a MIPS eligible 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.

Tips for Successful Participation in MIPS Using Claims Data Submission

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 for the 2018 performance period.
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. A claim cannot be resubmitted to the MAC for the sole purpose of adding or correcting a QDC.
5. You can only submit claims-based data for the Quality performance category. To fully participate in MIPS, you should use your certified EHR technology to submit your Promoting Interoperability data and attest to your practice improvement activities.
6. To meet data completeness requirements for quality measures, you should start appending QDCs as soon as possible after January 1, 2018. Be aware that some measures contain a shortened measurement period to accommodate evaluation of the most appropriate numerator quality action outcome. Review each measure specification to determine if it has a shorter measurement period.

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7. Quality measure denominator criteria and numerator codes are subject to change from one performance year to the next. Check the [Quality Measure Specification supporting documents](#) to ensure you are using the appropriate criteria and codes for the 2018 performance period.

Technical Assistance for Small, Underserved, and Rural Practices

We give you flexible options and help if you're in a small practice and/or practice 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](#).

Resources

If you have additional questions, please contact The Quality Payment Program 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.