Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2022 Reporting MIPS Quality Measures through Medicare Part B Claims Quick Start Guide for Small Practices (Traditional MIPS)

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Purpose: This resource walks through the steps needed for small practices to report Medicare Part B claims measures (whether participating as an individual, group, virtual group, or Alternative Payment Model (APM) Entity). A small practice is defined as a group that has 15 or fewer clinicians identified by National Provider Identifier (NPI), billing under the groups Taxpayer Identification Number (TIN). To see if you have the small practice designation, visit the Quality Payment Program Participation Status Lookup Tool.

How to Use This Guide

How to Use This Guide

Table of Contents

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Please note: This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Hyperlinks

Hyperlinks to the Quality Payment Program website are included throughout the guide to direct the reader to more information and resources.

Overview

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP), a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program describes how we reimburse MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Under MIPS, we evaluate your performance across multiple categories that lead to improved quality and value in our healthcare system.

If you're eligible for MIPS in 2022:

- You generally have to submit data for the quality, improvement activities, and Promoting Interoperability performance categories. (We collect and calculate data for the cost performance category for you.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based on your performance during the 2022 performance year and applied to payments for covered professional services beginning on January 1, 2024.

To learn more about MIPS eligibility and participation options:

- Visit the How MIPS Eligibility is Determined and Participation Options web pages on the Quality Payment Program website.
- View the 2022 MIPS Quick Start Guide.
- Check your current participation status using the QPP Participation Status Tool.

To learn more about the APP:

- Visit the APM Performance Pathway (APP) webpage on the Quality Payment Program website
- View 2021 APM Performance Pathway (APP) for MIPS APM Participants and 2021 APM Performance Pathway (APP) Infographic resources.

To learn more about the MVPs:

- Visit the MIPS Value Pathways (MVPs) webpage on the Quality Payment Program website.

What is the Merit-based Incentive Payment System? (Continued)

Traditional MIPS, established in the first year of the QPP, is the original framework for collecting and reporting data to MIPS.

Under the traditional MIPS, participants select from 200 quality measures and over 100 improvement activities, in addition to reporting the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

In addition to traditional MIPS, 2 other MIPS reporting frameworks, designed to reduce reporting burden, will be available to MIPS eligible clinicians:

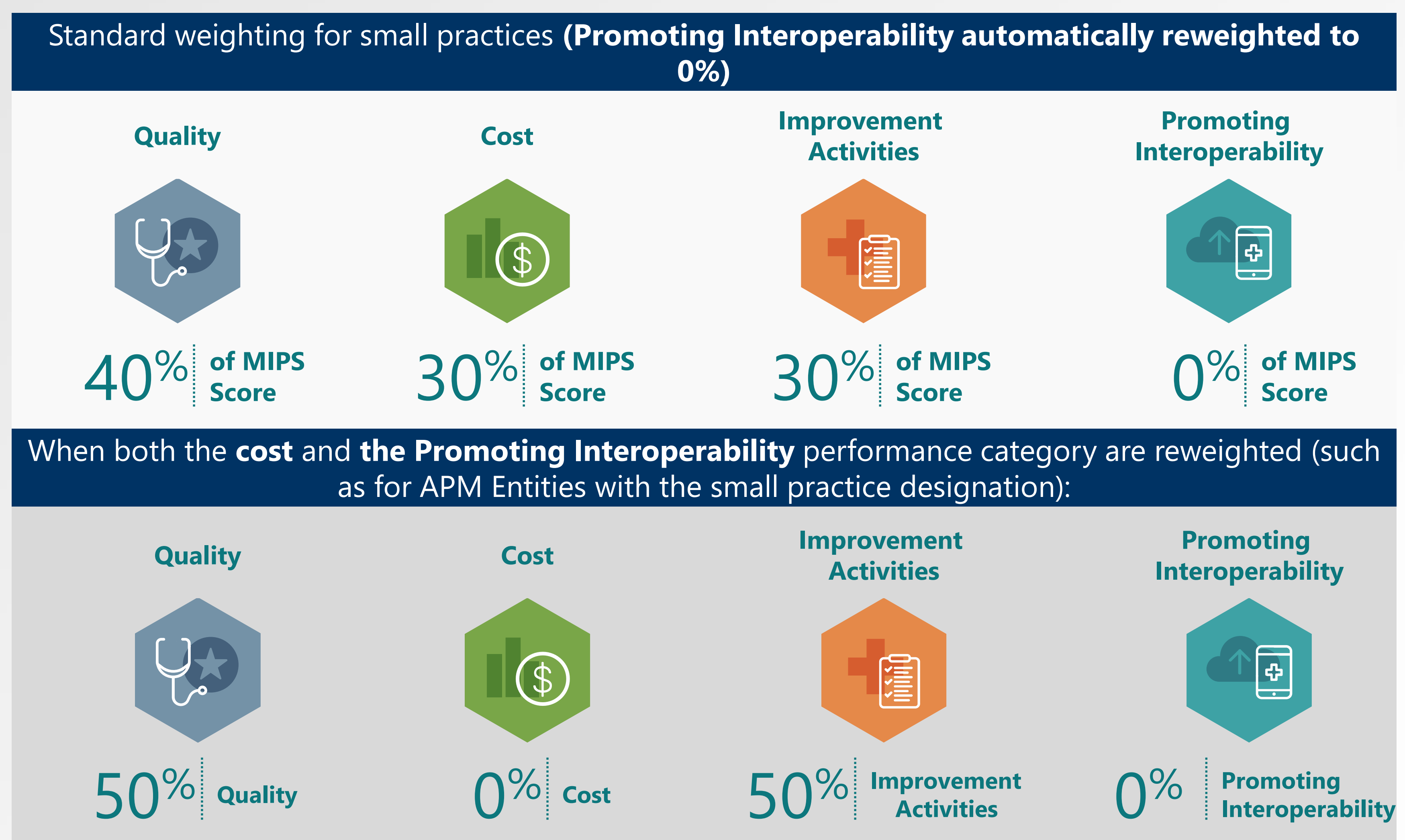
- The **APM Performance Pathway (APP)**, is a streamlined reporting framework available beginning with the 2021 performance year for MIPS eligible clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs.
- **MIPS Value Pathways (MVPs)** are subsets of measures and activities, established through rulemaking, that can be used to meet MIPS reporting requirements beginning with the 2023 performance year. The MVP framework aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties or conditions. In addition, MVPs incorporate a foundational layer that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health/public health priorities. **There are 7 MVPs that will be available for reporting in the 2023 performance year:**

1. Advancing Rheumatology Patient Care
2. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
3. Advancing Care for Heart Disease
4. Optimizing Chronic Disease Management
5. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
6. Improving Care for Lower Extremity Joint Repair
7. Support of Positive Experiences with Anesthesia

We encourage clinicians interested in reporting an applicable MVP to become familiar with the MVP's requirements in advance of the 2023 performance year. For more information on the finalized MVPs, please refer to the CY 2022 Physician Fee Schedule Final Rule. We'll also be adding more information to MIPS Value Pathways section of the QPP website.

Final Score Calculation – Redistribution Policies for Small Practices

Did you know? Beginning in PY 2022, we're automatically reweighting the Promoting Interoperability performance category for clinicians in small practices. We also finalized changes to the redistribution policies specifically for small practices.



What's New with Medicare Part B Claims Reporting in 2022?

- **Beginning in the 2022 performance year, we'll only calculate a group-level quality score from Medicare Part B claims measures if the practice submits data for another performance category as a group (signaling their intent to participate as a group).**

- **13 Medicare Part B claims measures were removed** from the 2022 MIPS quality measure set and can no longer be reported. Review Appendix A for a list of these measures.

- **21 Medicare Part B claims measures received substantive changes** from the 2021 measure specifications and will have no historical benchmarks for 2022. Review the 2022 Quality Benchmarks to identify which claims measures won't have a historical benchmark for 2022.

Get Started with Claims Measure Reporting for Traditional MIPS in 5 Steps

Get Started with Claims Measure Reporting for Traditional MIPS in 5 Steps

Quality Payment PROGRAM

Step 1. Check Your Current Availability

Enter your NPI in the Quality Payment Program (QPP) Participation Status Tool on the QPP website. This tool will show you your current eligibility and indicate if you're considered a small practice. Practices can also sign in to qpp.cms.gov to review eligibility for all clinicians in the practice.

Virtual groups and APM Entities need to sign in to qpp.cms.gov to see if they have the small practice status that allows them to report Medicare Part B claims measures.

What if I'm....

Eligible?
If you (or any of the clinicians in your practice) are eligible to participate in MIPS, then you can choose to participate as an individual or group.

Not Eligible?
If you are not eligible to participate in MIPS, then you are not required to participate but may be eligible to opt-in.

Did you know?

If your practice has 15 or fewer clinicians billing between October 1, 2021, and September 30, 2022, and has selected Medicare Part B claims measures for reporting, continue to report through Medicare Part B claims even if you don't see the small practice status.

- **We'll update eligibility, including small practice status, in December 2022.** If you're currently identified as a small practice, that won't change when we update eligibility.

If you (or any of the clinicians in your practice) are eligible to participate in MIPS and you want to report Medicare Part B claims measures, **start reporting your quality measures through claims now.** You cannot report quality measures on previously submitted claims.

Note: If the clinicians in your practice are not eligible to participate in MIPS as individuals, your practice may be eligible to participate as a group. However, a practice that is eligible to participate in MIPS as a group is not required to do so.

Beginning in the 2022 performance year, we'll only calculate a group-level quality score from Medicare Part B claims measures if the practice submits data for another performance category as a group (signaling their intent to participate as a group).

Step 2. Understand the Available Resources

The 2022 Medicare Part B Claims Measure Specifications and Supporting Documents zip file on the Quality Payment Program Resource Library (and Explore Measures & Activities tool) includes 3 supporting documents to help you understand how to report quality measures through claims.

- **2022 Quality Payment Program (QPP) Measure Specification and Measure Flow Guide for Medicare Part B Claims Measures –** This document defines the common terms included in measure specifications, walks you through a sample measure specification, and reviews how the measure flows (included in each specification) can help you interpret who is included in and excluded from the measure's patient population.
- **Medicare Part B Claims Measure Specifications Release Notes –** This document details changes to existing measures that will go into effect in the 2022 performance period.
- **2022 Quality Payment Program (QPP) Medicare Part B Claims Measures Single Source –** This spreadsheet is a tool that can help you identify measures that may apply to your practice based on common codes that you bill.

Additionally, the 2022 MIPS Quality Measures List is available on the Quality Payment Program Resource Library. This spreadsheet is a tool that MIPS eligible clinicians can use to search for current 2022 quality measures, including Medicare Part B claims measures.

Note : A sample measure description is provided in Appendix B to help you identify important measure definitions and features.

Step 3. Choose Your Measures (Traditional MIPS Only)

Whether you're participating as an individual, small practice (15 or fewer clinicians) group, virtual group, or APM Entity, you must select 6 measures if you're reporting traditional MIPS. You must report either:

6 measures for the small practice group, virtual group, or APM Entity as a whole if participating as a group, virtual group, or APM Entity

OR

6 measures for each MIPS eligible clinician if participating as individuals

Clinicians in a MIPS APM who choose to report the APM Performance Pathway (or APP) need to report the quality measures specified in the APP, 3 of which can be reported as Medicare Part B claims measures. **If reporting the APP, you can skip ahead to the next step.**

Of these 6 measures, 1 must be an outcome measure OR a high priority measure (if an outcome measure is not available).

If reporting traditional MIPS, you may also select a specialty-specific set of measures, if applicable to you, your group, your virtual group or APM Entity.

- If less than 6 measures apply to you or your group, then you should report on each applicable measure.

If your practice is reporting as individuals, then all of the MIPS eligible clinicians within your practice can report the same measures as long as the measures are applicable to the services they provide.

Not sure how to get started? In addition to reviewing measure specifications, you can:

- Use the **2022 Quality Payment Program (QPP) Medicare Part B Claims Measures Single Source** document (from Step 2) to search for encounter, procedure, and diagnosis codes that you routinely bill.
- On the Explore Measures & Activities Tool on the Quality Payment Program website, **search for key terms** that are applicable to the care that you provide or patient population you serve or **filter by specialty set**. (The Explore Measures & Activities Tool will not be updated with 2022 measures and activities until early 2022)

Step 4. Establish an Office Workflow

The next step to 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 this, make sure that all of your supporting staff (including billing services):

- Understand the intent of the measures you've selected for submission.
- Can identify all denominator-eligible claims for the measure(s) you've selected
    - Review the measures specifications to identify your denominator eligible case(s).
- Understand how often the measures you've selected have to be submitted on Medicare Part B claims within the performance period.
- If applicable, contact your software billing vendor to verify that chosen measures can be coded within the office workflow system and updated yearly.

Note: Review the sample measure numerator codes in Appendix C to find where the numerator and denominator codes are located within each measure's specifications.

Step 5. Add Your Quality Measure Performance Data to Your Medicare Part B Claims

To add your quality measure performance data to your Medicare Part B claims, you'll code your claims as usual and add quality data codes (QDCs) and Current Procedural Terminology (CPT) codes as appropriate for the measure being reported.

- **Append QDC(s):** Submit your quality data for MIPS through your Medicare Part B claims by appending a QDC to your claims form with dates of service during the performance period – January 1 through December 31, 2022. QDCs must be included on the originally submitted claim. You cannot go back and add QDCs to a previously submitted claim.
- **Insert a Charge:** When you attach a QDC to your claim, you must include $0.00 line item charge for the QDC. If your billing software will not accept a code without a charge, attach a $0.01 line item charge for the QDC. An entry in the line item charge box on the claim form is a requirement for quality reporting via Medicare Part B claims to CMS.
- **Check for Accuracy:** We encourage you to review your Medicare Part B claims for accuracy prior to submission for reimbursement and reporting purposes. It's important to confirm that you are using the 2022 measure specifications to appropriately code your claims as the specifications may change each year.
- **MAC Processing:** Claims (including claims adjustments, re-openings, or appeals) are processed by the Medicare Administrative Contractors (MACs) and must get to the national Medicare claims system data warehouse (National Claims History file) no later than 60 days following the close of the performance period to be analyzed.
- **Don't wait!** For patient encounters that occur towards the end of the performance year (December 31, 2022), be sure to file claims quickly. Medicare Part B claims (with the appropriate QDCs) must be processed no later than 60 days after the close of the performance period to be counted for quality reporting. Please work with your MAC to determine the last day a claim can be submitted for 2022 quality reporting.

Looking for an example? Visit Appendix D to view a sample CMS-1500 claim form that is coded for a quality data submission.

Step 5. Add Your Quality Measure Performance Data to Your Medicare Part B Claims (Continued)

Did you know? To meet the 70% data completeness requirement, you should start appending QDCs as soon as possible after January 1, 2022. Some measures have a shortened measurement period, so be sure to review measure specifications carefully.

Quality data codes must be reported:

On the claim(s) with the denominator billing code(s) that represent(s) the eligible Medicare Part B Physician Fee Schedule (PFS) encounter.

AND

For the same Medicare patient.

AND

For the same date of service (DOS).

AND

By the same clinician who performed the covered service, applying the appropriate encounter codes (I[CD-10-CM, CPT Category I, or HCPCS codes). These codes are used to identify the measure's denominator.

Quality measure denominator criteria and numerator codes are subject to change from one performance year to the next. **Make sure you are reviewing the 2022 Medicare Part B Claims Measure Specifications** to ensure you are using the appropriate criteria and codes for the 2022 performance period.

Make sure you are billing services under the clinician's individual (Type 1) NPI, and not the organization (Type 2) NPI. We will automatically aggregate individual reporting into a quality score for the group (and virtual group or APM Entity as appropriate).

Frequently Asked Questions

Frequently Asked Questions

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How Do I know if the QDCs I Submitted are Valid for MIPS in 2022?

Once you've submitted the claim form and included the QDC(s) and other information to report your quality data via claims, you'll need to review the information you receive back from the MAC in the Remittance Advice (RA) or the Explanation of Benefits (EOB) to see if it the data submission was valid and successful.

What Should I Expect to See on My Remittance Advice (RA)/Explanation of Benefits (EOB)?

The RA/EOB lists denial codes that correspond to the information you submitted on the claim form. When **N620** is listed as a denial code, it tells you that the QDC(s) are valid for the 2022 MIPS performance period.

The N620 denial code tells you that the QDC(s) are valid for the 2022 MIPS performance period, but it doesn't mean the QDC(s) were reported correctly for the intended measure or that you met the measure requirements.

- If you bill a $0.00 QDC line item, you'll get the N620 code. If you bill 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 and check whether or not you received the RA N620 code.
- See Appendix E for examples of when a valid QDC was submitted unsuccessfully.

Remember to keep track of all the denominator eligible cases you've reported to prove the QDCs you reported compared to the RA notice you received from your MAC. Each QDC line item will be listed with the N620 denial remark code.

Troubleshooting Tips: If the RA shows only the billed charge and no QDC(s):

- Check to ensure that the billable charge and the QDC(s) were billed on the same claim form for the same date of service at the same time.
- Check to ensure your software is transmitting the QDC(s) with a 0-charge amount or a 1-cent charge for transmission.
- (If applicable) Check with your clearinghouse to ensure it is receiving the QDC(s) and that it is transmitting the QDC(s) to the MAC.
- Check with the MAC to ensure the codes came through on the same claim and to verify how the MAC processed them. You will need the claim number and transmittal batch number in order for the MAC to research the matter.

Note: You can't resubmit a claim solely to add or correct missing QDCs. The submission will be rejected as a duplicate and non-payable claim.

What Should I Expect to See on My Remittance Advice (RA)/Explanation of Benefits (EOB)? (Continued)

Valid QDCs with a $0.01 Charge Receive a Claim Adjustment Reason Code (CARC).

When you successfully submit a valid QDC, the RA/EOB will list the CARC 246 along with a Group Code (CO or PR) and the Remittance Advice Remark Code (RARC) N620.

- If you bill with a charge of $0.01 on a QDC item, you'll get CO 246 N620 on the EOB.
- CARC 246 says: **This non-payable code is for required reporting only.**

The CARC and RARC tell you that the QDC you submitted is valid for the 2022 MIPS performance period, but **it doesn't mean the QDC was reported correctly for the intended measure or that you met the measure requirements.**

What's the difference between a RARC & a CARC?

CARCs communicate a reason for a payment adjustment that describes why a claim or service line was paid differently than it was billed. RARCs are used to provide an additional explanation for an adjustment already described by a CARC or to convey information about remittance processing. When you submit the $0.01 line item charge with the QDC, you don't get reimbursed the $0.01 so the MAC adjusts that down to $0.00 when processing your claim and sends a CARC to explain the adjustment.

Valid QDCs with a $0.00 Charge Receive a RARC code.

When you successfully submit a valid QDC, the RA/EOB will list the RARC code N620 which means that the QDC got to the NCH database.

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

What Happens if a Medicare Part B Claim is Denied?

If your MAC denies payment for all the billable services on your claim, the QDCs won't be included in the MIPS analysis, and that claim's data won't count towards your quality measure submission for the 2022 performance period.

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.

IMPORTANT: Beginning in the 2022 performance year, we'll only calculate a group-level quality performance category score from Medicare Part B claims measures if the practice submits data from another performance category as a group (signaling their intent to participate as a group).

Can I Resubmit a Medicare Part B Claim to Add Quality Data?

No, a claim cannot be resubmitted to the MAC for the sole purpose of adding or correcting a QDC. However, 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 (e.g., $0.00 or $0.01) associated with that QDC.

Can I Use Medicare Part B Claims to Report for Other Performance Categories?

No, but you can sign in to the QPP website and attest to your Promoting Interoperability measures (collected in 2015 Edition Certified Electronic Health Record Technology (CEHRT)) and improvement activities. We'll use claims to evaluate you on cost measures; no action is needed from you or your practice. If you want to participate as a group, then you will need to report your Promoting Interoperability and improvement activity data at the group level—we won't aggregate individual data into a group score for these categories.

How Does Group, Virtual Group, or APM Entity Participation Work for Medicare Part B Claims Measures?

Unlike other types of quality measures, Medicare Part B claims quality measures are always reported at the individual clinician level. If you are participating as a group, virtual group, or APM Entity, then we'll aggregate the individually reported quality measures into a group, virtual group, or APM Entity quality score.

When Will I See Feedback on My Medicare Part B Claims Reporting?

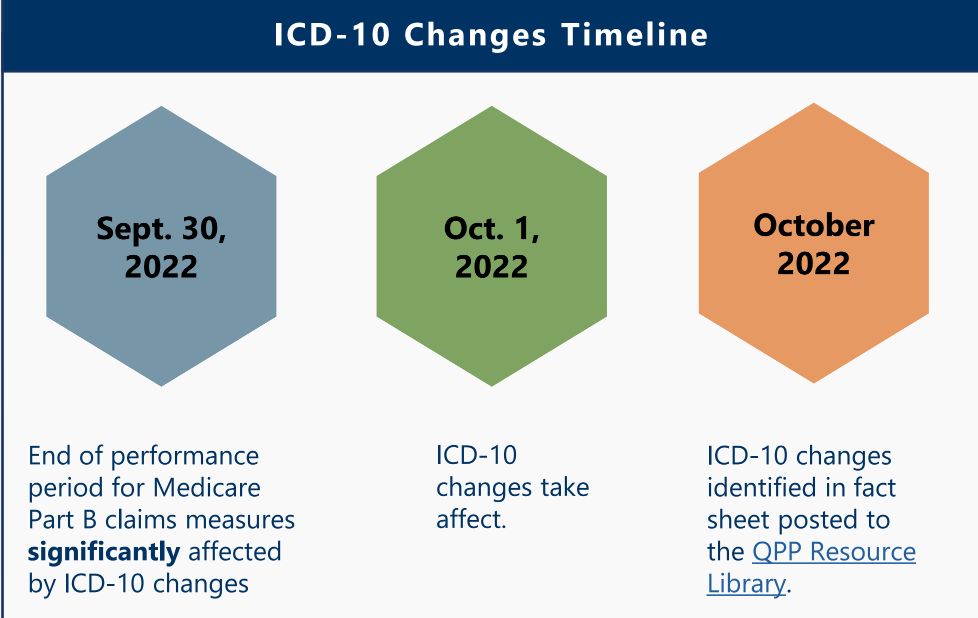
If you submit quality performance category data via Medicare Part B claims, then you can login to the Quality Payment Program website and review your preliminary performance feedback in February 2023.

What about ICD-10 Changes?

Some Medicare Part B claims measures may be significantly impacted by ICD-10 changes, which take effect every year on October 1. These measures will have a 9-month performance period (ending September 30, before the ICD-10 code changes take effect). We'll identify these measures in a fact sheet that will be posted to the Quality Payment Program Resource Library by October 2022.

Some measures will be impacted by the annual update, but not significantly enough to reduce the performance period. For these measures:

- You should follow the current guidance on ICD-10 coding.
- You don't need to report on any encounters that use new codes (those not included in the current measure specifications).
- You'll continue to report on any encounters that use existing codes (those included in the current measure specifications).



NEW: We expanded the list of reasons that a quality measure may be significantly impacted during the performance period to include errors contained in the finalized measure specifications and offer scoring flexibilities for measures where these reasons impact the clinicians' ability to submit the measure.

Based on the timing of the change and the availability of data, we would:

- Truncate the performance period to 9 consecutive months if there were no concerns with potential patient harm and 9 consecutive months of data were available.
- Suppress the measure from scoring (0 achievement points and total measure achievement points reduced by 10 for each measure submitted that is impacted) if 9 consecutive months of data were not available.

What If I’m a Clinician at a Critical Access Hospital?

For the 2022 performance period, if you’re a MIPS eligible clinician in a Critical Access Hospital Method II (CAH II) designated as a small practice, then you can participate in MIPS using Medicare Part B claims reporting through the CMS-1450 form. If you’re a CAH II clinician, then you’ll have to keep adding your NPI to the CMS-1450 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, then you can use the CMS-1450 form to bill a MAC. 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.

Help, Resources, and Version History

Where Can I Get Help?

Contact the Quality Payment Program Service Center at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov (Monday-Friday 8 a.m.- 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Visit the QPP website for other help and support information, to learn more about MIPS, and to check out the resources available in the Quality Payment Program Resource Library.

Additional Resources

The Quality Payment Program Resource Library houses fact sheets, measure specifications, specialty guides, technical guides, user guides, helpful videos, and more. We will update this table as more resources become available.

Resource	Description
2022 MIPS Quick Start Guide	A high-level overview of the Merit-based Incentive Payment System (MIPS) requirements to get you started with participating in the 2022 performance year.
2022 Eligibility and Participation Quick Start Guide: Traditional MIPS	A high-level overview and actionable steps to understand your 2022 MIPS eligibility and participation requirements.
2022 Quality Performance Category Quick Start Guide: Traditional MIPS	A high-level overview and practical information about quality measure selection, data collection, and submission for the 2022 MIPS quality performance category.
2022 Promoting Interoperability Performance Category Quick Start Guide: Traditional MIPS	A high-level overview and practical information about data collection and submission for the 2022 MIPS Promoting Interoperability performance category.
2022 Improvement Activities Performance Category Quick Start Guide: Traditional MIPS	A high-level overview and practical information about data collection and submission for the 2022 MIPS improvement activities performance category.
2022 Cost Performance Category Quick Start Guide: Traditional MIPS	A high-level overview of cost measures, including calculation and attribution, for the 2022 MIPS cost performance category.
2022 Medicare Part B Claims Measures Specifications and Supporting Documents	This set of resources provides comprehensive descriptions of the 2022 Medicare Part B claims measures for the MIPS quality performance category, including tools to search for applicable Medicare Part B claims measures, a measure specification and measure flow guide, and detailed specifications for each 2022 Medicare Part B claims measure.
2022 Quality Payment Program Final Rule Resources	This zip file includes: the 2022 Quality Payment Program (QPP) final rule overview fact sheet; a policy comparison table; a set of frequently asked questions; and a MIPS Value Pathways (MVP) Candidate policy table.

Help, Resources, and Version History

Version History

If we need to update this document, changes will be identified here.

Date	Description
01/18/2022	Updated to reflect correct links on slide 27.
12/31/2021	Original Posting.

Appendix

Appendix A - Medicare Part B Claims Measures Finalized for Removal in the CY2022 Quality Payment Program Final Rule

MIPS Quality ID	MIPS Quality Measure Title
014	Age-Related Macular Degeneration (AMD): Dilated Macular Examination
021	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin
023	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
050	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 years and older
093	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use
154	Falls: Risk Assessment
182	Functional Outcome Assessment
195	Radiology: Stenosis Measurement in Carotid Imaging Reports
225	Radiology: Reminder System for Screening Mammograms

Appendix A - Medicare Part B Claims Measures Finalized for Removal in the CY2022 Quality Payment Program Final Rule (Continued)

MIPS Quality ID	MIPS Quality Measure Title
254	Ultrasound Determination of Pregnancy Location for Pregnant Parents with Abdominal Pain
326	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy
425	Photodocumentation of Cecal Intubation
429	Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy

Appendix B- Medicare Part B Claims Measure Specifications for Denominator Eligible Case

Quality ID #261: Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness

- Meaningful Measure Area: Transfer of Health Information and Interoperability

2022 Collection Type:

MEDICARE PART B CLAIMS

MEASURE TYPE:

Process – High Priority

Measure Description Location

High-level description of measure including patient characteristics

Reporting Frequency

DESCRIPTION:

Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with acute or chronic dizziness.

INSTRUCTIONS:

This measure is to be submitted a minimum of once per performance period for all patients seen during the performance period who present with acute or chronic dizziness. This measure is intended to ensure that patients with acute or chronic dizziness receive a referral in order to receive appropriate care. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

MEASURE SUBMISSION TYPE:

Measure data may be submitted by individual MIPS eligible clinicians using Medicare Part B claims. The listed denominator criteria are used to identify the intended patient population. The numerator quality-data codes included in this specification are used to submit the quality actions allowed by the measure on the claim form(s). All measure-specific coding should be submitted on the claim(s) representing the denominator eligible encounter and selected numerator option.

DENOMINATOR:

All patients aged birth and older presenting with acute or chronic dizziness

Appendix B- Medicare Part B Claims Measure Specifications for Denominator Eligible Case (Continued)

Denominator Criteria (Eligible Cases):

All patients aged birth and older

AND

Patient encounter during the performance period (CPT):

92540, 92541, 92542, 92544, 92545, 92546, 92548, 92550, 92557, 92567, 92568, 92570, 92575

AND

Diagnosis for Dizziness (ICD-10-CM):

H81.10, H81.11, H81.12, H81.13, R42

Appendix C- Medicare B Claims Measure Specifications for Numerator Codes (QDCs)

In the snapshot below, a sample Medicare Part B claims measure specification (Quality ID #261) is provided with call-out boxes identifying the 4 quality measure numerator options for the measure (performance met, performance not met, denominator exception, or denominator exclusion) and the corresponding QDC you would submit on the claim form.

Numerator Quality-Data Coding Options:

Referral for Otologic Evaluation

Performance Met: G8856:

Referral to a physician for an otologic evaluation performed.

OR

Referral for Otologic Evaluation Not Performed for Documented Reasons

Denominator Exception: G8857:

Patient is not eligible for the referral for otologic evaluation measure (e.g., patients who are already under the care of a physician for acute or chronic dizziness.

OR

Referral for Otologic Evaluation Not Performed: Reason Not Given

Performance Not Met: G8858:

Referral to a physician for an otologic evaluation not performed, reason not given.

Appendix

Quality Payment PROGRAM

Appendix D- Sample CMS 1500 Form for Quality Data Submission

HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE [X] (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123-456-7890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): John J. Smith
3. PATIENT'S BIRTH DATE (MM DD YY): 07 04 1949 SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 567 Hilltop Drive
6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY: Johnsonville STATE: CA
8. RESERVED FOR NUCC USE
ZIP CODE: 34586 TELEPHONE (Include Area Code): (980) 756-5932
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 SEX M F
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES NO PLACE (State)
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. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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: JJS 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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 11 01 2022 QUAL.
15. OTHER DATE QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
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.
A. H81.10 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 CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
11 01 22	11 02 22	11		92540	A	100.00	1		NPI	987654321
11 01 22	11 02 22	11		G8856	A	0.01	1		NPI	987654321

25. FEDERAL TAX I.D. NUMBER: 111222444333 SSN EIN [X]
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? YES NO
28. TOTAL CHARGE: $ 100.01
29. AMOUNT PAID: $ 0.00
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.) JJS
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. 987654321 b.
33. BILLING PROVIDER INFO & PH #: Physician Medical Services Inc. 756 Medical Building Drive, Youngsville CA 76589 (980) 456-3245
a. 987654321 b.

In the snapshot to the left, we have provided an example of an individual NPI reporting on a single CMS-1500 claim a quality measure on 1 patient encounter.

The boxes identify the key items to include so your claim is used to capture your quality data. Otherwise, follow normal coding rules for filing a claim.

The patient in this example was seen for an encounter service (92540).

The eligible clinician is reporting a quality measure (Quality ID #261) related to Otologic Evaluations:

Measure Quality ID #261 is reported with quality data code (QDC) G8856 + the AMD diagnosis (Item 24e points to the diagnosis code in item 21, line a, H81.10

Appendix D- Sample CMS 1500 Form for Quality Data Submission (continued)

- The QDC must be submitted with a line item charge of $0.00, or (if your system requires it) a line item charge of $0.01.
- If transmission of your QDC was successful to your MAC, then you will receive RARC and/or CARC N620, PR 246 N620, or CO 246 N620, depending on the amount of your line item charge.
- For purposes of this form, a Federal Taxpayer Identification Number (TIN) may be a 9-digit:
    - Social Security number (SSN) formatted like 123-45-6789 used for individuals.
    - Employer Identification Number (EIN) formatted like 12-3456789 used for employers or the self-employed.

The CARC and RARC tell you that the QDC(s) you submitted are valid for the 2022 MIPS performance period, but it doesn't mean the QDC was reported correctly for the intended measure or that you met the measure requirements.

Important Reminders for Diagnosis Codes when Submitting Quality Data via Medicare Part B Claims

- Diagnoses should be reported in form locator field (FL) 66-67 a-q on the CMS-1450 claim form. Up to 12 diagnoses can be reported in item 21 on the CMS-1500 paper claim (02/12) and up to 12 diagnoses can be reported in the header on the electronic claim.
    - Only 1 diagnosis can be linked to each line item.
    - The Medicare Part B claims data is analyzed using ALL diagnoses from the base claim (item 21 of the CMS-1500 or electronic equivalent) and service codes for each individual eligible clinician (identified by individual NPI).
    - Eligible clinicians should review ALL diagnosis and encounter codes listed on the claim to make sure they are capturing ALL measures chosen to report that are applicable to the patient's care.
- All diagnoses reported on the base claim will be included in the Medicare Part B claims data analysis, as some measures require reporting more than 1 diagnosis on a claim.
    - For line items containing QDCs, only 1 diagnosis from the base claim should be referenced in the diagnosis pointer field.
    - To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to 1 of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, all diagnoses on the claim(s) are considered in Medicare Part B claims analysis.

Appendix E- Sample Explanation of Benefits (EOB)

In the snapshot below, a sample EOB outlines 4 examples (1 correct and 3 incorrect) of Medicare Part B claims submissions for the purposes of reporting quality data.

Sample EOB for Medicare Part B Claims Quality Data Reporting									
Billing Provider	123456			Invoice Number					
Service Provider	123456			Check Number	56789				
Tax ID	999999			Payment Date	10/10/2022				
Correct	Complete with CPT II Code and Correct POS, QDC, & DX Code								
PERF									
Recipients	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS
Name A	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005					
	123-567-9876	11	1	99213		100	75.95	0	
REM	N620		1	2027F		0.01	0	0	
PT RESP									
CLAIM INFO									
The Next Three Examples will not meet the Requirements for Claims-Based Measures for the MIPS Program.									
	Complete without CPT II code								
Name B	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005					
	123-567-9876	11	1	99213		100	75.95	0	
PT RESP	15.19								
CLAIM INFO									
	Complete CPT II Code split off from Service								
Name C	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005					
REM	N620		1	2027F		0.01	0	0	
	Incorrect POS								
Name D	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005					
	123-567-9876	10	1	99213		100	75.95	0	
REM	N620		1	2027F		0.01	0	0	
PT RESP	15.19								
CLAIM INFO									

Valid, but unsuccessful 2022 MIPS QDC Submission

Example A: This claim was correct because the appropriate QDC (G-code) and place of service (POS) code were included; the line item charge is correct; and the procedure/service (CPT) code is present with the QDC. The N620 confirms that the QDC submitted is valid for the 2022 MIPS performance period, but **it doesn't mean the QDC was reported correctly for the intended measure or that you met the measure requirements**.

Example B: This claim was processed without the corresponding QDC (G-code). It either wasn't submitted on the original claim or was broken off from the procedure or service code on the claim during processing. The N620 is not present here, because there is no QDC to validate.

Example C: This claim was processed without the corresponding procedure/service (CPT) code. It either wasn't submitted on the original claim or was broken off from the QDC on the claim during processing. The N620 code is present here because the QDC is valid for 2022, but this claim was not a successful quality data submission for the patient encounter billed.

Example D: This claim has an incorrect POS code. The N620 code is present here because the QDC is valid for 2022, but this claim was not a successful quality data submission for the patient encounter billed.