Merit-based Incentive Payment System (MIPS)

2023 Reporting MIPS Quality Measures through Medicare Part B Claims Quick Start Guide for Small Practices

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Already know what MIPS is?
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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.

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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.

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Overview

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 rewards MIPS eligible clinicians for providing high quality care to their patients by reimbursing Medicare Part B-covered professional services.

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

If you're eligible for MIPS in 2023:

- You generally have to report measure and activity data for the quality, improvement activities, and Promoting Interoperability performance categories. (We collect and calculate data for the cost performance category for you, if applicable.)
- 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 2023 performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1, 2025.

To learn more about MIPS:

- Visit the Learn about MIPS webpage
- View the 2023 MIPS Overview Quick Start Guide.
- View the 2023 MIPS Quick Start Guide for Small Practices.

To learn more about MIPS eligibility and participation options:

- Visit the How MIPS Eligibility is Determined and Participation Options Overview webpages on the Quality Payment Program website.
- View the 2023 MIPS Eligibility and Participation Quick Start Guide.
- Check your current participation status using the QPP Participation Status Tool.

Overview

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

There are 3 reporting options available to MIPS eligible clinicians to meet MIPS reporting requirements:

Traditional MIPS, established in the first year of QPP, is the original reporting option for MIPS. You select the quality measures and improvement activities that you'll collect and report from all of the quality measures and improvement activities finalized for MIPS. You'll also report the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

The Alternative Payment Model (APM) Performance Pathway (APP) is a streamlined reporting option for 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. You'll report a predetermined measure set made up of quality measures in addition to the complete Promoting Interoperability measure set (the same as reported in traditional MIPS). MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.

MIPS Value Pathways (MVPs) are the newest reporting option that offer clinicians a subset of measures and activities relevant to a specialty or medical condition. MVPs offer more meaningful groupings of measures and activities, to provide a more connected assessment of the quality of care. Beginning with the 2023 performance year, you'll select, collect, and report on a reduced number of quality measures and improvement activities (as compared to traditional MIPS). You'll also report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS). We collect and calculate data for the cost performance category and population health measures for you.

To learn more about traditional MIPS:

- Visit the Traditional MIPS Overview webpage on the Quality Payment Program website.

To learn more about the APP:

- Visit the APM Performance Pathway webpage on the Quality Payment Program website.

To learn more about MVPs:

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

Overview

Final Score Calculation – Redistribution Policies for Small Practices

We automatically reweight the Promoting Interoperability performance category for clinicians in small practices. Under this redistribution policy, Promoting Interoperability is weighted at 0%.

Standard weighting for small practices
(Promoting Interoperability automatically **reweighted** to 0%)

Quality	Cost	Improvement Activities	Promoting Interoperability
			
40% of MIPS Score	30% of MIPS Score	30% of MIPS Score	0% of MIPS Score

When both the **cost** and the **Promoting Interoperability** performance categories are reweighted (such as for APM Entities with the small practice designation):

50% Quality	0% Cost	50% Improvement Activities	0% Promoting Interoperability

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What's New with Medicare Part B Claims Reporting in 2023?

- **4 Medicare Part B claims measures were removed** from the 2023 MIPS quality measure set and can no longer be reported. Review Appendix A for a list of measures removed for the 2023 performance period.
- **Quality IDs 110 and 111 were removed** from the 2023 MIPS quality measure set and can no longer be reported through traditional MIPS. **However, these measures were retained for use in MIPS Value Pathways (MVPs).**
- **13 Medicare Part B claims measures received substantive changes** from the 2022 measure specifications, 1 of which won't have a historical benchmark for 2023 (Quality ID 145).
- Beginning in the 2023 performance period, MIPS eligible clinicians, groups, subgroups, virtual groups, and APM Entities will be required to **submit an identifier that corresponds with the MVP being submitted by the small practice.**

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Get Started with Claims Measure Reporting in 5 Steps

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Get Started with Claims Measure Reporting in 5 Steps

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Step 1. Check Your Current Eligibility

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 the QPP website to review eligibility for all clinicians in the practice.

Virtual groups and APM Entities need to sign in to the QPP website 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're currently eligible and wish to report quality measures through Medicare Part B claims, start reporting now. You can't go back and add performance data to claims you've already submitted.

What if I'm...

X Not Eligible

If you are not eligible to participate in MIPS, then you aren't 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, 2022, and September 30, 2023, 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 2023.** If you're currently identified as a small practice, that won't change when we update eligibility.

Note: If the clinicians in your practice aren't 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 isn't required to do so. A practice has the option to participate in MIPS as individuals or as a group.

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).

Get Started with Claims Measure Reporting in 5 Steps

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Step 2. Understand the Available Resources

The 2023 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.

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

1. **2023 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.

2. **Medicare Part B Claims Measure Specifications Release Notes –** This document details changes to existing measures that will go into effect in the 2023 performance period.

3. **2023 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.

Get Started with Claims Measure Reporting in 5 Steps

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Step 3. Identify Your Measures

Your quality measure options are determined by your MIPS reporting option.

Traditional MIPS	MVPs	APP
Select 6 measures (including 1 outcome or high priority measure) from the complete MIPS quality measure inventory. **OR** Report 1 **complete specialty measure set.** **Did you know?** If the specialty set includes fewer than 6 Medicare Part B claims measures, you'll meet reporting requirements if you report all the Medicare Part B claims measures in the specialty set.	**Select 4 measures** (including 1 outcome or high priority measure) from your chosen MVP. **Did you know?** If your selected MVP includes fewer than 4 Medicare Part B claims measures, you'll meet reporting requirements if you report all the Medicare Part B claims measures in the MVP.	**No measure selection** - Report the 3 Medicare Part B claims measures required by the APP + the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure.

Get Started with Claims Measure Reporting in 5 Steps

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Step 3. Identify Your Measures (Continued)

Not sure how to get started for traditional MIPS?	In addition to reviewing measure specifications, you can: • Use the **2023 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 2023 measures and activities until early 2023)
Not sure how to get started for MVPs?	• Use the **Explore MVPs webpage** to review detailed measure specifications and other measure information in the MVP toolkit, available for each MVP. • To signal your intent to report Medicare Part B claims through an MVP, MIPS eligible clinicians, groups, subgroups, virtual groups, and APM Entities will be required to submit an identifier, via Medicare Part B claims, that corresponds with the MVP being submitted. Review Appendix F to determine the appropriate identifier for your MVP.
Not sure how to get started for the APP?	• Use the APM Performance Pathway: Quality Requirements webpage to review more information on the quality performance category reporting requirements for the APP.

Get Started with Claims Measure Reporting in 5 Steps

Step 4. Establish an Office Workflow

The next step is to set up an office workflow that will let the denominator eligible patients for each of the measures be accurately identified on your Medicare Part B claims.

To do this, make sure that your supporting staff (including billing services):

- Understand the intent of the measures identified for submission.
- Review the specifications for your measures so you can identify all denominator-eligible claims.
- Know how often the measures you're reporting must be submitted on Medicare Part B claims within the performance period. This information can be found within each measure specification.
- If applicable, contact your software billing vendor to verify that the 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.

Get Started with Claims Measure Reporting in 5 Steps

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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, 2023. QDCs must be included on the originally submitted claim. You cannot go back and add QDCs to a previously submitted claim.

- **Append MIPS Identifier for the MVP:** Submit an identifier that corresponds with the MVP being submitted. This identifier informs CMS of your intent to report an MVP. The identifier is required to be appended on at least one Medicare Part B claim, for the Medicare Part B claims collection type or contained within the data submitted by you or your third party intermediary. To determine the identifier required for the MVP that you plan to submit, please refer to Appendix F.
- **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 2023 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, 2023), 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 2023 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.

TIP: Reporting a multi-performance rate measure?

Verify your office workflow captures the appropriate QDCs on your Medicare Part B claims by reviewing the performance rate used for scoring in the 2023 Multi-Performance Rate file in the 2023 Quality Benchmarks, available in late January.

Get Started with Claims Measure Reporting in 5 Steps

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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, 2023. Some measures have a shortened measurement period, so be sure to review measure specifications carefully.

Note: The data completeness requirement will increase to 75% for the 2024 and 2025 performance periods.

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 (ICD-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 2023 Medicare Part B Claims Measure Specifications** to ensure you are using the appropriate criteria and codes for the 2023 performance period.

Make sure you are billing services under the clinician's individual (Type 1) NPI, and not the organization (Type 2) NPI.

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).

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Frequently Asked Questions

Frequently Asked Questions

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Key Topics

Frequency Asked Questions

How Do I Know if the QDCs I Submitted Are Valid for MIPS in 2023?

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 the QDC(s) are valid for the 2023 MIPS performance period.

The N620 denial code tells you that the QDC(s) are valid for the 2023 MIPS performance period, but it doesn't mean the QDC(s) were reported correctly for the intended measure, or 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.

Important

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.

Frequency Asked Questions

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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 2023 MIPS performance period, but **it doesn't mean the QDC was reported correctly for the intended measure, or 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, and as a result, the MAC reduces 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.**

Frequency Asked Questions

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 2023 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.

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.

IMPORTANT: 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 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 Cures Update 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.

Frequency Asked Questions

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

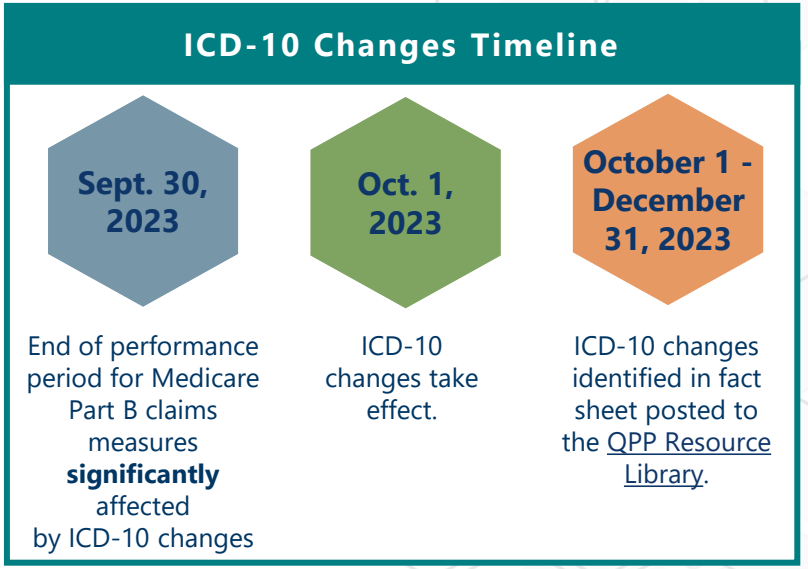
If you submit quality performance category data via Medicare Part B claims, then you can login to the QPP website and review your preliminary performance feedback in February 2024.

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 1st if technically feasible, but no later than the beginning of the data submission period (i.e., January 2, 2024).

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).



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, as revised clinical guidelines, measure specifications or codes impacted a clinician's ability to submit information on the measure or may lead to potentially misleading results.

Frequency Asked Questions

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

For the 2023 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.

What Happens If I Don't Include the MVP Identifier Code?

If you're reporting Medicare Part B claims measures for an MVP and don't report the appropriate MVP identifier on at least one claim, your measures will be attributed to traditional MIPS instead of the MVP. To signal your intent to report an MVP, you must submit an identifier, via Medicare Part B claims, that corresponds with the MVP being reported. The appropriate identifier must be appended on at least one Medicare Part B claim that includes an applicable QDC for one of the quality measures in your selected MVP.

The MVP identifier only needs to be reported once during the performance period to attribute your quality measures to the MVP. (Please note the MVP identifier would also need to be included in any MVP measure and/or activity data submitted to CMS during the submission period that begins January 2, 2024.)

To determine the identifier required for the MVP that you plan to report, please refer to Appendix F.

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Help and Version History

Help and Version History

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Where Can You Go for Help?

Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, create a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday through 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 Quality Payment Program 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.

Visit the Small, Underserved and Rural Practices page of the Quality Payment Program website where you can **sign up for the monthly QPP Small Practices Newsletter** and find resources and information relevant for small practices.

Help and Version History

Version History

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

Date	Description
12/27/2022	Original Posting.

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Appendix

Appendix

Appendix A: Medicare Part B Claims Measures Finalized for Removal in the CY2023 Quality Payment Program Final Rule

MIPS Quality ID	MIPS Quality Measure Title
076	Prevention of Central Venous Catheter (CVC) – Related Bloodstream Infections
117	Diabetes: Eye Exam
130	Documentation of Current Medications in the Medical Record
416	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years

Appendix

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

2023 Collection Type:
MEDICARE PART B CLAIMS

MEASURE TYPE:
Process – High Priority

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.

Measure Description Location

High-level description of measure including patient characteristics

Reporting Frequency

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

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

Denominator Criteria (Eligible Cases):

Patients aged birth and older

AND

Diagnosis for Dizziness (ICD-10-CM):

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

AND

Patient encounter during the performance period (CPT):

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

WITHOUT

Telehealth Modifier:

GQ, GT, 95, POS 02

Appendix

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 3 quality measure numerator options for the measure (performance met, performance not met, and denominator exception) 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

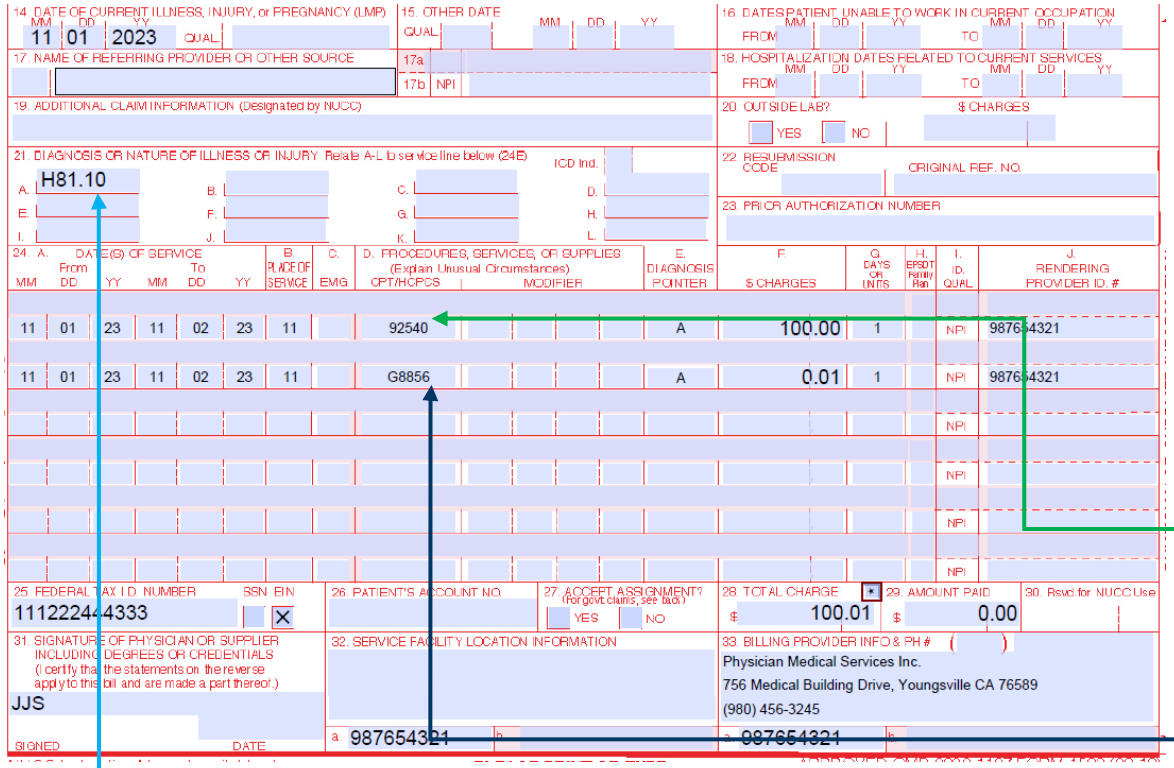
Referral for Otologic Evaluation Not Performed: Reason Not Given

Performance Not Met: G8858:

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

Appendix

Appendix D: Sample CMS 1500 Form for Quality Data Submission



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 11 01 2023 QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 17b NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY 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 (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. #
11	01	23	11	02	23	11		92540		A	100.00	1		NPI	987654321
11	01	23	11	02	23	11		G8856		A	0.01	1		NPI	987654321
														NPI	
														NPI	
														NPI	
														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 111222444333 X
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 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

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 2023 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

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	11/10/2023				
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	92540		100	75.95	0	
REM	N620		1	G8856		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	92540		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	G8856		0.01	0	0	
	Incorrect POS								
Name D	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005					
	123-567-9876	10	1	92540		100	75.95	0	
REM	N620		1	G8856		0.01	0	0	
PT RESP	15.19								
CLAIM INFO									

Valid, but unsuccessful 2023 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 2023 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 2023, 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 2023, but this claim was not a successful quality data submission for the patient encounter billed.

Appendix

Appendix F: MVP Identifiers for MVPs that Include Medicare Part B Claims Measures

Identifier	MVP Title
G0053	Advancing Rheumatology Patient Care MIPS Value Pathway
G0054	Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MIPS Value Pathway
G0055	Advancing Care for Heart Disease MIPS Value Pathway
G0056	Optimizing Chronic Disease Management MIPS Value Pathway
G0058	Improving Care for Lower Extremity Joint Repair MIPS Value Pathway
M0001	Advancing Cancer Care MIPS Value Pathway
M0002	Optimal Care for Kidney Health MIPS Value Pathway
M0003	Optimal Care for Patients with Episodic Neurological Conditions MIPS Value Pathway
M0004	Supportive Care for Neurodegenerative Conditions MIPS Value Pathway
M0005	Promoting Wellness MIPS Value Pathway