

## 2023 QPP JavaScript Object Notation (JSON) Template Instructions for Traditional MIPS

### Introduction

This resource provides instructions for using the associated QPP JSON templates to submit data for traditional MIPS that you've collected for MIPS Clinical Quality Measures (MIPS CQMs). **These instructions are valid for the performance year 2023 submission period (January 2, 2024 – April 1, 2024) for traditional MIPS reporting only.**

These instructions and attached templates:

- **Don't** include information about reporting quality measures with multiple performance rates.
- **Don't** include instructions for the MIPS Value Pathway (MVP) or APM Performance Pathway (APP) reporting options.
- **Don't** include the improvement activities and Promoting Interoperability performance categories because you can manually attest to those categories when you sign in to the QPP website.

For step-by-step instructions with screenshots about uploading files and attesting to Promoting Interoperability and improvement activities data on the QPP website, review the **Submitting and Reviewing Data** section of the [2023 Traditional MIPS Data Submission User Guide](#).

**Group Submissions**: Instructions for those submitting aggregated quality measure data (MIPS CQMs) for all clinicians in the group using the group JSON template.

**Individual Submissions**: Instructions for those submitting quality measure data (MIPS CQMs) for a single MIPS eligible clinician using the individual JSON template.

**Data Completeness**: Expectations for reporting quality measures and how to meet the 70% data completeness criteria.

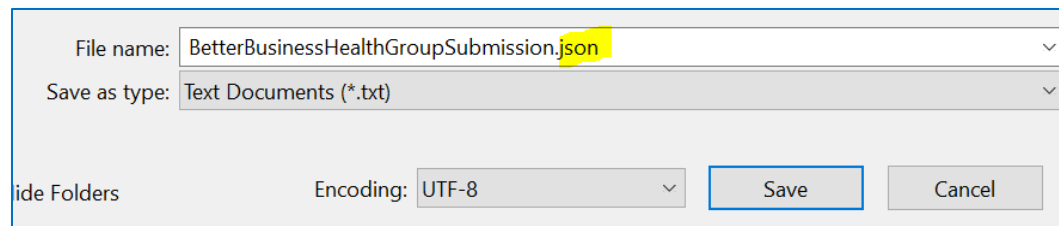
**Verifying the TIN and NPI**: Instructions for finding the TIN, and NPI if reporting for an individual, in your QPP account to ensure the quality measure data you submit is correctly attributed to the group or MIPS eligible clinician.



## Group Submissions

Follow these instructions if you're reporting as a group.

1. Open the **GROUP.Quality.Template.json** file in the ZIP file
  - **Windows/PC** users: This will open in Notepad.
  - **Mac** users: You'll need to open this file in TextEdit.
2. Save it as a new file on your computer – make sure to include “.json” at the end of the file name.
  - **Example:** BetterBusinessHealthGroupSubmission.json



3. Replace the **highlighted** information (as shown in screenshots for sub-steps 3a, 3b, and 3c) with your group's specific information.
  - 3a. Add your **Taxpayer Identification Number** in the first section, but don't change anything else. (Screenshot on next page.)
    - Make sure you leave the quotation marks around this value.

```
{
  "entityType": "group",
  "taxpayerIdentificationNumber": "000000000",
  "performanceYear": 2023,
  "measurementSets": [
```

**3b.** Don't change any of the values below.

```
{
  "programName": "mips",
  "category": "quality",
  "submissionMethod": "registry",
  "performanceStart": "2023-01-01",
  "performanceEnd": "2023-12-31",
  "measurements": [
```

**TIP:** Sign in to the QPP website and verify that the numbers you enter for “taxpayerIdentificationNumber” match the 9-digit TIN displayed for your practice.

[Where do I find this?](#)

The “registry” submission method is how the system knows you’re reporting MIPS CQMs.

**3c.** In the first **measureID** section (below), add the measureID for the first measure you’re reporting, along with the measure’s eligible population and performance data you’ve collected for the measure.

- Make sure you review the [data completeness information](#) provided after these instructions.

```
{
  "measureId": "XXX",
  "value": {
    "isEndToEndReported": false,
    "performanceMet": 0,
    "performanceNotMet": 0,
    "eligiblePopulation": 0,
    "eligiblePopulationException": 0
  }
},
```

If you're using these instructions, you must leave "isEndToEndReported" as false.

Your measures don't meet the end-to-end electronic reporting criteria because you're manually entering the measure data into a file. (As a reminder, these bonus points were removed as of the 2022 performance year.)

- The "measureID" is the 3-digit Quality ID associated with the measure.
  - For example, you'd replace **xxx** with 047 if you're reporting the Advance Care Plan measure.
  - Make sure you leave the quotation marks and comma.
- For "performanceMet", enter the number of patients or encounters (aggregated across all clinicians in the group) that qualify as **Performance Met in the Numerator** as outlined in the measure specification.
  - There are no quotation marks for this value.
- For "performanceNotMet", enter the number of patients or encounters (aggregated across all clinicians in the group) that qualify as **Performance Not Met in the Numerator** as outlined in the measure specification.
  - There are no quotation marks for this value.

- For “**eligiblePopulation**”, enter the number of patients or encounters (aggregated across all clinicians in the group) that qualify for the **Denominator** as outlined in the measure specification.
  - There are no quotation marks for this value.
- For “**eligiblePopulationException**”, enter the number of patients or encounters (aggregated across all clinicians in the group) that qualify as **Denominator Exceptions** as outlined in the measure specification. If the measure doesn’t include Denominator Exceptions, or none of your patients/encounter qualified, leave the value as 0.
  - There are no quotation marks for this value.

**3d.** Repeat step 3c for your remaining measures. (See next page if reporting fewer than 6 measures.)

```

        "isEndToEndReported": false,
        "performanceMet": 0,
        "performanceNotMet": 0,
        "eligiblePopulation": 0,
        "eligiblePopulationException": 0
    },
    {
        "measureId": "XXX",
        "value": {
            "isEndToEndReported": false,
            "performanceMet": 0,
            "performanceNotMet": 0,
            "eligiblePopulation": 0,
            "eligiblePopulationException": 0
        }
    },
    {
        "measureId": "XXX",
        "value": {
            "isEndToEndReported": false,
            "performanceMet": 0,
            "performanceNotMet": 0,
            "eligiblePopulation": 0,
            "eligiblePopulationException": 0
        }
    }
}
]
}
}
}

```

The file **must** include these last 4 brackets/braces.

If you're **reporting fewer than 6 measures** (for example a specialty set with fewer than 6 MIPS CQMs included), you'll need to delete the remaining measureID sections.

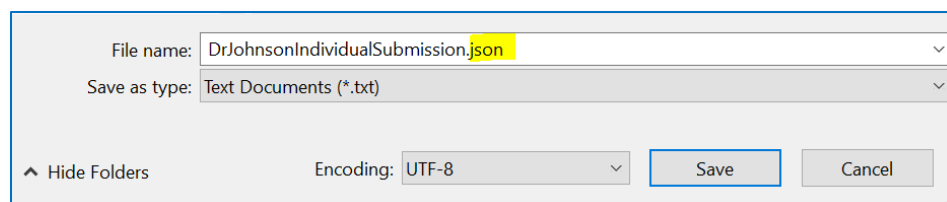
Starting with the comma (",") that appears after the last measure you're reporting, highlight all of the text until the last 4 brackets/braces in the file and delete it.

In this example, the group is reporting 4 measures and is highlighting the last 2 measureID sections for deletion.

## Individual Submissions

Follow these instructions if you're reporting for an individual clinician. **You'll repeat these steps for each clinician you're reporting for.**

1. Open the **INDIVIDUAL.Quality.Template.json** file in the ZIP file
  - **Windows/PC** users: This will open in Notepad.
  - **Mac** users: You'll need to open this file in TextEdit.
2. Save it as a new file on your computer – make sure to include “.json” at the end of the file name.
  - **Example:** DrJohnsonIndividualSubmission.json



3. Replace the **highlighted** information (as shown in screenshots for sub-steps 3a, 3b, and 3c) with the clinician's specific information
  - 3a. Add the practice's **Taxpayer Identification Number (TIN)** and the clinician's **National Provider Identifier (NPI)** but don't change anything else. (Screenshot on next page.)
    - Make sure you leave the quotation marks around these values.



```
{
  "entityType": "individual",
  "taxpayerIdentificationNumber": "000000000",
  "nationalProviderIdentifier": "0000000000",
  "performanceYear": 2023,
  "measurementSets": [
```

**TIP:** Sign in to the QPP website to verify that the numbers you enter for “taxpayerIdentificationNumber” and “nationalProviderIdentifier” match the 9-digit TIN displayed for your practice and the clinician’s 10-digit NPI.

[Where do I find this?](#)

**3b.** Don't change any of the values below:

```
{
  "programName": "mips",
  "category": "quality",
  "submissionMethod": "registry",
  "performanceStart": "2023-01-01",
  "performanceEnd": "2023-12-31",
  "measurements": [
```

The “registry” submission method is how the system knows you’re reporting MIPS CQMs.

**3c.** In the first **measureID** section, add the measureID for the first measure you’re reporting, along with the eligible population and performance data you’ve collected for the measure.

- Make sure you review the [data completeness information](#) provided after these instructions.



```
{  
  "measureId": "XXX",  
  "value": {  
    "isEndToEndReported": false,  
    "performanceMet": 0,  
    "performanceNotMet": 0,  
    "eligiblePopulation": 0,  
    "eligiblePopulationException": 0  
  }  
},
```

If you're using these instructions, you must leave "isEndToEndReported" as false.

Your measures don't meet the end-to-end electronic reporting criteria because you're manually entering the measure data into a file. (As a reminder, these bonus points were removed as of the 2022 performance year.)

- The "measureID" is the 3-digit Quality ID associated with the measure.
  - For example, you'd replace xxx with 047 if you're reporting the Advance Care Plan measure.
  - Make sure you leave the quotation marks and comma.
- For "performanceMet", enter the number of patients or encounters that qualify as **Performance Met in the Numerator** as outlined in the measure specification.
  - There are no quotation marks for this value.
- For "performanceNotMet", enter the number of patients or encounters that qualify as **Performance Not Met in the Numerator** as outlined in the measure specification.
  - There are no quotation marks for this value.
- For "eligiblePopulation", enter the number of patients or encounters that qualify for the **Denominator** as outlined in the measure specification.
  - There are no quotation marks for this value.

- For “**eligiblePopulationException**”, enter the number of patients or encounters that qualify as **Denominator Exceptions** as outlined in the measure specification. (If the measure doesn’t include Denominator Exceptions, or none of your patients/encounter qualified, leave the value as 0.)
  - There are no quotation marks for this value.

**3d.** Repeat step 3c for your remaining measures. (See next page if reporting fewer than 6 measures.)

```

        "isEndToEndReported": false,
        "performanceMet": 0,
        "performanceNotMet": 0,
        "eligiblePopulation": 0,
        "eligiblePopulationException": 0
    },
    {
        "measureId": "XXX",
        "value": {
            "isEndToEndReported": false,
            "performanceMet": 0,
            "performanceNotMet": 0,
            "eligiblePopulation": 0,
            "eligiblePopulationException": 0
        }
    },
    {
        "measureId": "XXX",
        "value": {
            "isEndToEndReported": false,
            "performanceMet": 0,
            "performanceNotMet": 0,
            "eligiblePopulation": 0,
            "eligiblePopulationException": 0
        }
    }
}
]
}

```

The file **must** include these last 4 brackets/braces.

If you're **reporting fewer than 6 measures** (for example a specialty set with fewer than 6 MIPS CQMs included), you'll need to delete the remaining measureID sections.

Starting with the comma (",") that appears after the last measure you're reporting, highlight all of the text until the last 4 brackets/braces in the file and delete it.

In this example, the clinician is reporting 4 measures and is highlighting the last 2 measureID sections for deletion.

## Data Completeness

Data completeness refers to the volume of **performance** data reported for the measure's eligible population. When reporting a quality measure, your submission must identify the total eligible population (or denominator) as outlined in the measure's specification. To meet data completeness criteria, you must then report performance data (performance met or not met, or denominator exceptions) for at least 70% of the total eligible population (denominator).

Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance (only submitting favorable performance data, commonly referred to as "cherry-picking"), would not be considered true, accurate, or complete and may subject you to audit.

## Verifying the TIN and NPI

You'll want to verify that the 9-digit TIN you enter in your submission, and 10-digit NPI if reporting for an individual, match the information listed in your QPP account.

If the TIN (and NPI) in your submission don't match the information listed in your QPP account, your quality measure submission won't be attributed to your group (or the clinician.)

[Group submission](#): Verifying the TIN

[Individual submission](#): Verifying the TIN and NPI

## Group submission

1. [Sign in to the QPP website.](#)
2. Click Eligibility & Reporting in the left-hand navigation.
3. View the TIN listed beneath your practice's name on the page and compare to the TIN you entered in your JSON file.

Account Home

**Eligibility & Reporting**

Performance Feedback

Exceptions Application

Targeted Review

Reports

Manage Access

Help and Support

Search by practice name

3 Practices | Download

**Pfeffer Group**

TIN: #000839403 | 01712 Amy Well Apt. 337 Suite 5150, Douglasburgh, NM 693839346567033

MIPS ELIGIBLE

Exceeds Low Volume Threshold: Yes

Medicare Patients at this practice: 485,804

Allowed Charges at this practice: \$499,934.00

Covered Services at this practice: 296,442

Special Statuses, Exceptions and Other Reporting Factors: None

## Individual submission

1. [Sign in to the QPP website.](#)
2. Click **Eligibility & Reporting** in the left-hand navigation, then click **Report as Individuals** or **View Clinician Eligibility** – these will take you to the same page during the submission period.

The screenshot displays the QPP website interface. On the left, a dark blue navigation menu lists several options: 'Account Home', 'Eligibility & Reporting' (highlighted with a red box), 'Performance Feedback', 'APM Incentive Payments', 'Exceptions Application', 'Targeted Review', 'Reports', 'Manage Access', and 'Help and Support'. The main content area is white and features the practice name 'ITScoring-53' at the top. Below the name, the TIN is listed as '#000043553 | 842 Marisa Terrace Suite 7960, Ricardochester, PA 216324809655845'. A green checkmark icon indicates 'MIPS ELIGIBLE'. Further down, practice statistics are provided: 'Exceeds Low Volume Threshold: Yes', 'Medicare Patients at this practice: 300,378', 'Allowed Charges at this practice: \$701,543.00', 'Covered Services at this practice: 259,262', and 'Special Statuses, Exceptions and Other Reporting Factors: None'. On the right side of the main content area, there are two blue buttons: 'Report as Group' and 'Report as Individuals' (highlighted with a red box). At the bottom right, a link 'View practice details & clinician eligibility >' is highlighted with a red box.

3. View the TIN listed beneath your practice's name at the top of the page or on the left-hand navigation.

The screenshot shows the 'Practice Details & Clinicians' page for 'ITScoring-53'. In the left-hand navigation, the 'TIN: 000043553' is highlighted with a red box. The main content area shows the practice name 'ITScoring-53' and the TIN '000043553' highlighted with a red box. Below the TIN, it says '842 Marisa Terrace Suite 7960, Ricardochester, PA 216324809655845'. There is a 'Report as group' button on the right. The page also indicates 'MIPS ELIGIBLE' and 'Special Statuses, Exceptions and Other Reporting Factors: None'. A link to 'View complete eligibility details' is at the bottom.

4. Scroll down the page to find the correct clinician; the NPI is listed below their name.

The screenshot shows the 'One Scoring-53 at ITScoring-53' clinician details page. The NPI '#0507742746' is highlighted with a red box. The page also shows 'Doctor of Medicine' and 'MIPS Eligibility: INDIVIDUAL GROUP'. There is a 'Report as individual' button on the right. Below the NPI, there is a section for 'REPORTING REQUIREMENTS' which states: 'This clinician is required to report because they are a MIPS eligible clinician type, have been enrolled in Medicare for greater than a year, and exceed the individual low-volume threshold.'

5. Compare the TIN and NPI to the values in your JSON.



## Contact the Quality Payment Program

Contact the Quality Payment Program Service Center at 1-866-288-8292 or by email at: [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov) (Monday-Friday 8 a.m.- 8 p.m. ET). Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

## Additional Resources

Resource	Description
<a href="#">2023 Traditional MIPS Data Submission User Guide (PDF)</a>	Step-by-step instructions (with screenshots) for submitting and submitting and reviewing your 2023 performance year data for traditional MIPS.

## Version History

Date	Change Description
12/20/2023	Original Posting.