

Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2024 Reporting MIPS Quality Measures
through Medicare Part B Claims Quick
Start Guide for Small Practices



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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, subgroup, 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](#).

Already know what MIPS is? Skip ahead by clicking the links in the Table of Contents.




How to Use This Guide

How to Use This Guide

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.

Table of Contents

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Hyperlinks

Hyperlinks to the [Quality Payment Program website](#) are included throughout the guide to direct the reader to more information and resources.

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). 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 2024:

- 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 2024 performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1, 2026.

To Learn More About MIPS:

- Visit the [Learn about MIPS webpage](#).
- View the [2024 MIPS Overview Quick Start Guide](#).
- View the [2024 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 [2024 MIPS Eligibility and Participation Quick Start Guide](#).
- Check your current participation status using the [QPP Participation Status Tool](#).



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

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

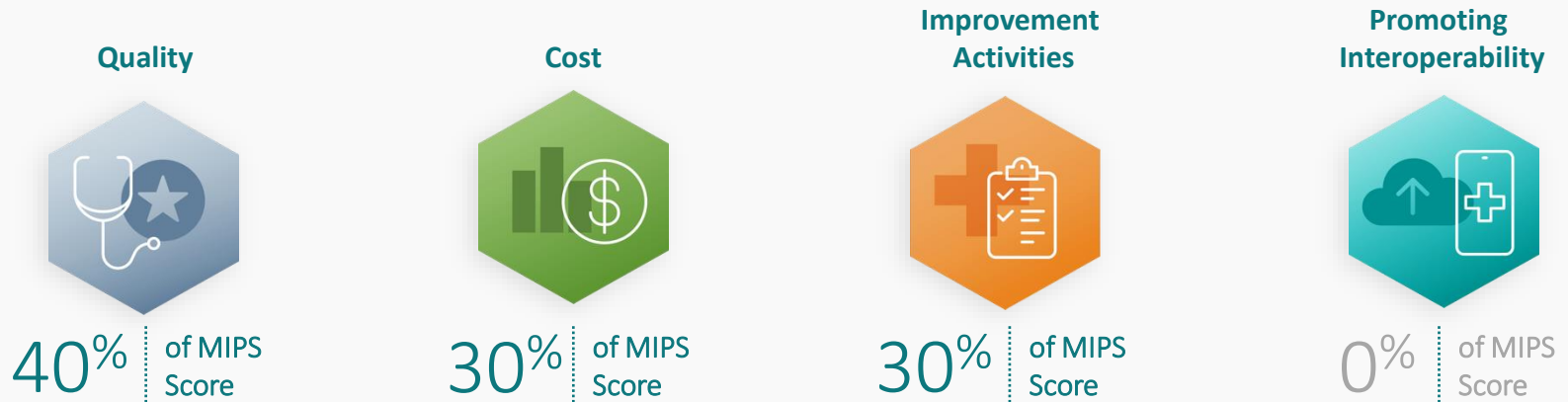
 <p>Traditional MIPS</p>	 <p>MIPS Value Pathways (MVPs)</p>	 <p>APM Performance Pathway (APP)</p>
<ul style="list-style-type: none"> The original reporting option for MIPS. Visit the Traditional MIPS Overview webpage to learn more. 	<ul style="list-style-type: none"> The newest reporting option, offering clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition. Visit the MIPS Value Pathways (MVPs) webpage to learn more. 	<ul style="list-style-type: none"> A streamlined reporting option for clinicians who participate in a MIPS Alternative Payment Model (APM). Visit the APM Performance Pathway webpage to learn more.
<ul style="list-style-type: none"> You select the quality measures and improvement activities that you'll collect, and report from all the quality measures and improvement activities finalized for MIPS. 	<ul style="list-style-type: none"> You select an MVP that's applicable to your practice. Then you choose from the quality measures and improvement activities available in your selected MVP. You'll report a reduced number of quality measures and improvement activities as compared to traditional MIPS. 	<ul style="list-style-type: none"> You'll report a predetermined set of quality measures. MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.
<ul style="list-style-type: none"> You'll report the complete Promoting Interoperability measure set. 	<ul style="list-style-type: none"> You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS). 	<ul style="list-style-type: none"> You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).
<ul style="list-style-type: none"> We collect and calculate data for the cost performance category for you. 	<ul style="list-style-type: none"> We collect and calculate data for the cost performance category and population health measures for you. 	<ul style="list-style-type: none"> Cost isn't evaluated under the APP.



Small Practices Participation in MIPS

Promoting Interoperability is automatically reweighted to 0%.

Traditional MIPS and MVP Performance Category Weights in 2024:



What's New with Medicare Part B Claims Reporting in 2024?

- **3 Medicare Part B claims measures were removed** from the 2024 MIPS quality measure set and can no longer be reported. Review [Appendix A](#) for a list of measures removed for the 2024 performance period.
- **Quality IDs 112, 113, and 128 were removed** from the 2024 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).**
- **10 Medicare Part B claims measures received substantive changes** from the 2023 measure specifications, however, these measures will have a historical benchmark for 2024.

Get Started with Claims Measure Reporting in 5 Steps

Overview




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...

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.

 **Not Eligible**

If you're not eligible to participate in MIPS, then you aren't required to participate but may be eligible to opt-in to traditional MIPS.

Did you know?

If your practice has 15 or fewer clinicians billing between October 1, 2023, and September 30, 2024, 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 2024.** 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).

Step 2. Understand the Available Resources

The 2024 Medicare Part B Claims Measure Specifications and Supporting Documents zip file on the [Quality Payment Program Resource Library](#) (and [Explore Measures & Activities](#) tool which won't be updated until the end of January 2024) 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. 2024 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 2024 performance period.
- 3. 2024 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.



Step 3. Identify Your Measures

Your quality reporting requirements are determined by your MIPS reporting option.

Traditional MIPS	MVPs	APP
<p>Select a minimum of 6 quality measures (including 1 outcome or high priority measure) from the complete MIPS quality measure inventory.</p> <p>OR</p> <p>Report 1 complete specialty measure set.</p> <p>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.</p>	<p>Select a minimum of 4 quality measures (including 1 outcome or high priority measure) from your chosen MVP.</p> <p>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.</p>	<p>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.</p>



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 **2024 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 won't be updated with 2024 measures and activities until early 2024)

Not sure how to get started for [MVPs](#)?

- Use the [Explore MVPs webpage](#) to review detailed measure specifications and other measure information 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.
- **Note:** You'll need to [register for your selected MVP](#) between April 1 and December 2, 2024.

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.



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.



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, 2024. QDCs must be included on the originally submitted claim. You cannot go back and add QDCs to a previously submitted claim.

- **Append the Appropriate MVP Identifier:** 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 2024 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, 2024), 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 2024 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 2024 Multi-Performance Rate file on the 2024 Quality Benchmarks webpage, available in late January.



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

Did you know? To meet the 75% data completeness requirement, you should start appending QDCs soon after January 1, 2024. Some measures have a shortened measurement period, so be sure to review measure specifications carefully.

Note: The data completeness requirement has increased to a threshold of 75% for the 2024 performance period and will remain at 75% for the 2025-and 2026 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 [2024 Medicare Part B Claims Measure Specifications](#)** to ensure you are using the appropriate criteria and codes for the 2024 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).



Frequently Asked Questions

Key Topics

<u>Valid QDCs</u>	<u>21</u>
<u>Remittance Advice</u>	<u>21</u>
<u>Denied Claims</u>	<u>23</u>
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How Do I Know if the QDCs I Submitted Are Valid for MIPS in 2024?

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 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 2024 MIPS performance period.

The N620 denial code tells you that the QDC(s) are valid for the 2024 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.



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 2024 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.**



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 2024 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 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, Subgroup, 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, subgroup, or APM Entity, then we'll aggregate the individually reported quality measures into a group, virtual group, subgroup, or APM Entity quality score.



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

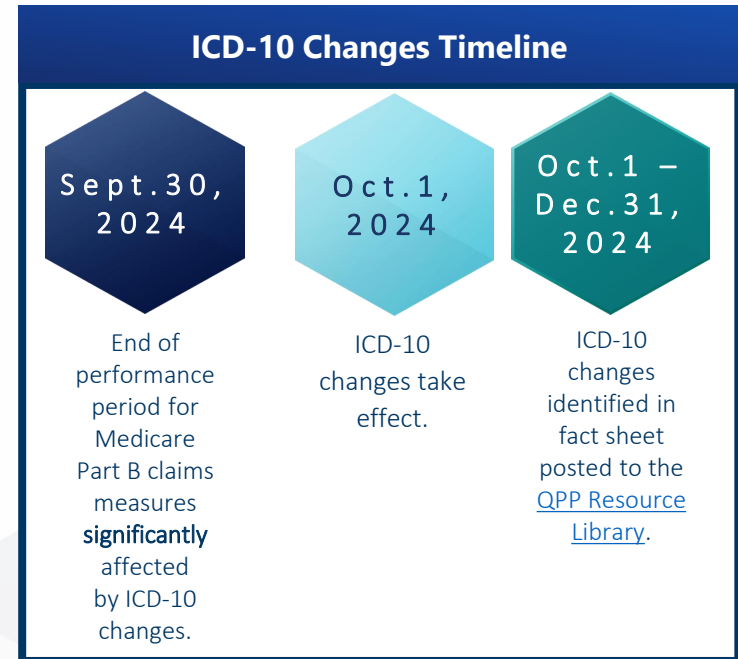
If you submit quality performance category data via Medicare Part B claims, then you can login to the [QPP website](#) and review your preliminary performance feedback in February 2025.

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, 2025).

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 are 9 consecutive months of accurate, available data.
- Suppress the measure if 9 consecutive months of data aren't available, or revised clinical guidelines, measure specifications and/or codes impact a clinician's ability to submit data on the measure.

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

For the 2024 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, 2025.)

To determine the identifier required for the MVP that you plan to report, please refer to [Appendix F](#).



Help and Version History

Where Can You Go for Help?

Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, by creating 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

- People who are deaf or hard of hearing 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 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.



Version History

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

Date	Description
12/27/2023	Original Posting.

Appendix

Appendix A: Medicare Part B Claims Measures Finalized for Removal Starting with the 2024 Performance Period

MIPS Quality ID	MIPS Quality Measure Title
110	Preventive Care and Screening: Influenza Immunization
111	Pneumococcal Vaccination Status for Older Adults
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy

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

Reporting Frequency

2024 Collection Type:
MEDICARE PART B CLAIMS

MEASURE TYPE:
Process – High Priority

Measure Description Location

High-level description of measure including patient characteristics

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):

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, POS 10



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 D: Sample CMS 1500 Form for Quality Data Submission

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)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 10 2024				15. OTHER DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				17b NPI				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) 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) OPT/HCP/CS MODIFIER		E. DIAGNOSIS PC/INTER		F. \$ CHARGES		G. DAYS OF UNITS		H. ICD-9-CM PROCEDURE CODE		I. ID. QUAL.		J. RENDERING PROVIDER ID. #					
10 10 24 10 11 24						92540		A		100.00		1		NPI		987654321							
10 10 24 10 11 24						G8856		A		0.01		1		NPI		987654321							
25. FEDERAL TAX I.D. NUMBER SSN EIN 1234567890 X				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 100.01				29. AMOUNT PAID \$ 0.00				30. Resid. 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				32. SERVICE FACILITY LOCATION INFORMATION 756 Medical Building Drive, Youngsville CA 76589 980-456-3245				33. BILLING PROVIDER INFO & FH# Physician Medical Services, Inc.															
SIGNED DATE				a. 987654321 b.				a. b.															



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 2024 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	10/10/2024						
Correct Complete with CPT II Code and Correct POS, QDC, & DX Code											
PERF											
Recipients	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PO
Name	A WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005							
	123-567-9876	11				100	75.95	0			
REM	N620				92540	0.01		0			
					G8856						
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				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					0.01	0	0			
					G8856						
Valid, but unsuccessful 2024 MIPS QDC Submission											
Incorrect POS											
Name	D WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005							
	123-567-9876	10				100	75.95	0			
REM	N620					0.01	0	0			
					G8856						
PT RESP	15.19										
CLAIM INFO											

- 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 2024 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 2024, 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 2024, but this claim was not a successful quality data submission for the patient encounter billed.



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

Identifier	MVP Title
G0053	Advancing Rheumatology Patient Care
G0054	Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
G0055	Advancing Care for Heart Disease
G0058	Improving Care for Lower Extremity Joint Repair
M0001	Advancing Cancer Care
M0002	Optimal Care for Kidney Health
M0003	Optimal Care for Patients with Episodic Neurological Conditions
M0004	Supportive Care for Neurodegenerative Conditions
M0005	Value in Primary Care
M1366	Focusing on Women's Health
M1367	Quality Care for the Treatment of Ear, Nose, and Throat Disorders
M1368	Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
M1369	Quality Care in Mental Health and Substance Use Disorders
M1370	Rehabilitative Support for Musculoskeletal Care