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Merit-based Incentive Payment System (MIPS)

2026 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 QPP Participation Status Tool.

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

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How to Use This Guide

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Click this icon (on the bottom left of each page) **to return to the table of contents.** 

Hyperlinks

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

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.

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Overview

What Is The Merit-based Incentive Payment System?

If you're eligible for MIPS:

- You report measure and activity data for the quality, improvement activities, and Promoting Interoperability performance categories.
  - Exceptions to these reporting requirements include your MIPS reporting option, special status, extreme and uncontrollable circumstances, or hardship exception. Detailed information for each performance year will be available in the Traditional MIPS Scoring Guide, APP Scoring Guide, and MIPS Value Pathways Implementation Guide. These resources are updated annually and will be posted to the QPP Resource Library.
- We collect and calculate data for the cost performance category for you, if applicable.
  - Exceptions include your MIPS reporting option, participation option, extreme and uncontrollable circumstances, and whether or not you meet case minimum for any cost measures.

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.
- Check your current participation status using the QPP Participation Status Tool.

What Is The Merit-based Incentive Payment System? (Continued)

If you're eligible for MIPS (Continued):

- 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.
  - **Positive payment adjustment** for clinicians with a final score **above** the performance threshold (**75 points** in 2026 – 2028 performance years).
  - **Neutral payment adjustment** for clinicians with a final score **equal to** the performance threshold (**75 points** in 2026 – 2028 performance years).
  - **Negative payment adjustment** for clinicians with a final score **below** the performance threshold (**75 points** in 2026 – 2028 performance years).

- Your MIPS payment adjustment is based on your performance during the performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1 of the payment year.
  - E.g., 2028 is the payment year for the 2026 performance year.

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.
- 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:

Traditional MIPS	MIPS Value Pathways (MVPs)	APM Performance Pathway (APP)
• The original reporting option for MIPS. • Visit the Ways to Report - Traditional MIPS webpage to learn more..	• This reporting option offers clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition. • Visit the Ways to Report - MIPS Value Pathways (MVPs) webpage to learn more.	• A streamlined reporting option for **clinicians who participate in a MIPS Alternative Payment Model (APM)**. • Visit the Ways to Report - APM Performance Pathway webpage to learn more.
• 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 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.	• You'll report a predetermined set of quality measures. There are 2 quality measure sets available (APP and APP Plus). • MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.
• You'll report the complete Promoting Interoperability measure set.	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).	• You'll 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 any applicable administrative claims measures for you.	• We collect and calculate data for the cost performance category and population health measures for you.	• Cost isn't evaluated under the APP.

Performance Category Flexibilities for Small Practices

For the 2026 performance year, we remain committed to identifying flexibilities and options to help clinicians in small practices meaningfully participate and succeed in MIPS. These flexibilities apply to all 3 MIPS reporting options (traditional MIPS, MVPs, and APP) unless otherwise specified.

Quality Performance Category

Small practices will receive:

- 3 points for submitting quality measures without an available benchmark (historical or performance period) – all other clinicians receive zero points.
- 3 points for submitting quality measures that don't meet the case minimum or data completeness requirements – all other clinicians receive zero points.
- 6 bonus points added to the quality performance category score when at least 1 quality measure is submitted (applies to individual, group, virtual group, and APM Entity participation, but not to clinicians or groups who are scored under facility-based scoring).

Reminder: 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). CMS makes this determination by reviewing claims data.

Small Practices Participation in MIPS

Promoting Interoperability Automatically Reweighted to 0%.

Traditional MIPS and MVP Performance Category Weights in 2026:

Quality

40% | of MIPS Score

Cost

30% | of MIPS Score

Improvement Activities

30% | of MIPS Score

Promoting Interoperability

0% | of MIPS Score

What's New with Medicare Part B Claims Reporting in 2026?

- **7 Medicare Part B claims measures will be subject to the topped-out measure benchmarks policy** for the 2026 performance period. Review Appendix A for a list of these Medicare Part B claims measures.
- **4 Medicare Part B claims measures received substantive measure changes** from the 2025 measure specifications; however, these measures will have a historical benchmark for 2026.
  - 2 of the 4 Medicare Part B claims measures with substantive measure changes are available in MVPs only (Measure 112 and 113).

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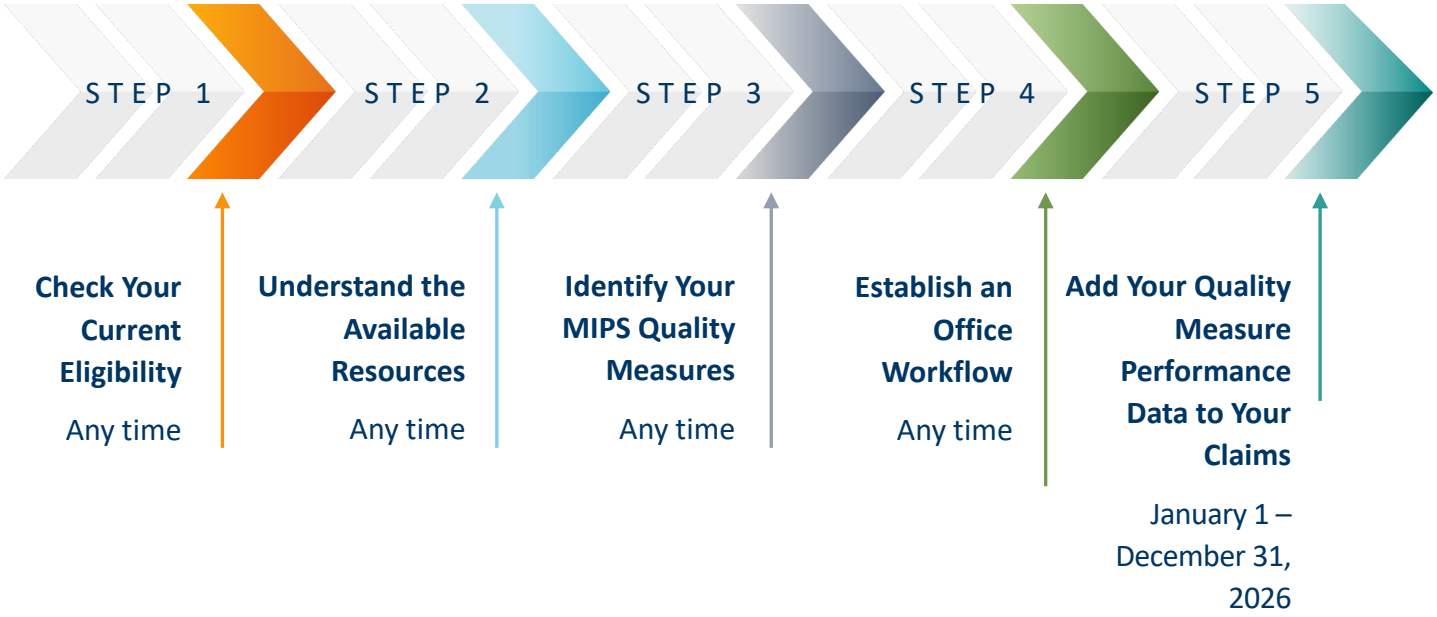
Get Started with Claims Measure Reporting in 5 Steps

Overview


STEP 1
STEP 2
STEP 3
STEP 4
STEP 5
Check Your Current Eligibility
Any time
Understand the Available Resources
Any time
Identify Your MIPS Quality Measures
Any time
Establish an Office Workflow
Any time
Add Your Quality Measure Performance Data to Your Claims
January 1 – December 31, 2026

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'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, 2025, and September 30, 2026, 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 2026.** 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 2026 Medicare Part B Claims Measure Specifications and Supporting Documents zip file (ZIP, 1KB) on the Quality Payment Program Resource Library (and Explore Measures for Traditional MIPS tool which won't be updated until the end of January 2026) includes the individual measure specifications and 3 supporting documents listed below 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. **2026 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 2026 performance period.
3. **2026 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/APP Plus
Select a minimum of 6 quality 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 a minimum of 4 quality 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 measures required by the APP (or the 4 measures required by the APP Plus). You'll also need to register for and administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure.

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 **2026 Quality Payment Program (QPP) Medicare Part B Claims Measures Single Source document** (from Step 2) to search for available measures based on encounter, procedure, and diagnosis codes that you routinely bill. • On the Explore Measures for Traditional MIPS 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**. (Explore Measures for Traditional MIPS won't be updated with 2026 measures and activities until early 2026).
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. **(Explore MVPs won't be updated with 2026 MVPs until early 2026).** • 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 and $0.00 line-item charge, 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 November 30, 2026.
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.
- Review your office workflows annually to determine if all measures your practice is intending to report have appropriate quality data codes (QDC) attached, and if your practice no longer intends to report a measure, you'll need to remove the QDC codes attached to your claims to avoid this measure receiving a score.

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 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, 2026. QDCs must be included on the originally submitted claim. You can't go back and add QDCs to a previously submitted claim.

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 2026 Multi-Performance Rate file on the Quality Benchmarks webpage, which will be updated with 2026 benchmarks in late January.

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. For an example as to how to append the MVP identifier to a claim, please refer to Appendix D.

Insert a Charge: When you attach a QDC or MVP identifier to your claim, you must include $0.00 line-item charge. If your billing software will not accept a code without a charge, attach a $0.01 line-item charge for the QDC and the MVP identifier, if applicable. 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.

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

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

- **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're using the 2026 measure specifications to appropriately code your claims as the specifications may change each year.
    - **Ex: Measure 226 (Tobacco Use: Screening and Cessation Intervention)** has 3 submission criteria that include 3 different patient populations ("denominator") with 3 different sets of performance data ("numerator") outlined in the specification. We use the QDCs you report for submission criteria 1 to evaluate data completeness and case minimum, and **the QDCs you report for submission criteria 2** for scoring purposes. **However**, all 3 submission criteria must be reported to meet measure requirements and receive a measure score.
    - Review the FAQ section to determine what information your MAC will provide regarding the QDCs you submitted.
- **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, 2026), 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 2026 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.

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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 75% data completeness requirement, you should start appending QDCs soon after January 1, 2026. Some measures have a shortened measurement period, so be sure to review measure specifications carefully.

Note: For the 2026 performance period, the data completeness requirement will remain at the 75% threshold and maintained through the 2028 performance period for all available collection types.

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're reviewing the 2026 Medicare Part B Claims Measure Specifications (ZIP, 1KB)** to ensure you're using the appropriate criteria and codes for the 2026 performance period.

Make sure you're 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

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How Do I Know if the QDCs I Submitted Are Valid for MIPS in 2026?

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

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

The RA/EOB lists denial codes that correspond to the information you submitted on the claim form.

When N620 is listed as a denial code, it tells you that the QDC(s) are valid for the 2026 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. This code confirms the QDCs were received and are valid for the 2026 performance year. It doesn't confirm that the QDCs were reported accurately for the measure.
- 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 2025 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 2026 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.

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're 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 only after you report another performance category at the group, virtual group, subgroup, or APM Entity level.

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 2027.

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 1 if technically feasible, but no later than the beginning of the data submission period (i.e., January 4, 2027).

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 2026 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. You should append an MVP identifier following the same steps as when appending a QDC to a claim.

The MVP identifier only needs to be reported once during the performance period to attribute your quality measures to the MVP. Any data submitted without the necessary MVP ID will be attributed to traditional MIPS instead of 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 4, 2027.)

If you submit quality data without the MVP identifier, review the quality performance category under traditional MIPS to determine if your measures are attributing to the incorrect reporting option.

To determine the identifier required for the MVP that you plan to report, please refer to Appendix F. For an example of how to append the MVP identifier to a claim, please refer to Appendix D.

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Help and Version History

Where Can You Go for Help?

Contact the Quality Payment Program (QPP) Service Center by emailing QPP@cms.hhs.gov, creating a QPP Service Center ticket, or calling 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET). Please consider calling during non-peak hours, before 10 a.m. and after 2 p.m. ET.

People 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 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
12/19/2025	Original Posting.

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Appendix

Appendix A: Medicare Part B Claims Measures Subject to the Topped-Out Measure Benchmarks Policy for the 2026 Performance Year

MIPS Quality ID	MIPS Quality Measure Title
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care
249	Barrett's Esophagus
250	Radical Prostatectomy Pathology Reporting
320	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
395	Lung Cancer Reporting (Biopsy/Cytology Specimens)
397	Melanoma Reporting
406	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients

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

2026 Collection Type:
MERIT BASED INCENTIVE PAYMENT SYSTEM (MIPS) 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:
Reporting Frequency:

Reporting Frequency Location

Reporting Frequency

This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:
This measure is intended to reflect the quality of services provided for patients with acute or chronic dizziness. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:
This measure contains one strata defined by a single submission criteria.
This measure produces a single performance rate.

Implementation Considerations:
For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient for the performance period. The most advantageous quality data code will be used if the measure is submitted more than once.

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

Telehealth:

NOT TELEHEALTH ELIGIBILE: This measure **is not appropriate for nor applicable to the telehealth setting**. Patient encounters for this measure conducted via telehealth should be removed from the denominator eligible patient population. Therefore, if the patient meets all denominator criteria but the encounter is conducted via telehealth, it would be appropriate to remove them from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

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 denominator exclusion(s) (as applicable) or selected numerator option. Denominator exclusions describe a circumstance where the patient should be removed from the denominator. Within Medicare Part B claims submissions, denominator exclusions identify circumstances where the patient should be removed from the performance rate calculation prior to determining which numerator outcome is appropriate. QDCs are available to describe the denominator exclusion within the Measure Specification and should be submitted on the claim.

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

Encounters conducted via telehealth: M1440

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, denominator exception, and performance not met) 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)

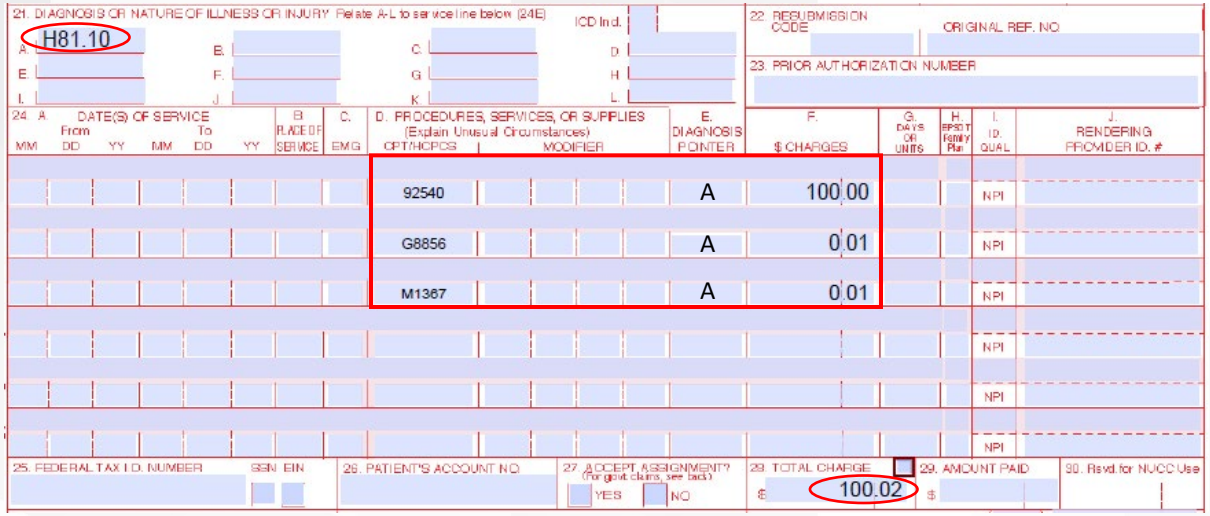
OR

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



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. #
				92540		A	100 00			NPI	
				G8856		A	0 01			NPI	
				M1367		A	0 01			NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER — SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $ 100.02
29. AMOUNT PAID $
30. Rsvd. for NUCC Use

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 G8856 and the diagnosis for dizziness (Item 24e points to the diagnosis code in item 21, line a, H81.10.

This practice intends to report the MVP, Quality Care for the Treatment of Ear, Nose and Throat Disorders. The MVP ID, M1367, is appended to the claim with a 0.01 line-item charge to signify the intent to report this MVP.*

*The use of the MVP ID on this claim is for sample purposes only. Quality ID #261 is not included in the Quality Care for Treatment of Ear, Nose and Throat Disorder MVP for the 2026 performance year.

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.

IMPORTANT: The CARC and RARC tell you that the QDC(s) you submitted are valid for the 2026 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 of incorrect Medicare Part B claims submissions for the Medicare Part B Claims Measure #261: Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness.

Sample EOB for Medicare Part B Claims Quality Data Reporting

Billing Provider	123456			Invoice Number							
Service Provider	123456			Check Number	56789						
Tax ID	123456789			Payment Date	11/11/2026						
	Missing DX, Complete with CPT code, Correct POS and QDC										
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	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 QDC										
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 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 2026 MIPS QDC Submission

- **Example A:** This claim was incorrect because it was processed without a relevant diagnosis code. 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 2026 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 2026, 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 2026, 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
M0004	Quality Care for Patients with Neurological 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

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

Identifier	MVP Title
M1420	Complete Ophthalmologic Care
M1421	Dermatological Care
M1498	Diagnostic Radiology
M1422	Gastroenterology Care
M1499	Interventional Radiology
M1500	Neuropsychology
M1501	Pathology
M1502	Podiatry Care
M1424	Pulmonology Care
M1425	Surgical Care
M1503	Vascular Surgery