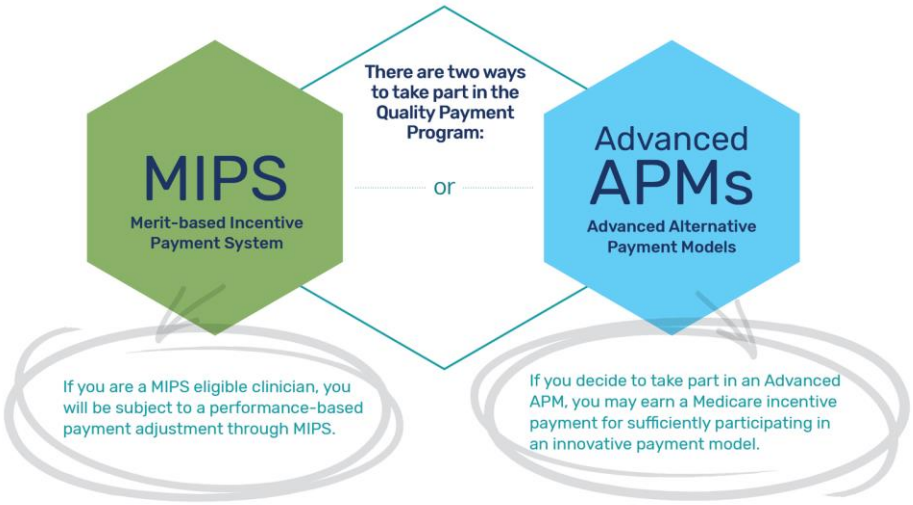
Quality Payment
PROGRAM

2019 Merit-based Incentive Payment System (MIPS) Quality Performance Category: Medicare Part B Claims Data Submission Fact Sheet

Updated 4/27/2020

*CMS is implementing multiple flexibilities to provide relief to clinicians responding to the 2019 Novel Coronavirus (COVID-19) pandemic. Refer to the **Quality Payment Program COVID-19 Response Fact Sheet** for more information.*

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), which provides two participation tracks for clinicians:



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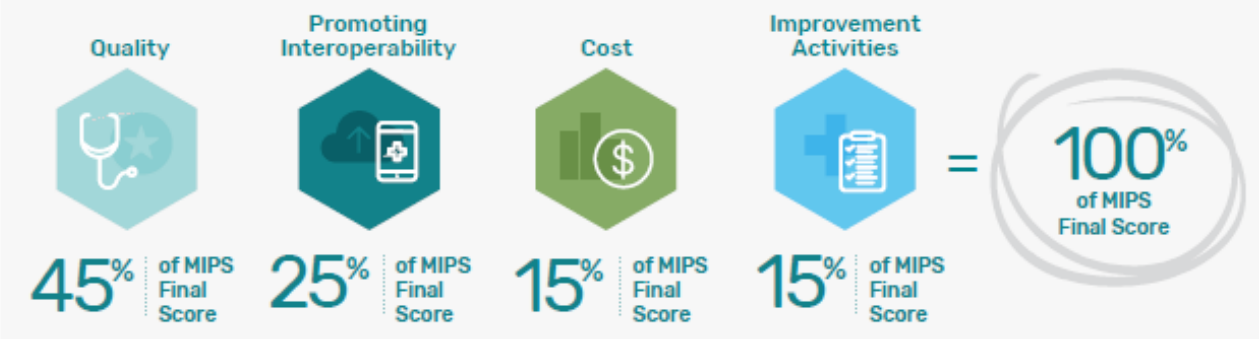
Under MIPS, there are four performance categories that may affect your 2019 final score, and the MIPS payment adjustment that applies to Medicare payments in the 2021 payment year:



If you're eligible for MIPS in 2019, you generally have to submit data for the Quality, Improvement Activities, and Promoting Interoperability performance categories by March 31, 2020[1]. Your performance across the MIPS performance categories will result in a MIPS final score of 0 to 100 points, which will determine whether you receive a negative, neutral, or positive MIPS payment adjustment. The MIPS payment adjustment is based off your performance in 2019 and will be applied to payments for covered professional services beginning on January 1, 2021.

Beginning in Year 3 of the program (2019), you have up to four submission type options (direct, log-in and upload, CMS Web Interface (for registered groups of 25 or more eligible clinicians) and Medicare Part B claims) to report your Quality performance category data.

For the small practices that choose to use the Medicare Part B claim submission type, as an individual or group, to submit Quality performance category data, this fact sheet:

- Tells you how to submit data through your Medicare Part B claims for the Quality performance category; and
- Gives you and your billing staff helpful data collection and submission tips.

Note: In Year 3, Medicare Part B claims measures can ONLY be submitted by clinicians in a small practice (15 or fewer eligible clinicians),[1] whether participating individually or as a group.

[1] Data submission is not required for the Cost performance category; CMS will calculate your cost measures using administrative claims data.

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What are the MIPS Quality Performance Category Requirements in 2019?

In Year 3 of the QPP (2019), the Quality performance category:

- Has a 12-month performance period (January 1 – December 31, 2019), and
- Is 45% of your overall MIPS final score.

Clinicians, groups, and virtual groups should report the measures that are most meaningful to their practice and choose the submission types and collection types that best meets their needs. Note that not all quality measures can be reported through all collection types.

Under MIPS, there are 65 quality measures that can be submitted through Medicare Part B claims. To fulfill the Quality performance category requirements, a clinician must generally submit:

1. Six quality measures (or at least six measures within a specialty measure set, unless the set contains fewer measures) for the 12-month performance period.
2. Among the six quality measures submitted, you must include at least one outcome measure. If there isn't an applicable outcome measure for you, then you must include a high priority measure instead.

Note: Quality measures submitted via Medicare Part B claims are not eligible for the end-to-end electronic reporting bonus.

In order to fully meet these two requirements, individuals and groups can collect their quality data using more than one collection type (MIPS Clinical Quality Measures (CQMs), Electronic clinical quality measures (eCQMs), Qualified Clinical Data Registry (QCDR) measures, and for small practices, Medicare Part B claims measures) and they can then submit their quality data using more than one submission type (direct, log in and upload, Medicare Part B claims (for small practices), and the CMS Web Interface (for registered groups of 25 or more)). This means if you are only able to submit 3 Medicare Part B claims measures, you can meet the requirements by submitting data for 3 eCQMs, 3 MIPS CQMs, etc. as long as at least one outcome measure or high-priority measure is submitted among the 6 total measures.

If you are exclusively submitting Medicare Part B claims measures and submit less than 6 measures, we will use the Eligibility Measure Applicability (EMA) process to see if there are clinically related measures you could have submitted. For more information on the EMA process, please refer to the 2019 Eligible Measure Applicability fact sheet (when available).

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How are the Quality Measures scored?

Quality measures that meet case minimum requirements (20 cases) and data completeness requirements (60% in Year 3) are eligible for scoring against a benchmark and will earn 3 – 10 points based on performance as compared to the related benchmark.[2] In 2019, individuals and groups can submit measures via multiple collection types (MIPS CQM, eCQM, QCDR measures, and for small practices, Medicare Part B claims measures). If the same measure is submitted via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring. For additional information on MIPS scoring, please refer to the 2019 MIPS Scoring Guide (when available).

What is the deadline for submitting quality data through Medicare Part B Claims?

To collect and submit quality data through Medicare Part B Claims, you will attach quality data codes (QDCs) to your Medicare Part B claims throughout the 2019 performance year. The last day for submitting 2019 Medicare Part B claims with QDCs for the 2019 performance period is determined by your Medicare Administrative Contractor (MAC) but must be processed no later than 60 days after the close of the performance period. Please check with your MAC for this guidance.

Note: Medicare Part B claims can only be used for submitting measures in the Quality performance category. Clinicians submitting quality measures via Medicare Part B claims need to select a different submission type to submit their Promoting Interoperability data and Improvement Activities.

Who Can Use the Medicare Part B Claims Submission Type?

Small practices participating in MIPS, individually or as a group, can submit their quality measures through Medicare Part B claims. **New in 2019:** For anyone participating in MIPS as an individual, group, or virtual group, that does not have the small practice designation can no longer use this submission type as an option for your quality data reporting. To see if you have the small practice designation, visit the QPP Participation Look Up Tool. A small practice is defined as a group that has 15 or fewer clinicians (NPIs) billing under the group's Taxpayer Identification Number (TIN).

For more information on other collection types and submission types available in 2019, please refer to the 2019 MIPS Quality Performance Category Fact Sheet.

[2] There are exceptions in place for measures identified as "topped out" which means, if a benchmark for the measure can be calculated, then they are capped at 7 points. For more information on these measures, visit the 2019 Quality Performance Category Fact Sheet and/or the 2019 Scoring Guide (when available).

How Do Small Practices Identify Medicare Part B Claims Measures that They Can Submit?

To submit quality data through your Medicare Part B claims, you have to:

- Select the Medicare Part B claims quality measures most meaningful to your practice
  - Review the list of 2019 Quality measures on qpp.cms.gov that are specific to Medicare Part B claims
- Submit the measures through your regular billing processes by adding certain billing codes to denominator eligible Medicare Part B claims

There are a few ways to select the Medicare Part B claims quality measures that are most meaningful to your practice. You can review each measure specifications' basic description of the measure or you can search our quality measure resources for measures that pertain to services you commonly perform.

When reviewing the measure specification, the description section will describe how often the numerator/denominator codes for a measure have to be included in a claim for the patient. It also provides the denominator criteria which identify whether the patient encounter is counted in the denominator of a quality measure. The denominator criteria of Medicare Part B claims quality measures generally include three elements:[3]

- **Patient Characteristics**: This can include patient demographics (such as age and gender) and is located in the "Measure Description" section.
- **Diagnosis Codes**: This includes International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.
- **HCPCS Codes**: This includes Current Procedural Terminology (CPT) Category II codes, and/or Healthcare Common Procedure Coding System (HCPCS) codes.

Note: The quality measure may also have exclusions for the denominator. *Review the sample measure description in Appendix A to find where these sections and denominator codes are located.*

Each quality measure specification includes the code(s) to identify denominator eligible encounters. If you are unsure if a patient encounter falls in denominator of any Medicare Part B claims measures, visit the Explore Measures and Activities Tool, select the 2019 Medicare Part B Claims Measure Specifications and Supporting Documents zip file, and open the **2019 Claims Single Source** spreadsheet from the Supporting Documents folder. This spreadsheet is a tool that small practices can use to search for codes, measure number, etc. within each individual Medicare Part B claims measure for the 2019 QPP. This may help you identify measures that apply to your practice based on common codes you use when seeing beneficiaries or to determine if you attached the correct QDC for the patient encounter for a certain quality measure.

[3] Some measures also include modifiers or place of service codes in their denominator criteria. Please review the quality measure specifications to find out which information is used to identify denominator eligible encounters for your measure(s).

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Note: CMS has established an annual review process to assess Medicare Part B claims quality measures impacted by ICD-10-CM code changes that occur during the performance period.

How Do I Submit Quality Data via Medicare Part B Claims?

If you choose to submit your quality measure data through Medicare Part B Claims, you must first code your claim form for reimbursement. When you begin, you'll follow normal coding rules for filing a claim. If the patient encounter for that claim meets the denominator criteria for the quality measure you have chosen to submit, you will apply the corresponding QDCs found within the numerator of that quality measure.

Each quality measure that you select to report via Medicare Part B Claims has more than one QDC. The QDCs correspond to a quality action that could have occurred during the denominator eligible encounter. You choose the most appropriate quality option for that denominator eligible encounter and apply the corresponding QDC or QDCs to your claim form in the CPT/HCPCS item (for the CMS-1500 form, this is item 24d). QDCs may include CPT Category II codes (with or without modifiers) and/or HCPCS G-codes for submission of quality data in MIPS. The QDC(s) included on your claim form identify for CMS which Medicare Part B claims quality measure(s) you are submitting.

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

How do I choose the appropriate QDC(s) for the measure(s) I submit?

Once you've identified your denominator eligible cases and have started filling out the claim form for your patient encounter, you'll need to append the appropriate QDC(s) on the claim form. For each Medicare Part B claim measure, there are separate QDCs to identify whether the patient encounter is included in the Numerator and why. The Numerator is based on CPT Category II codes, and these QDCs are organized into four options:

1. **Performance Met** - Patient is Included in Numerator, Patient is Included in Denominator
2. **Denominator Exclusion** - Patient is Not Included in Numerator, Patient is Not Included in Denominator
3. **Denominator Exception** – Patient is Not Included in the Numerator, Patient is Not Included in Denominator
4. **Performance Not Met** - Patient is Not Included in Numerator, Patient is Included in Denominator

Review the sample measure numerator codes in Appendix B to find where these sections and numerator codes are located within each measure's specifications.

Which claim form should I use to submit Medicare Part B claims measures and what type of NPI should I submit on the form?

As a Medicare provider, you submit claims using the CMS-1500 claim form (02/12) or CMS-1450 claim form (UB-04) (or the electronic version). On either form, you submit your individual/rendering Type 1 NPI to be paid for billable services provided to Medicare Part B Fee-for-Service (FFS) beneficiaries.

Whether you choose to report as an individual or group for MIPS, it does not affect the type of NPI information that you submit on your claim form for Medicare Part B claims measures. When you submit quality data to CMS through claims, these claims will have QDC line items for each clinician's Type 1 NPI. These claims will be processed to a final action by the MAC. All claims reimbursed are sent to the National Claims History (NCH). This is the data source that MIPS will use for measure analysis.

Note: Medicare Part B Claims measures should **not** be billed under the Type 2 (organizational) NPI.

5 Steps for Medicare Part B Claims Quality Measure Submission

Step 1: Figure out if you're required to participate in MIPS	For 2019, you're required to participate in MIPS if you: • Are 1 of these types of clinicians: ○ Physicians (including: ○ doctors of medicine, ○ doctors of osteopathy, ○ osteopathic practitioners, ○ doctors of dental surgery, ○ doctors of dental medicine, ○ doctors of podiatric medicine, ○ doctors of optometry, and ○ chiropractors) ○ Physician Assistants ○ Nurse Practitioners ○ Clinical Nurse Specialists ○ Certified Registered Nurse Anesthetists ○ **Physical therapist** ○ **Occupational therapist** ○ **Qualified speech-language pathologist** ○ **Qualified audiologist** ○ **Clinical psychologist** ○ **Registered dietitian or nutrition professionals** ○ Groups that include the clinicians in this list Clinician types in **bold** are new to the program in 2019! If you are one of the clinician types listed above, you can still be excluded from participating in MIPS for the 2019 performance year if you: • Enrolled in Medicare for the first time in 2019,

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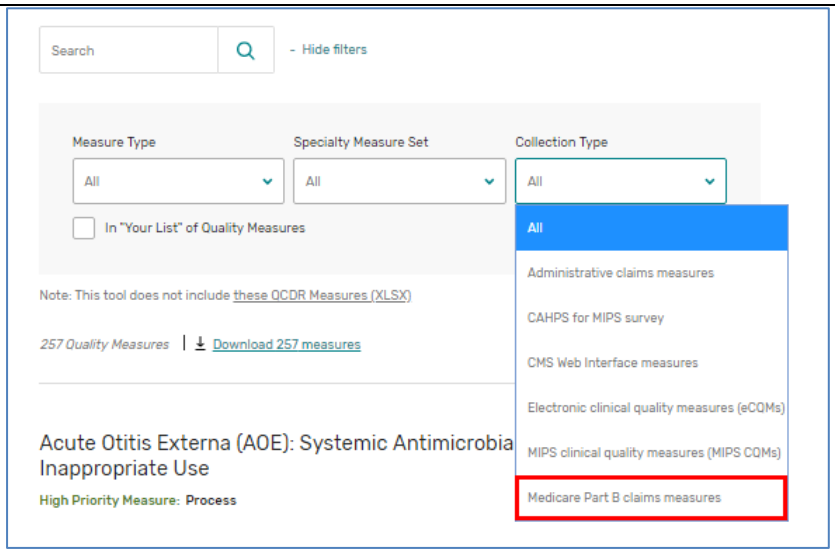
	• Participate in an Advanced APM and are determined to be a Qualifying APM Participant (QP), • Participate in an Advanced APM and are determined to be a Partial QP and do not elect to participate in MIPS, or • Do not exceed the low-volume threshold. For the 2019 performance period, CMS added a third element to the low-volume threshold; clinicians, groups and MIPS APM entities are excluded from MIPS if, during either segment of the MIPS determination period, you: Bill ≤ $90,000 in Medicare Part B allowed charges for covered professional services; OR • Provide care to ≤ 200 Part B-enrolled Medicare FFS beneficiaries; OR • Provide ≤ 200 covered professional services under the Physician Fee Schedule (PFS). Individual eligible clinicians and groups who exceed one or two of the elements above, during either segment of the MIPS determination period, can opt-in to MIPS or voluntarily report for performance year 2019. If you do not exceed any of the low-volume threshold criteria may voluntarily report, but are not able to opt-in. You can check your MIPS participation status by entering your NPI in the QPP Participation Status Tool on qpp.cms.gov. Practices can also sign in to qpp.cms.gov to review eligibility for all clinicians in the practice and to opt-in to participate in MIPS.
Step 2: Choose your quality measures	Visit the Explore Quality Measures section of the QPP website to: • See which quality measures work best for you • Learn if you can submit the measures through Medicare Part B claims • Review the Medicare Part B claims measure specifications that correspond with the measures you selected **Helpful hint:** You can filter measures on the Quality section of the Quality Payment Program website by collection type. Choose Medicare Part B claims measures from the drop-down menu.

	
Step 3: Find your eligible cases	Make sure that your practice finds all denominator-eligible cases for the measures you selected. Think about using a billing software that will flag claims every time the combination of codes in a measure's denominator is billed so that QDC entry is required before the final claims are submitted. If you are unsure if a patient encounter falls in the denominator of any Medicare Part B claims measures, you can visit the Explore Measures Page and select the Claims Single Source spreadsheet to search by diagnosis code (ICD-10-CM) and/or procedure/service code (CPT/HCPCS) and filter by the patient's demographics (i.e. gender, age). This document can be sorted and filtered to identify your denominator eligible case(s), however, the Quality Measure Specifications should also be referenced to understand the full combination of codes that will make a patient denominator eligible. There is a 60% data completeness requirement in 2019, which means that you must submit performance on at least 60% of your denominator-eligible instances per measure.
Step 4: Establish an office workflow	Set up an office workflow that will let the denominator-eligible patients for each of the measures you've selected be accurately identified on your Medicare Part B claims. To do, make sure that: • All of your supporting staff (including billing services) understand the measures you've selected for submission. • All of your supporting staff (including billing services) can identify all denominator-eligible claims for the measure(s) you've selected.

	• Review the Explore Measures page to identify your denominator eligible case(s). All of your supporting staff (including billing services) understand how often the measures you've selected have to be submitted.
Step 5: Submit your 2019 Medicare Part B claims data for the MIPS Quality performance category	**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, 2019 through December 31, 2019. **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 claims to CMS. **Check for Accuracy:** CMS encourages clinicians and their staff to review the claims for accuracy prior to submission for reimbursement and reporting purposes. **MAC Processing*:*** Claims are processed by the MACs (including claims adjustments, re-openings, or appeals) 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, 2019), 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 for specific instructions on how to bill.
Step 6: Sign in to qpp.cms.gov to monitor your performance on Medicare Part B Claims measures	**Updated 08/28/2019:** We anticipate that preliminary performance feedback on your Medicare Part B claims measures will be available when the 2019 MIPS submission period opens in January 2020. At the bottom of the QPP homepage, you can subscribe to receive announcements about the availability of this preliminary feedback and other important QPP information. 

How Do I Know if the QDC I Submitted are Valid for MIPS in 2019?

Once you've submitted the claim form and included the QDC 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 or the Explanation of Benefits to see if it the data submission was valid and successful.

Review the 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 2019 MIPS performance period.

- When the N620 denial code is returned to you on your RA/EOB it does not guarantee the QDC was **correct** or that reporting thresholds *were met*. However, when a QDC is valid, the N620 can indicate that the claim will be used in calculating satisfactory reporting.
- The N620 denial code tells you that the QDC(s) are valid for the 2019 MIPS performance period, but it **doesn't** mean the QDC was reported correctly for the *intended measure* or that you met the *measure requirements*.
    - If you bill a $0.00 QDC line item, you'll get the N620 code. If you bill a $0.01 QDC line item, you'll get the CO 246 N620 code.
    - All of your submitted QDCs on fully processed claims get sent to our warehouse for analysis, so you'll want to be sure you see the QDCs' line items on the RA/EOB and check whether or not you received the RA N620 code.
    - See Appendix D for examples of when a valid QDC was submitted unsuccessfully.
- Remember to keep track of all the denominator eligible cases you've reported to prove the QDCs you reported compared to the RA notice you received from your MAC. Each QDC line-item will be listed with the N620 denial remark code.

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

1. 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.
2. Check to ensure your software is transmitting the QDC(s) with a zero charge amount or a one cent charge for transmission.
3. (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.
4. 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 cannot resubmit a claim solely to add or correct missing QDCs. The submission will be rejected as a duplicate and non-payable claim.

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 are valid for the 2019 MIPS performance period, but **it doesn't mean the QDC was reported correctly for the intended measure or that you met the measure requirements.**

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

Valid QDCs with a $0.00 Charge Receive a RARC code

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

Note: The N620 denial code tells you that the QDC(s) are valid for the 2019 MIPS performance period, but it **doesn't** mean the QDC was reported correctly for the intended measure or that you met the measure requirements.

Did CMS Approve the 2019 Truncated Performance Period for Quality ID 001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) Medicare Part B Claims Submissions?

Yes. The Centers for Medicare & Medicaid Services (CMS) will truncate the 2019 performance period for the claims-based submission of Quality ID (QID) 001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%). The performance period will be truncated from 12 months (January 1 to December 31, 2019) to 9 months (January 1 to September 30, 2019).

In July of 2019, the American Medical Association issued an update to the CPT 2020 code set which inadvertently removed the CPT Category II code 3045F (Most recent hemoglobin A1c (HbA1c) level 7.0% to 9.0%). The update went into effect on October 1, 2019, and CMS did not have a comparable replacement code for reporting the most recent hemoglobin A1c levels until January 1, 2020. Stakeholders expressed concerns that their claims-based reporting of the CPT

II code 3045F was denied, affecting their performance on QID 001 during the fourth quarter of the performance period (October 1 to December 31, 2019).

CMS has listened to the concerns from stakeholders and determined that the removal of the CPT Category II code 3045F may negatively affect claims-based reporting and impact performance rates during the fourth quarter for QID 001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%). Therefore, CMS is truncating the 2019 performance period from January 1 to September 30, 2019 for the Medicare Part B reporting of QID 001. MIPS eligible clinicians do not need to submit any additional documentation or resubmit rejected claims solely for the purpose of adding a quality data code for the impacted timeframe.

Clinicians at Critical Access Hospitals (CAHs)

For the 2019 performance period, if you're a MIPS eligible clinician in a Critical Access Hospital Method II (CAH II) designated as a small practice, you can participate in MIPS using Medicare Part B claims reporting through the CMS-1450 form. If you're a CAH II clinician, 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, 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.

Tips for Successfully Submitting MIPS Quality Data through Medicare Part B Claims Measures

1. 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 2019 performance period.
2. 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.
3. A claim cannot be resubmitted to the MAC for the sole purpose of adding or correcting a QDC.
4. 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 (i.e. $0.00 or $0.01) associated with that QDC.
5. The Medicare Part B claims collection type is only available for the Quality performance category. To fully participate in MIPS, you should use your certified EHR technology to submit your Promoting Interoperability data and attest to your improvement activities.

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6. To meet data completeness requirements for quality measures, you should start appending QDCs as soon as possible after January 1, 2019. Be aware that some measures contain a shortened measurement period to accommodate evaluation of the most appropriate numerator quality action outcome. Review each measure specification to determine if it has a shorter measurement period.
7. QDCs must be reported:
    - On the claim(s) with the denominator billing code(s) that represents the eligible Medicare Part B PFS encounter.
    - For the same beneficiary.
    - For the same date of service (DOS).
    - 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.
8. Quality measure denominator criteria and numerator codes are subject to change from one performance year to the next. Check the Explore Measures Page to ensure you are using the appropriate criteria and codes for the 2019 performance period.
9. If you submit Quality performance category data via Medicare Part B claims, you can login to the QPP website and review your preliminary performance feedback, which will be available in January 2020.

Technical Assistance

We provide no cost technical assistance to small, underserved and rural practices to help you successfully participate in the Quality Payment Program. To learn more about this support, or to connect with your local technical assistance organization, we encourage you to visit our Small, Underserved, and Rural Practices page on the Quality Payment Program website.

Resources

If you have additional questions, please contact The Quality Payment Program at 1-866-288-8292, available Monday through Friday 8:00 AM-8:00 PM Eastern Time, or by e-mail at QPP@cms.hhs.gov.

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

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Version History Table

Date	Change Description
4/27/2020	• Added disclaimer language regarding changes to 2019 MIPS in response to COVID-19. • Added FAQ about the 2019 truncated performance period for Quality ID 001 for Medicare Part B Claims submissions.
8/28/2019	Revised the timeline for the expected release of preliminary performance feedback for Medicare Part B claims measures (January 2020).
6/28/2019	• Revised the timeline for the expected release of preliminary performance feedback for Medicare Part B claims measures. • Corrected references to external resources, added new links, and updated screenshots • Limited the information about the Eligible Measures Applicability (EMA) process to Medicare Part B claims measures.

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Appendix A – Medicare Part B Claims Measure Specifications for Denominator Eligible Case

In the snapshot below, a sample Medicare Part B claims measure specification (Quality ID #19) is provided with call out boxes identifying where the measure description is located, what the patient characteristics are, and what the reporting frequency is for the measure. The Quality measure denominator codes for the measure are immediately follow this section of each measure description.

Quality ID #19 (NQF 0089): Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measure Area: Transfer of Health Information and Interoperability

2019 COLLECTION TYPE:
MEDICARE PART B CLAIMS

MEASURE TYPE:
Process – High Priority

Measure Description Location

Patient Characteristic

Reporting Frequency

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for all patients with diabetic retinopathy seen during the performance period. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

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 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

DENOMINATOR NOTE: **Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for Medicare Part B claims measures.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis of diabetic retinopathy (ICD-10-CM): E08.311, E08.319, E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E09.311, E09.319, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492, E10.3493, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3291, E13.3292, E13.3293, E13.3311, E13.3312, E13.3313, E13.3391, E13.3392, E13.3393, E13.3411, E13.3412, E13.3413, E13.3491, E13.3492, E13.3493, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593
AND
Patient encounter during the performance period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
WITHOUT
Telehealth Modifier: GQ, GT, 95, POS 02

Appendix B – Medicare Part B Claims Measure Specifications for Numerator Codes (QDCs)

In the snapshot below, a sample Medicare Part B claims measure specification (Quality ID #134) is provided with call out boxes identifying the four Quality measure numerator options for the measure (performance met, performance not met, denominator exception, or denominator exclusion) and the corresponding QDC you would submit on the claim form.

Numerator Quality-Data Coding Options:

Depression Screening or Follow-Up Plan not Documented, Patient not Eligible

Denominator Exclusion: **G9717:** Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required

OR

Screening for Depression Documented as Positive, AND Follow-Up Plan Documented

Performance Met: **G8431:** Screening for depression is documented as being positive AND a follow-up plan is documented

OR

Screening for Depression Documented as Negative, Follow-Up Plan not Required

Performance Met: **G8510:** Screening for depression is documented as negative, a follow-up plan is not required

OR

Screening for Depression not Completed, Documented Reason

Denominator Exception: **G8433:** Screening for depression not completed, documented reason

OR

Screening for Depression not Documented, Reason not Given

Performance Not Met: **G8432:** Depression screening not documented, reason not given

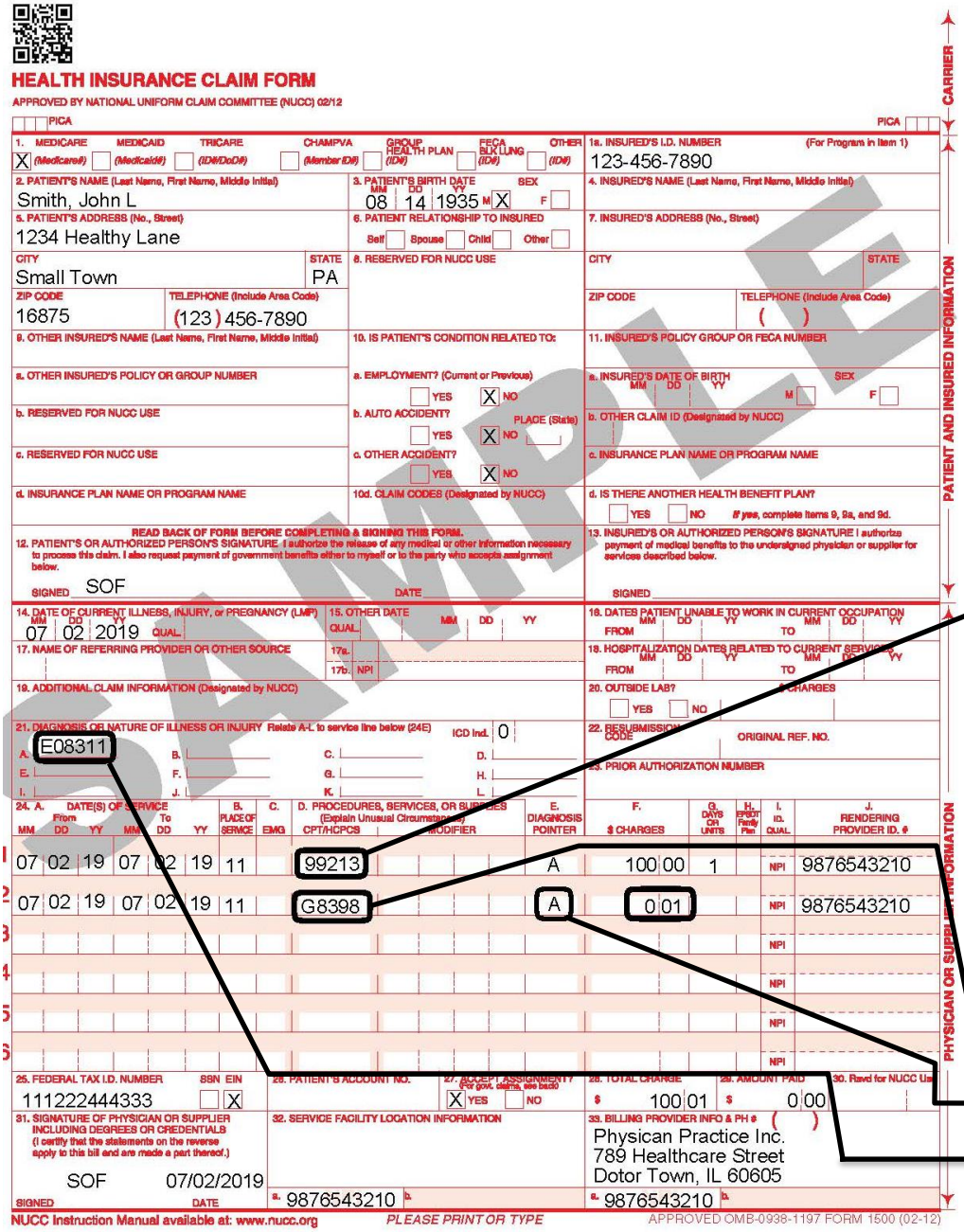
OR

Screening for Depression Documented as Positive, Follow-Up Plan not Documented, Reason not Given

Performance Not Met: **G8511:** Screening for depression documented as positive, follow-up plan not documented, reason not given

Updated: 4/27/2020

Appendix C – Sample CMS 1500 Form for Quality Data Submission



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (X) (Medicare#) | MEDICAID | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123-456-7890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John L

3. PATIENT'S BIRTH DATE: 08 14 1935 SEX: M (X) F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 Healthy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Small Town STATE: PA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 16875 TELEPHONE (Include Area Code): (123) 456-7890

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES (X) NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES (X) NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES (X) NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SOF DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 02 2019 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. E08311 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. #
07 02 19	07 02 19	11		99213		A	100 00	1		NPI	9876543210
07 02 19	07 02 19	11		G8398		A	0 01			NPI	9876543210
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 111222444333 (X)

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (X) YES NO

28. TOTAL CHARGE $ 100 01

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SOF 07/02/2019

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. 9876543210 b.

33. BILLING PROVIDER INFO & PH # ( )

Physican Practice Inc.
789 Healthcare Street
Dotor Town, IL 60605

a. 9876543210 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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 one 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 encounter was seen for an office visit (99213).

The clinician is reporting a quality measure (Quality ID# 19) related to Diabetic Retinopathy communication:

- Measure (Quality ID) # 204 is reported with QDC G8398 + the diabetes mellitus diagnosis[4] (Item 24e points to the diagnosis code in item 21, line a, E08.311).

[4] The full diagnosis is Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema.

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- 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 you will receive RARC and/or CARC N620, PR 246 N620, or CO 246 N620, depending on the amount of your line-item charge.

The CARC and RARC tell you that the QDC(s) you submitted are valid for the 2019 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 one 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 EC (identified by individual NPI).
    - ECs 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 one diagnosis on a claim.
    - For line items containing QDCs, only one 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 one 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 D – Sample EOB

In the snapshot below, a sample EOB outlines four examples (one correct and three incorrect) of Medicare Part B claims submissions for the purposes of reporting Quality data.
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; the procedure/service (CPT) code is present with the QDC. The N620 confirms that the QDC submitted is valid for the 2019 MIPS performance period, **but it doesn't mean the QDC was reported correctly for the intended measure or that you met the measure requirements**.

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		8/10/2019					
Correct	Complete with G codes 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	SMITH, JOHN L		HIC 1234567890	ACCT SMITHJ0008							
	123-456-7890	11	1	99213		100.00	75.94	0			
REM	N620		1	G8398		0.01	0	0			
PT RESP	15.19										
CLAIM INFO											

The Next Three Examples will not meet the Requirements for Claims-Based Measures for the MIPS Program.

	Complete without G codes							
Name B	SMITH, JOHN L		HIC 1234567890	ACCT SMITHJ0008				
	123-456-7890	11	1	99213	100.00	75.94	0	
PT RESP	15.19							
CLAIM INFO								
	Complete G codes split off from Service							
Name C	SMITH, JOHN L		HIC 1234567890	ACCT SMITHJ0008				
REM	N620		1	G8398	0.01	0	0	
	Incorrect POS							
Name D	SMITH, JOHN L		HIC 1234567890	ACCT SMITHJ0008				
	123-456-7890	10	1	99213	100.00	75.94	0	
REM	N620		1	G8398	0.01	0	0	
PT RESP	15.19							
CLAIM INFO								

Valid, but unsuccessful 2019 MIPS QDC submission

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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 2019 but this claim was not a successful quality data submission for the patient encounter billed. Note: this claim would not count either way as it will not be in the denominator eligible cohort for the measure (because the CPT code that identified it as denominator eligible was not included).

Example D this claim has an incorrect POS code. The N620 code is present here because the QDC is valid for 2019 but this claim was not a successful quality data submission for the patient encounter billed.

Updated: 4/27/2020