Quality Payment PROGRAM

Merit-based Incentive Payment System (MIPS)

2021 Reporting MIPS Quality Measures through Medicare Part B Claims Quick Start Guide (Traditional MIPS)

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Purpose: This resource walks through the steps needed for small practices to report Medicare Part B Claims measures (whether participating as an individual, group, virtual group, or Alternative Payment Model (APM) Entity)*. A small practice is defined as a group that has 15 or fewer clinicians identified by National Provider Identifier (NPI), billing under the groups Taxpayer Identification Number (TIN). To see if you have the small practice designation, visit the Quality Payment Program Participation Status Lookup Tool.*

Did you know no-cost assistance is available for small practices? *Visit the Small, Underserved, and Rural Practices page on the Quality Payment Program website to learn more.*

How to Use This Guide

How to Use This Guide

Please Note: This guide was prepared for informational purposes only and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Table of Contents

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Hyperlinks

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

Overview

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP), a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program changes how we reimburse MIPS eligible clinicians for Medicare Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

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

If you're eligible for MIPS in 2021:

- You generally have to submit data for the quality, improvement activities, and Promoting Interoperability performance categories.
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS Final Score of 0 to 100 points.
- Your MIPS Final Score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based on your performance during the 2021 performance year and applied to payments for covered professional services beginning on January 1, 2023.

To learn more about MIPS eligibility and participation options:

- *Visit the How MIPS Eligibility is Determined and Participation Overview webpages on the Quality Payment Program website.*
- *View the 2021 MIPS Eligibility and Participation Quick Start Guide.*
- *Check your current participation status using the Quality Payment Program Participation Status Tool.*

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

Traditional MIPS, established in the first year of the Quality Payment Program, is the original framework for collecting and reporting data to MIPS.

Under traditional MIPS, participants select from over 200 quality measures and over 100 improvement activities, in addition to reporting the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

In addition to traditional MIPS, 2 other MIPS reporting frameworks will be available to MIPS eligible clinicians:

The **APM Performance Pathway (APP)** is a streamlined reporting framework beginning with the 2021 performance year for MIPS eligible clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs.

MIPS Value Pathways (MVPs) are a reporting framework that will offer clinicians a subset of measures and activities, established through rulemaking. MVPs are tied to our goal of moving away from siloed reporting of measures and activities towards focused sets of measures and activities that are more meaningful to a clinician's practice, specialty, or public health priority. We anticipate the first MVP candidates to be proposed in the CY 2022 Quality Payment Program Proposed Rule. .

To learn more about the APP:

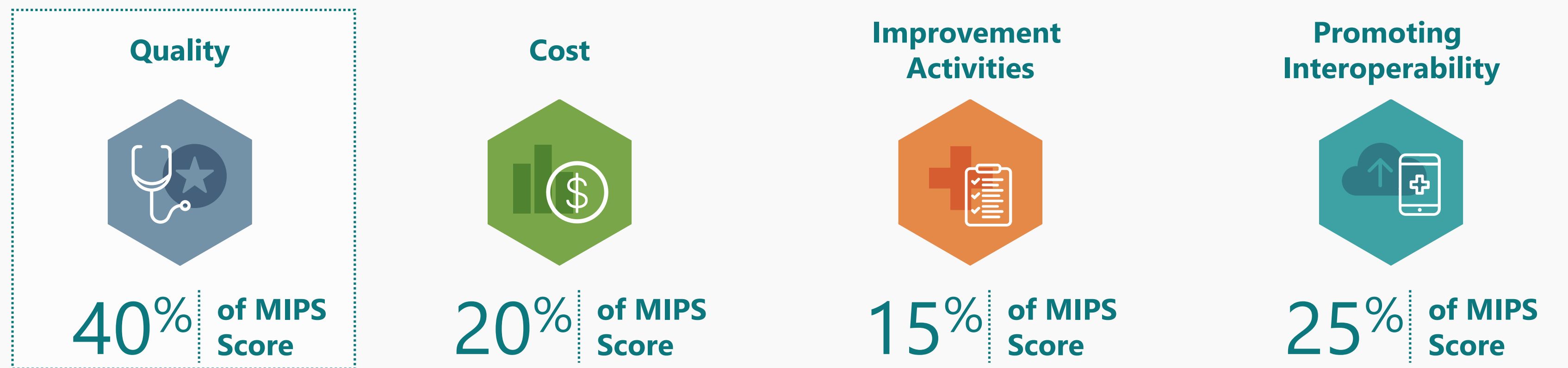
- *Visit the APM Performance Pathway webpage on the Quality Payment Program website.*
- *View the 2021 APM Performance Pathway (APP) for MIPS APM Participants and 2021 APM Performance Pathway (APP) Infographic resources.*

To learn more about MVPs:

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

Reporting Quality Measures through Medicare Part B Claims

Medicare Part B claims are one way that clinicians in small practices can report their quality measures. Please refer to the 2021 Quality Quick Start Guide for more information on the quality performance category and other options for reporting quality measures



While some of the steps in this guide focus on traditional MIPS policies, the act of reporting quality measures through Medicare Part B claims is the same regardless of framework. For information about the quality measures required under the APP, please refer to the APP Quality Requirements.

What's New with Medicare Part B Claims Reporting in 2021?

8 Medicare Part B claims measures were removed from the 2021 MIPS quality measure set and can no longer be reported:

- **Quality ID #012**: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
- **Quality ID #048**: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- **Quality ID #052**: Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy
- **Quality ID #146**: Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms
- **Quality ID #268**: Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy
- **Quality ID #419**: Overuse of Imaging for the Evaluation of Primary Headache
- **Quality ID #435**: Quality of Life Assessment for Patients With Primary Headache Disorders
- **Quality ID #437**: Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure.

Get Started with Claims Measure Reporting for Traditional MIPS in 5 Steps

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Get Started with Claims Measure Reporting for Traditional MIPS in 5 Steps

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 qpp.cms.gov to review eligibility for all clinicians in the practice.

Virtual groups and APM Entities need to sign in to qpp.cms.gov 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 (or any of the clinicians in your practice) are eligible to participate in MIPS, then you can choose to participate as an individual or group.

X ***Not* Eligible?**
If you are not eligible to participate in MIPS, then you are not required to participate but may be eligible to opt-in.

Note: If the clinicians in your practice are not 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 is not required to do so.

Did you know?

If your practice has 15 or fewer clinicians billing between October 1, 2020, and September 30, 2021 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 2021**. If you're currently identified as a small practice, that won't change when we update eligibility.*

*If you (or any of the clinicians in your practice) are eligible to participate in MIPS and you want to report Medicare Part B Claims measures, **start reporting your quality measures through claims now**. You cannot report quality measures on previously submitted claims.*

Step 2. Understand the Available Resources

The 2021 Medicare Part B Claims Measure Specifications and Supporting Documents zip file on the Quality Payment Program Resource Library (and Explore Measures & Activities tool) includes 3 supporting documents to help you understand how to report quality measures through claims.

- **2021 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.
- **Medicare Part B Claims Measure Specifications Release Notes –** This document details changes to existing measures that will go into effect in the 2021 performance period.
- **2021 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.

Additionally, the 2021 MIPS Quality Measures List is available on the Quality Payment Program Resource Library. This spreadsheet is a tool that MIPS eligible clinicians can use to search for current 2021 quality measures, including Medicare Part B claims measures.

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

Get Started with Claims Measure Reporting for Traditional MIPS in 5 Steps

Step 3. Choose Your Measures (*Traditional MIPS Only*)

Clinicians in a MIPS APM who choose to report the APM Performance Pathway (or APP) need to report the quality measures specified in the APP, 3 of which can be reported as Medicare Part B Claims measures. ***If reporting the APP, you can skip ahead to the next step.***

Whether you're participating as a group, virtual group APM Entity or individual, you must select 6 measures if you're reporting traditional MIPS. You must report either:

6 measures for the group, virtual group, or APM Entity as a whole if participating as a group, virtual group, or APM Entity

OR

6 measures for each MIPS eligible clinician if participating as individuals

Of these 6 measures, 1 must be an outcome measure OR a high-priority measure (if an outcome measure is not available).

Note: Bonus points are available for reporting additional outcome or high-priority measures beyond the one that is required.

If reporting traditional MIPS, you may also select a specialty-specific set of measures, if applicable to you, your group, your virtual group or APM Entity.

- If less than 6 measures apply to you or your group, then you should report on each applicable measure.

If your practice is reporting as individuals, then all of the MIPS eligible clinicians within your practice can report the same measures as long as the measures are applicable to the services they provide.

Not sure how to get started? In addition to reviewing measure specifications, you can:

- Use the **2021 Quality Payment Program (QPP) Medicare Part B Claims Measures Single Source** document (from Step 2) to search for encounter, procedure, and diagnosis codes that you routinely bill.
- On the Explore Measures & Activities Tool on the Quality Payment Program website, **search for key terms** that are applicable to the care that you provide or patient population you serve or **filter by specialty set**. (*The Explore Measures & Activities Tool will not be updated with 2021 measures and activities until early 2021)*

Get Started with Claims Measure Reporting for Traditional MIPS in 5 Steps

Step 4. Establish an Office Workflow

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

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

- Understand the intent of the measures you've selected for submission.
- Can identify all denominator-eligible claims for the measure(s) you've selected
  - Review the measures specifications to identify your denominator eligible case(s).
- Understand how often the measures you've selected have to be submitted on Medicare Part B claims within the performance period.

Note: Review the sample measure numerator codes in Appendix B 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 will code your claims as usual and add quality data codes (QDCs) and Current Procedural Terminology (CPT) codes as appropriate for the measure being reported.

- **Append QDC(s)**: Submit your quality data for MIPS through your Medicare Part B claims by appending a QDC to your claims form with dates of service during the performance period – January 1 through December 31, 2021. QDCs must be included on the originally submitted claim. You cannot go back and add QDCs to a previously submitted claim.
- **Insert a Charge:** When you attach a QDC to your claim, you must include $0.00 line item charge for the QDC. If your billing software will not accept a code without a charge, attach a $0.01 line item charge for the QDC. An entry in the line item charge box on the claim form is a requirement for quality reporting via Medicare Part B claims to CMS.
- **Check for Accuracy:** We encourage you to review your Medicare Part B claims for accuracy prior to submission for reimbursement and reporting purposes. It's important to confirm that you are using the 2021 measure specifications to appropriately code your claims as the specifications may change each year.
- **MAC Processing:** Claims (including claims adjustments, re-openings, or appeals) are processed by the Medicare Administrative Contractors (MACs) and must get to the national Medicare claims system data warehouse (National Claims History file) no later than 60 days following the close of the performance period to be analyzed.
- **Don't wait!** For patient encounters that occur towards the end of the performance year (December 31, 2021), 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 2021 quality reporting.

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

Get Started with Claims Measure Reporting for Traditional MIPS in 5 Steps

Quality Payment PROGRAM

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

Did you know? To meet the 70% data completeness requirement, you should start appending QDCs as soon as possible after January 1, 2021. Some measures have a shortened measurement period, so be sure to review measure specifications carefully.

Quality data codes must be reported:

On the claim(s) with the denominator billing code(s) that represent(s) the eligible Medicare Part B PFS encounter

AND

For the same Medicare patient.

AND

For the same date of service (DOS).

AND

By the same clinician who performed the covered service, applying the appropriate encounter codes (ICD-10-CM, CPT Category I, or HCPCS codes). These codes are used to identify the measure's denominator.

Quality measure denominator criteria and numerator codes are subject to change from one performance year to the next. **Make sure you are reviewing the 2021 Medicare Part B Claims Measure Specifications** to ensure you are using the appropriate criteria and codes for the 2021 performance period.

Make sure you are billing services under the clinician's individual (Type 1) NPI, and not the organization (Type 2) NPI. We will automatically aggregate individual reporting into a quality score for the group (and virtual group or APM Entity as appropriate).

Frequently Asked Questions

Frequently Asked Questions

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Frequently Asked Questions

How Do I Know if the QDCs I Submitted are Valid for MIPS in 2021?

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 2021 MIPS performance period.

Important

- **The N620 denial code tells you that the QDC(s) are valid for the 2021 MIPS performance period, but it doesn't mean the QDC(s) were 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(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 cannot resubmit a claim solely to add or correct missing QDCs. The submission will be rejected as a duplicate and non-payable claim.*

Frequently Asked Questions

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 2021 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.

Frequently Asked Questions

What Happens if a Medicare Part B Claim is Denied?

If your MAC denies payment for all the billable services on your claim, the QDCs won't be included in the MIPS analysis, and that claim's data won't count towards your quality measure submission for the 2021 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 qpp.cms.gov and attest to your Promoting Interoperability measures (collected in 2015 Edition Certified Electronic Health Record Technology (CEHRT)) and improvement activities. We'll use claims to evaluate you on cost measures; no action is needed from you or your practice. If you want to participate as a group, then you will need to report your Promoting Interoperability and improvement activity data at the group level—we will not aggregate individual data into a group score for these categories.

How Does Group, Virtual Group, or APM Entity Participation Work for Medicare Part B Claims Measures?

Unlike other types of quality measures, Medicare Part B claims quality measures are always reported at the individual clinician level. If you are participating as a group, virtual group, or APM Entity, then we will aggregate the individually reported quality measures into a group, virtual group, or APM Entity quality score.

This is the only circumstance in which we will aggregate individual data into a group score. If you're participating as a group or virtual group, then you will need to submit your improvement activities and Promoting Interoperability data at the group level.

Important

Frequently Asked Questions

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 Quality Payment Program website and review your preliminary performance feedback in January 2022.

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 will identify these measures in a fact sheet that will be posted to the Quality Payment Program Resource Library by October 2021.

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 will continue to report on any encounters that use existing codes (those included in the current measure specifications).

ICD-10 Changes Timeline

End of performance period for Medicare Part B claims measures **significantly** affected by ICD-10 changes

ICD-10 changes take affect.

ICD-10 changes identified in fact sheet posted to the QPP Resource Library.

NEW: We expanded the list of reasons that a quality measure may be significantly impacted during the performance period and offering scoring flexibilities for measures where these reasons impact the clinicians' ability to submit the measure. Reasons for the use of scoring flexibilities include updates to clinical guidelines and instances where the provided results would be misleading and not comparable to the historic benchmark.

Based on the timing of the change and the availability of data, we would:

- Truncate the performance period to 9 consecutive months if there were no concerns with potential patient harm and 9 consecutive months of data were available; or
- Suppress the measure from scoring (0 achievement points and total measure achievement points reduced by 10 for each measure submitted that is impacted) if 9 consecutive months of data were not available.

Frequently Asked Questions

What If I’m a Clinician at a Critical Access Hospital (CAH)?

For the 2021 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.

Help, Resources, and Version History

Quality Payment PROGRAM

Where Can You Go for Help?

Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8 a.m.-8 p.m. 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.

Connect with your local Technical Assistance organization. We provide no-cost technical assistance to **small, underserved, and rural practices** to help you successfully participate in the Quality Payment Program.

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.

Additional Resources

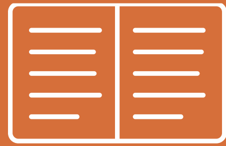
The Quality Payment Program Resource Library houses fact sheets, specialty guides, technical guides, user guides, helpful videos, and more. We will update this table as more resources become available.

Resource	Description
2021 MIPS Quick Start Guide	A high-level overview of the Merit-based Incentive Payment System (MIPS) requirements to get you started with participating in the 2021 performance year.
2021 Eligibility and Participation Quick Start Guide: Traditional MIPS	A high-level overview and actionable steps to understand your 2021 MIPS eligibility and participation requirements.
2021 Quality Performance Category Quick Start Guide: Traditional MIPS	A high-level overview and practical information about quality measure selection, data collection, and submission for the 2021 MIPS quality performance category.
2021 Promoting Interoperability Performance Category Quick Start Guide: Traditional MIPS	A high-level overview and practical information about data collection and submission for the 2021 MIPS Promoting Interoperability performance category.
2021 Improvement Activities Performance Category Quick Start Guide: Traditional MIPS	A high-level overview and practical information about data collection and submission for the 2021 MIPS improvement activities performance category.
2021 Cost Performance Category Quick Start Guide: Traditional MIPS	A high-level overview of cost measures, including calculation and attribution, for the 2021 MIPS cost performance category.
2021 Medicare Part B Claims Measures Specifications and Supporting Documents	This set of resources provides comprehensive descriptions of the 2021 Medicare Part B claims measures for the MIPS quality performance category, including tools to search for applicable Medicare Part B claims measures, a measure specification and measure flow guide, and detailed specifications for each 2021 Medicare Part B claims measure.
2021 Quality Payment Program Final Rule Resources	This zip file includes: the 2021 Quality Payment Program (QPP) final rule overview fact sheet; a policy comparison table; a set of frequently asked questions; and the MIPS Value Pathways (MVP) Candidate submission template.

Version History

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

Date	Description
1/14/2021	Original posting



Appendix

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

Quality ID #14 (NQF 0087): Age-Related Macular Degeneration (AMD): Dilated Macular Examination– National Quality Strategy Domain: Effective Clinical Care

- Meaningful Measure Area: Management of Chronic Conditions

2021 Collection Type:

MEDICARE PART B CLAIMS

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage AND the level of macular degeneration severity during one of more office visits within the 12 month performance period.

Measure Description Location

High-level description of measure including patient characteristics

Reporting Frequency

INSTRUCTIONS:

This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. It is anticipated that MIPS eligible clinicians who provide the primary management of patients with age-related macular degeneration (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 50 years and older with a diagnosis of AMD.

Appendix A – Medicare Part B Claims Measure Specifications for Denominator Eligible Case *(continued)*

Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on date of encounter

AND

Diagnosis for age-related macular degeneration (ICD-10-CM):

H35.3110, H35.3111, H35.3112, H35.3113, H35.3114, H35.3120, H35.3121, H35.3122, H35.3123, H35.3124, H35.3130, H35.3131, H35.3132, H35.3133, H35.3134, H35.3120, H35.3211, H35.3212, H35.3213, H35.3220, H35.3221, H35.3222, H35.3223, H35.3230, H35.3231, H35.3232, H35.3233

AND

Patient encounter during performance period (CPT): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 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 B Claims Measure Specifications for Numerator Codes (QDCs)

In the snapshot below, a sample Medicare Part B claims measure specification (Quality ID #14) is provided with call-out boxes identifying the 4 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:

Dilated Macular Examination Performed

Performance Met: G9974:

Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage AND the level of macular degeneration severity.

OR

Dilated Macular Examination Not Performed for Medical or Patient Reasons

Denominator Exception: G9975:

Documentation of medical reason(s) for not performing a dilated macular examination

OR

Denominator Exception: G9892:

Documentation of patient reason(s) for not performing a dilated macular examination

OR

Performance Not Met: G9893:

Submit code G9893 for circumstances when the action described in the numerator is not performed and the reason is not otherwise specified

Dilated macular exam was not performed, reason not otherwise specified.

Appendix C – Sample CMS 1500 Form for Quality Data Submission

HEALTH INSURANCE CLAIM FORM

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

SAMPLE

1. MEDICARE (Medicare#) [X] MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

1a. INSURED'S I.D. NUMBER: 123-456-7890

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

3. PATIENT'S BIRTH DATE: 09 13 1945 SEX: M [X]

5. PATIENT'S ADDRESS (No., Street): 3456 Rainbow Lane

CITY: Daisyland STATE: PA

ZIP CODE: 15437 TELEPHONE (Include Area Code): (223) 456-9876

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? NO [X] b. AUTO ACCIDENT? NO [X] c. OTHER ACCIDENT? NO [X]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: SOF

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 10 12 2021

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: ICD Ind. 0 — A. H35.3131

Line	24A. Date(s) of Service From	To	B. Place of Service	D. CPT/HCPCS	E. Diagnosis Pointer	F. $ Charges	G. Days or Units	J. Rendering Provider ID #
1	10 12 21	10 12 21	11	99213	A	100 00	1	NPI 9876543210
2	10 12 21	10 12 21	11	G9974	A	0 01		NPI 9876543210

25. FEDERAL TAX I.D. NUMBER: 111222444333

28. TOTAL CHARGE: $ 100 01 29. AMOUNT PAID: $ 0

31. SIGNATURE OF PHYSICIAN OR SUPPLIER: SOF

32a. 9876543210

33. BILLING PROVIDER INFO & PH #: Physician Practice Inc. 789 Healthcare Street, Doctor Town, PA 00012

33a. 9876543210

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

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 encounter was seen for an office visit (99213).

The eligible clinician is reporting a quality measure (Quality ID# 014) related to Age-Related Macular Degeneration (AMD):

Measure Quality ID #014 is reported with quality data code (QDC) G9974 + the AMD diagnosis (Item 24e points to the diagnosis code in item 21, line a, H35.3131

Appendix C – Sample CMS 1500 Form for Quality Data Submission (*continued*)

- The QDC must be submitted with a line item charge of $0.00, or (if your system requires it) a line item charge of $0.01.
- If transmission of your QDC was successful to your MAC, then you will receive RARC and/or CARC N620, PR 246 N620, or CO 246 N620, depending on the amount of your line item charge.
- For purposes of this form, a Federal Taxpayer Identification Number (TIN) may be a 9-digit:
  - Social Security number (SSN) formatted like 123-45-6789 used for individuals.
  - Employer Identification Number (EIN) formatted like 12-3456789 used for employers or the self-employed.

The CARC and RARC tell you that the QDC(s) you submitted are valid for the 2021~~0~~ 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 D – Sample Explanation of Benefits (EOB)

In the snapshot below, a sample EOB outlines 4 examples (1 correct and 3 incorrect) of Medicare Part B claims submissions for the purposes of reporting Quality data.

Sample EOB for Medicare Part B Claims Quality Data Reporting

Billing Provider	123456			Invoice Number							
Service Provider	123456			Check Number	56789						
Tax ID	999999			Payment Date	10/10/2021						
Correct	**Complete with CPT II Code and Correct POS, QDC, & DX Code**										
PERF											
Recipients	**SERV DATE**	**POS**	**NOS**	**PROC**	**MODS**	**BILLED**	**ALLOWED**	**DEDUCT**	**COINS**	**GRP/RC-AMT**	**PROV PD**
Name **A**	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005							
	123-567-9876	11	1	99213		100	75.95	0			
REM	N620		1	G9974		0.01	0	0			
PT RESP											
CLAIM INFO											
The Next Three Examples will not meet the Requirements for Claims-Based Measures for the MIPS Program											
	Complete without CPT II code										
Name **B**	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005							
	123-567-9876	11		99213		100	75.95	0			
PT RESP	15.19										
CLAIM INFO											
	Complete CPT II Code split off from Service										
Name **C**	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005							
REM	N620		1	G9974		0.01	0	0			
	Incorrect POS										
Name **D**	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005							
	123-567-9876	10	1	99213		100	75.95	0			
REM	N620		1	2027F		0.01	0	0			
PT RESP	15.19										
CLAIM INFO											

Valid, but unsuccessful 2021 MIPS QDC Submission

Example A: This claim was correct because the appropriate QDC (G-code) and place of service (POS) code were included; the line item charge is correct; and the procedure/service (CPT) code is present with the QDC. The N620 confirms that the QDC submitted is valid for the 2021 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 2021, 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 2021, but this claim was not a successful quality data submission for the patient encounter billed.