Quality Payment
PROGRAM

# MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

## 2020 Reporting MIPS Quality Measures through Part B Claims Quick Start Guide

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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*Already know what MIPS is?*
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***Purpose:*** *This resource is for small practices. A small practice is defined as a group that has 15 or fewer clinicians (NPIs) billing under the groups Taxpayer Identification Number (TIN). To see if you have the small practice designation, visit the QPP 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 QPP Website to learn more.*

# How to Use This Guide

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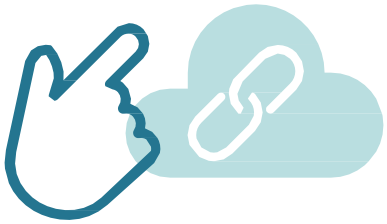


Please Note: This guide was prepared for informational purposes only and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of the written law, including the regulations. We encourage readers to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

## Table of Contents

The table of contents is interactive. Click on a chapter in the table of contents to read that section.

You can also click on the icon on the bottom left to go back to the table of contents.

## Hyperlinks

Hyperlinks to the QPP website are included throughout the guide to direct the reader to more information and resources.

# Overview

# Overview

## What is the Merit-based Incentive Payment System?

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

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

If you're eligible for MIPS in 2020:

- You generally have to submit data for the Quality, Improvement Activities, and Promoting Interoperability performance categories. (We collect and calculate data for the Cost performance category for you.)
- 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 off your performance during the 2020 performance period and applied to payments for covered professional services beginning on January 1, 2022.

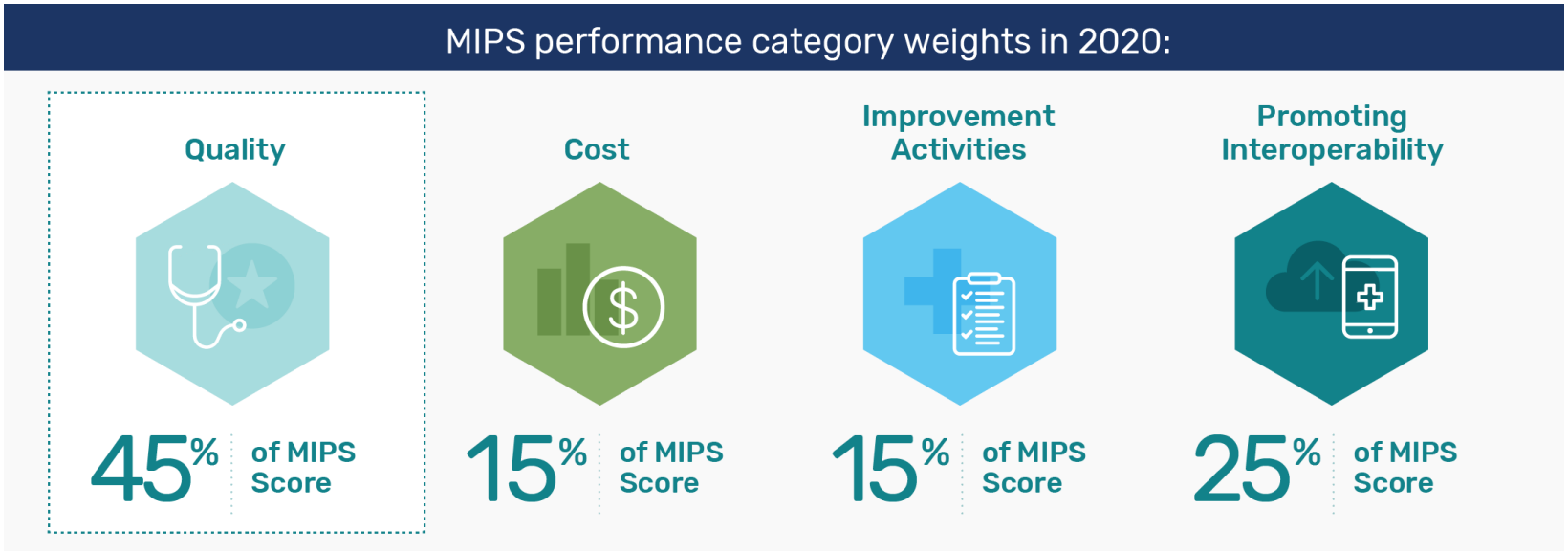
***To learn more about how to participate in MIPS:***

- *Visit the How MIPS Eligibility is Determined and Individual or Group Participation web pages on the Quality Payment Program website.*
- *View the 2020 MIPS Eligibility and Participation Quick Start Guide.*
- *Check your current participation status using the QPP Participation Status Tool.*

# Overview

## Reporting Quality Measures through Part B Claims

Part B claims are one way that clinicians in small practices can report their quality measures. Please refer to the 2020 Quality Quick Start Guide for more information on the Quality performance category and other options for reporting quality measures.




**What's New with Part B Claims Reporting in 2020?**

The data completeness threshold increased to 70% for the 2020 performance period, from 60% in 2019. For Medicare Part B claims measures, this means that **you must report performance data for at least 70% of your Medicare Part B claims patients that qualify for the measure**. If quality data is submitted selectively such that the data are unrepresentative of your performance, we may initiate an audit and, if appropriate, revise the payment adjustment.

Small practices will continue to get 3 points for quality measures that don't meet the data completeness requirement.

# Get Started in Five Steps

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## Step 1. Check Your Current Eligibility

Enter your NPI in the 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. Learn more.

✓ **What if I'm Eligible?**

If you (or any of the clinicians in your practice) are eligible to participate in MIPS, you can choose to report as an individual or group. Review Steps 2-5 below to get started.

✗ **What if I'm Not Eligible?**

If you are not eligible to participate in MIPS, you are not required to report but may be eligible to opt-in.

If the clinicians in your practice are not eligible to participate in MIPS as individuals, your practice may be eligible to report as a group. Practices can choose whether or not to participate as a group. There is no requirement that an eligible group has to participate.

**Did you know?**

If your practice has 15 or fewer clinicians billing between October 1, 2019, and September 30, 2020, you should continue to report through claims even if you don't see the small practice status.

- **We'll update eligibility, including small practice status, in December 2020.** If you are 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, **start reporting your quality measures through claims now.** You cannot report quality measures on previously submitted claims.

## Step 2. Understand the Available Resources

The 2020 Medicare Part B Claims Measure Specifications and Supporting Documents zip file on the QPP Resource Library (and Explore Measures & Activities tool) includes three supporting documents to help you understand how to report quality measures through claims.

1. **2020 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 2020 performance period.
3. **2020 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 2020 MIPS Quality Measures List is available on the QPP Resource Library. This spreadsheet is a tool that eligible clinicians can use to search for current 2020 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 in Five Steps

## Step 3. Choose Your Measures

Whether you're reporting as a group or individual, you must select 6 measures to report. You must report either:

6 measures for the group as a whole

OR

6 measures for each MIPS eligible clinician

Of these 6 measures, 1 must be an outcome measure OR a high-priority measure (if an outcome measure is not available). High-priority measures fall within the following categories: Outcome, Patient Experience, Patient Safety, Efficiency, Appropriate Use, Care Coordination, and Opioid-related. Note that bonus points are available for reporting additional outcome or high-priority measures beyond the one that is required.

You may also select a specialty-specific set of measures, if applicable to you or your group.

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

If your practice is reporting as individuals, all of the 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 **2020 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 QPP website, **search for key terms** that are applicable to the care that you provide or patient population you serve or **filter by specialty set**. (*Helpful Hint: Make sure to select the **2020 Performance Year**.*)

## 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 your supporting staff (including billing services):

- Understand the measures you've selected for submission.
- Can identify all denominator-eligible claims for the measure(s) you've selected
  - Review the measure specifications to identify your denominator eligible case(s).
- Understand how often the measures you've selected have to be submitted.

**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 Claims

To add your quality measure performance data to your claims, you will code your claims as usual and add quality data codes (QDCs) and Current Procedural Terminology (CPT) codes as appropriate to the measure.

1. **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, 2020 through December 31, 2020. You cannot go back and add QDCs to a previously submitted claim. QDCs must be included on the originally submitted claim.
2. **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.
3. **Check for Accuracy:** We encourage you to review the claims for accuracy prior to submission for reimbursement and reporting purposes. It's important to confirm that you are using the 2020 measure specifications to appropriately code your claims.
4. **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.
5. **Don't wait!** For patient encounters that occur towards the end of the performance year (December 31, 2020), 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 2020 quality reporting.

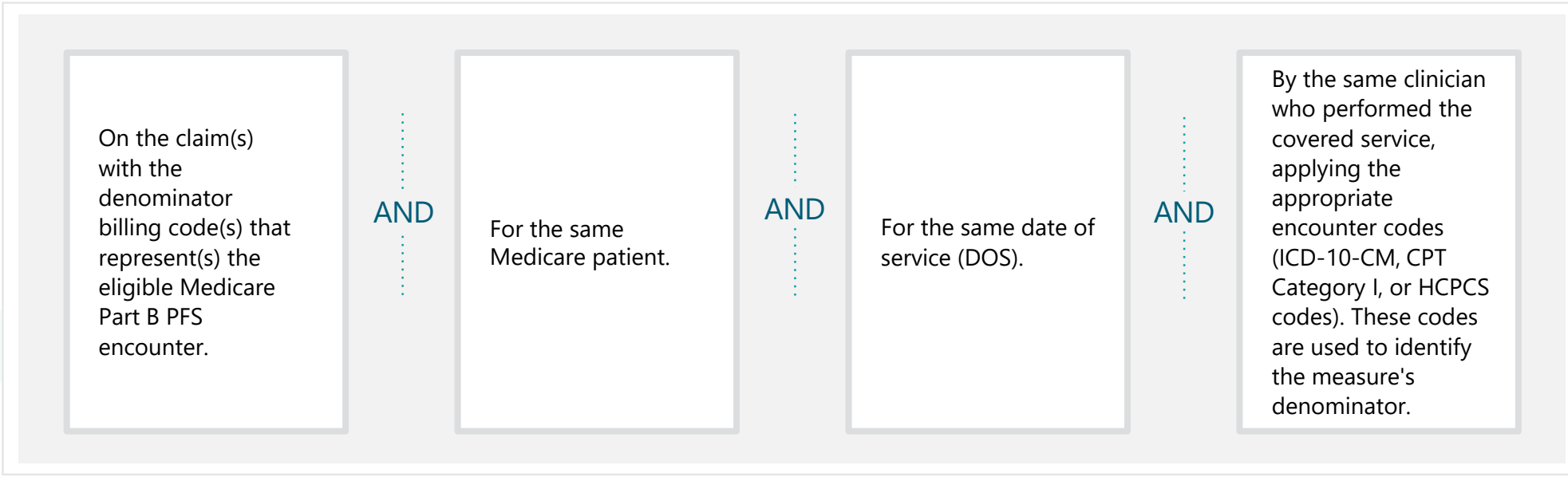
**Looking for an example?** Visit Appendix C to view a sample CMS-1500 claim form that is coded for a quality data submission.

## Step 5. Add Your Quality Measure Performance Data to Your Claims *(continued)*

**Did you know?**

To meet the 70% data completeness requirement, **you should start appending QDCs as soon as possible after January 1, 2020**. Some measures have a shortened measurement period, so be sure to review measure specifications carefully.

QDCs must be reported:




Quality measure denominator criteria and numerator codes are subject to change from one performance year to the next. **Make sure you are reviewing the 2020 Claims Measure Specifications** to ensure you are using the appropriate criteria and codes for the 2020 performance period.

**Make sure you are billing services under the clinician's individual (Type 1) NPI**, and not the organization (Type 2) NPI. If you are reporting as a group or virtual group, we will aggregate the individual reporting into a group or virtual group quality score.

# Frequently Asked Questions

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# Frequently Asked Questions

## How Do I Know if the QDCs I Submitted are Valid for MIPS in 2020?

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 2020 MIPS performance period.

Important

- The N620 denial code tells you that the QDC(s) are valid for the 2020 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):

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.

# 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 are valid for the 2020 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 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 2020 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 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 (i.e. $0.00 or $0.01) associated with that QDC.

## Can I Use Claims to Report for Other Categories?

No, but you can sign in and attest to your Promoting Interoperability measures (collected in 2015 Edition CEHRT) and Improvement Activities. We'll use claims to evaluate you on cost, however, no action is needed from you or your practice. If you want to participate as a group, 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 or Virtual Group Reporting Work for Part B Claims Measures?

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

Important

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

# Frequently Asked Questions

## When Will I See Feedback on My Claims Reporting?

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 in January 2021.


## What about ICD-10 Changes?

A few 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 QPP Resource Library by October 2020.

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.
- Do not need to report on any encounters that use new codes (those not included in the current measure specifications).
- Will continue to report on any encounters that use existing codes (those included in the current measure specifications).

**ICD-10 Changes Timeline**

| Sept. 30, 2020 | Oct. 1, 2020 | October 2020 |
|---|---|---|
| End of performance period for Medicare Part B claims measures affected by ICD-10 changes. | ICD-10 changes take affect. | ICD-10 changes identified in fact sheet posted to the QPP Resource Library. |

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

For the 2020 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.

# Help, Resources, and Version History

# Help, Resources, and Version History

## Where Can You Go for Help?

- Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 AM-8:00 PM ET 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 QPP Resource Library.

# Help, Resources, and Version History

## Additional Resources

The QPP 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 |
|---|---|
| 2020 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 2020 performance period. |
| 2020 MIPS Eligibility and Participation Quick Start Guide | A high-level overview and actionable steps to understand your 2020 MIPS eligibility and participation requirements. |
| 2020 Quality Performance Category Quick Start Guide | A high-level overview and practical information about quality measure selection, data collection and submission for the 2020 MIPS Quality performance category. |
| 2020 Medicare Part B Claims Measures Specifications and Supporting Documents | This set of resources provides comprehensive descriptions of the 2020 claims measures for the MIPS Quality performance category, including tools to search for applicable claims measures, a measure specification and measure flow guide, and detailed specifications for each 2020 claims measure. |

# Help, Resources, and Version History

## Version History

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

| Date | Change Description |
|---|---|
| 1/2/20 | Original posting |

# Appendix

# Appendix

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

**Quality ID #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)**

**– National Quality Strategy Domain: Effective Clinical Care**
**– Meaningful Measure Area: Management of Chronic Conditions**

**2020 COLLECTION TYPE:**
**MEDICARE PART B CLAIMS**

**MEASURE TYPE:**
Intermediate Outcome – High Priority

Measure Description Location

Patient Characteristics

Reporting Frequency

**DESCRIPTION:**
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.

**INSTRUCTIONS:**
This measure is to be submitted a minimum of **once per performance period** for patients with diabetes seen during the performance period. The most recent quality-data code submitted will be used for performance calculation. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

**Measure Submission Type:**
Measure data may be submitted by individual MIPS eligible clinicians using Medicare Part B claims. The listed denominator criteria are used to identify the intended patient population. The numerator quality-data codes included in this specification are used to submit the quality actions allowed by the measure on the claim form(s). All measure-specific coding should be submitted on the claim(s) representing the denominator eligible encounter and selected numerator option.

**DENOMINATOR:**
Patients 18 - 75 years of age with diabetes with a visit during the measurement period.

# Appendix

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

**Denominator Criteria (Eligible Cases):**

Patients 18 through 75 years of age on date of encounter

**AND**

**Diagnosis for diabetes (ICD-10-CM):** E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3219, E10.3291, E10.3292, E10.3293, E10.3299, E10.3311, E10.3312, E10.3313, E10.3319, E10.3391, E10.3392, E10.3393, E10.3399, E10.3411, E10.3412, E10.3413, E10.3419, E10.3491, E10.3492, E10.3493, E10.3499, E10.3511, E10.3512, E10.3513, E10.3519, E10.3521, E10.3522, E10.3523, E10.3529, E10.3531, E10.3532, E10.3533, E10.3539, E10.3541, E10.3542, E10.3543, E10.3549, E10.3551, E10.3552, E10.3553, E10.3559, E10.3591, E10.3592, E10.3593, E10.3599, E10.36, E10.37X1, E10.37X2, E10.37X3, E10.37X9, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3219, E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, E11.3312, E11.3313, E11.3319, E11.3391, E11.3392, E11.3393, E11.3399, E11.3411, E11.3412, E11.3413, E11.3419, E11.3491, E11.3492, E11.3493, E11.3499, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533, E11.3539, E11.3541, E11.3542, E11.3543, E11.3549, E11.3551, E11.3552, E11.3553, E11.3559, E11.3591, E11.3592, E11.3593, E11.3599, E11.36, E11.37X1, E11.37X2, E11.37X3, E11.37X9, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65,

E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3219, E13.3291, E13.3292, E13.3293, E13.3299, E13.3311, E13.3312, E13.3313, E13.3319, E13.3391, E13.3392, E13.3393, E13.3399, E13.3411, E13.3412, E13.3413, E13.3419, E13.3491, E13.3492, E13.3493, E13.3499, E13.3511, E13.3512, E13.3513, E13.3519, E13.3521, E13.3522, E13.3523, E13.3529, E13.3531, E13.3532, E13.3533, E13.3539, E13.3541, E13.3542, E13.3543, E13.3549, E13.3551, E13.3552, E13.3553, E13.3559, E13.3591, E13.3592, E13.3593, E13.3599, E13.36, E13.37X1, E13.37X2, E13.37X3, E13.37X9, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13, O24.311, O24.312, O24.313, O24.319, O24.32, O24.33, O24.811, O24.812, O24.813, O24.819, O24.82, O24.83

**AND**

**Patient encounter during performance period (CPT or HCPCS):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245*, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, G0438, G0439

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

# Appendix

## 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 #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**

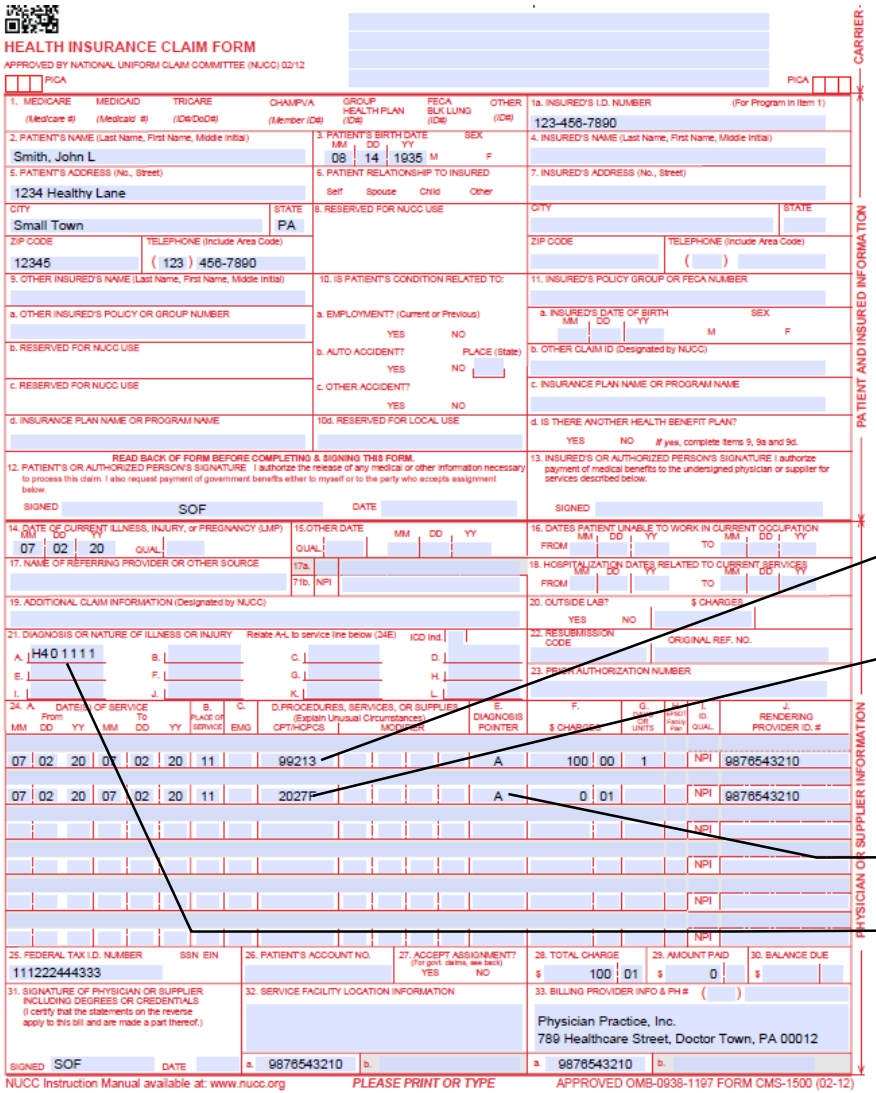
**Screening for Depression not Documented, Reason not Given**
***Performance Not Met:* G8432:** Depression screening not documented, reason not given

**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

# Appendix

## 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 (Medicare #) MEDICAID (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 MM DD YY: 08 14 1935 SEX M 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

ZIP CODE: 12345 TELEPHONE (Include Area Code): ( 123 ) 456-7890

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 NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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 20 QUAL

15. OTHER DATE MM DD YY QUAL

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.

A. H40 1111 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 20 | 07 02 20 | 11 | | 99213 | | A | 100 00 | 1 | | NPI | 9876543210 |
| 07 02 20 | 07 02 20 | 11 | | 2027F | | A | 0 01 | | | NPI | 9876543210 |
| | | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN: 111222444333

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE: $ 100 01

29. AMOUNT PAID: $ 0

30. BALANCE DUE: $

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.)

SIGNED SOF DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. 9876543210 b.

33. BILLING PROVIDER INFO & PH # ( )

Physician Practice, Inc.
789 Healthcare Street, Doctor Town, PA 00012

a. 9876543210 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-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 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 eligible clinician is reporting a quality measure (Quality ID# 012) related to Primary Open-Angle Glaucoma (POAG):

Measure Quality ID #012 is reported with quality data code (QDC) 2027F + the POAG diagnosis (Item 24e points to the diagnosis code in item 21, line a, H40.1111

## 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, 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 2020 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 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 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

## Appendix D – Sample Explanation of Benefits (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

**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, | | | | | | |
| 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 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; the procedure/service (CPT) code is present with the QDC. The N620 confirms that the QDC submitted is valid for the 2020 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 2020, 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 2020, but this claim was not a successful quality data submission for the patient encounter billed.