Q&A: Claims Submission for MIPS Quality Category

The Merit-based Incentive Payment System (MIPS) offers flexibility in providing multiple ways to report data. One approved method of reporting data for the Quality category of MIPS is to enter Quality codes on your submission of Medicare claims. If you choose this method of submission, it is crucial to be certain that these codes are added to all Medicare claims.

Question: How many points are possible for the Quality category in 2018?

Answer: The 2018 performance year includes reporting in all four categories of MIPS: Quality, Cost, Promoting Interoperability (formerly Advancing Care Information) and Improvement Activities (IA). Quality is worth 50 percent of the score, or 50 points. Should a clinician be excluded from reporting for Promoting Interoperability (PI) (for reasons of clinician type or hardship) then those 25 points are added to Quality and the Quality score will be 75 percent. In addition, if there is not sufficient data to calculate a Cost score, the 10 points for that category may also be moved to Quality. Therefore, in some circumstances, the Quality category may be 85 percent of the total MIPS score.

Q: How many measures do I need to submit?

A: A total of six measures (or a complete specialty measure set) must be submitted, with one measure to be an outcome measure (or high-priority measure if an outcome measure is not available). Additional outcome and high-priority measures may be submitted for bonus points.

Q: How many claims must be submitted for each measure?

A: In 2018 a full year of data must be submitted. Data completeness is important as well. This means that 60 percent of a MIPS-eligible clinician's patients who meet the denominator criteria for the measure must be included. To receive a score of up to 10 points for each measure, the reported measure must meet this criterion.

Q: What if we are just starting to code our claims for the measures? Is it too late to use this method?

A: Remember that to reach the maximum score for a measure, you must have 60 percent completeness. Beginning to code your claims for Quality now may meet that criterion, depending on when patients that are in the denominator are seen in your office. If you do not succeed in obtaining 60 percent completeness, the measure will still be scored, but will receive only one point (or three points if your practice falls under the Small, Underserved and Rural Support definition of 15 or fewer clinicians, Health Professional Shortage Area [HPSA] or rural.)

Q: Can we go back and add Quality codes to claims that have already been submitted for payment?

A: No, you may not resubmit claims for the purposes of updating your Quality coding.

Q: How do we know which Quality measures we can report using claims coding?

A: Go to the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP) website at https://qpp.cms.gov/measures/quality. Sort by "Data Submission Method" and select "Claims."

Q: How do we select the best measures for our practice?

A: You can filter by "Specialty Measure Set" to narrow down measures that apply to your practice after you filter by "Data Submission Method" for "Claims."

Q: Where can we find specific information on each of the Quality measures we plan to report?

A: Once you select your measures on the CMS QPP site, click the name of the measure to open additional information and locate the Quality ID. You can then reference the 2018 Measure Specification Sheet in the 2018 Resources on the CMS QPP site. Be certain you are using the 2018 specifications as they may be different from the specifications published for 2017.

Q: What parts of this description are important for me to note?

A: Verify the measure specifications are for "CLAIMS ONLY." Read through the description and instructions to see who is included in the measure and how often this measure must be reported. Then identify the coding needed for this measure (denominator, numerator and quality code).

Q: Is there any way to know if a claim has been submitted successfully for Quality reporting purposes?

A: You will not receive confirmation that the code was accepted, but the Remittance Advice (RA)/Explanation of Benefits (EOB) denial code N620 indicates Medicare has received your code.

Q: Do I have to enter anything into the QPP Portal to report Quality during the submission period (Jan. 1 – March 31, 2019)?

A: If you chose claims coding to report for the Quality category, you do not need to enter anything into the QPP Portal for Quality because you will be scored by CMS using your Medicare claims data. The QPP Portal now shows your Quality score if claims submission was your method of reporting.

For more details or to access free assistance with MIPS, contact a TMF consultant at QualityReporting@tmf.org or 1-844-317-7609. You can also visit https://tmf.org/qpp for more information.

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