

Using Claims to Report Quality Measures

MIPS in 2017

You can use claims to report quality measures for the MIPS program in 2017. To report on quality measures via claims, you will need to include additional ICD-10, CPT, HCPCS and G-codes within claims submitted by an individual clinician for covered services under the Medicare Part B Physician Fee Schedule—these codes identify which patients should be added toward the denominator/numerator of the quality measure.

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Find the Quality Measures You Want to Report On

- At [qpp.cms.gov/](https://qpp.cms.gov/measures/quality), you can search for quality measures that can be reported on in claims.

The screenshot shows the 'Select Measures' page. At the top, there's a search bar with 'Filtered' and 'Search for...' fields, and a green 'SEARCH' button. Below the search bar is a 'Filter by:' section with three dropdown menus: 'High Priority Measure', 'Data Submission Method', and 'Specialty Measure Set'. The 'Data Submission Method' dropdown is open, showing options like 'Administrative Claims', 'Claims' (which is checked), 'CSV', 'CMS Web Interface', 'EHR', and 'Registry'. A red arrow points from the 'Claims' button in the dropdown to the 'Claims' option itself. To the left, it says 'Showing 74 Measures'.

- Take note of the measure's Quality ID.

This screenshot shows a detailed view of a quality measure. At the top, it lists the measure as 'Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)' with an 'ADD' button. Below that, a description states: 'Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period'. The main information is presented in a grid:

Measure Number <ul style="list-style-type: none">eMeasure ID: CMS122v5eMeasure NQF: N/ANQF: 0059Quality ID: 001	NQS Domain Effective Clinical Care	Measure Type Intermediate Outcome
High Priority Measure Yes	Data Submission Method <ul style="list-style-type: none">ClaimsCMS Web Interface	Specialty Measure Set <ul style="list-style-type: none">Internal MedicinePreventive Medicine

Adding Codes to your Medicare Part B Claims

1. Go to the <https://qpp.cms.gov/resources/education> page.
2. Scroll down to the **For Registries, Qualified Clinical Data Registries (QCDRs) & EHR Vendors** section and download the **Quality Measures Specifications** zip file.

APMs: Medicaid Models and All-Payer Models (388KB) **PDF** December 29th, 2016

FOR REGISTRIES, QUALIFIED CLINICAL DATA REGISTRIES (QCDRS) & EHR VENDORS

[Quality Measure Specifications \(249.3MB\)](#) **ZIP** December 29th, 2016

3. Unzip the Claims-Registry-Measures folder, then find the claims-related file for the Quality ID.

Claims-Registry-Measures > Claims-Registry-Measures

Name	Type	Compress
2017_Measure_001_Claims	Microsoft Word Document	
2017_Measure_001_Registry	Adobe Acrobat Document	
2017_Measure_005_Registry	Adobe Acrobat Document	
2017_Measure_006_Registry	Adobe Acrobat Document	
2017_Measure_007_Registry	Adobe Acrobat Document	

4. This document tells you all you need to know about how to make a patient count toward the measures denominator and numerator.

Denominator: Under the denominator section, two things are listed:

- the attributes of a patient that make the patient part of the denominator (like age and/or sex)
- the codes that make a patient a part of the denominator (like denominator and/or procedure code)

DENOMINATOR:

Patients 18 - 75 years of age with diabetes with a visit during the measurement period

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, E10.3414, E10.3401, E10.3402, E10.3403, E10.3409, E10.3511, E10.3512, E10.3513, U24.319, U24.32, U24.53, U24.611, U24.612, U24.613, U24.619, U24.62, U24.63

AND

→ Patient encounter during performance period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0402, G0438, G0439

Numerator: Under the numerator section, you'll see the same kind of list. These codes are generally CPTII codes and modifier codes. CPTII codes are tracking codes that can be paired with a "cost" of \$0.00 or \$0.01 on the claim. (Note that the measure in this example is an inverse measure, so the lower the numerator (aka the fewer people with poor control), the better you've done.

- **Denominator Exclusion:** Notice in the screenshot below, there is a way to eliminate the patient from the denominator (even if the denominator codes have been added to the claim). In the case below, adding the G-code, G9687, to a claim will remove the patient from the denominator. You'll notice for this measure that only patients receiving hospice services during the measurement period can be excluded.
- **Add to the Numerator (or Performance Met):** Adding the CPT II code 3046F or the CPTII code 3046F with an 8P modifier will count the patient toward the numerator.
- **Doesn't add to the Numerator (or Performance Not Met):** Adding the CPT II code 3044F or 3045F will not count the patient toward the numerator (but will keep them in the denominator)

Numerator Quality-Data Coding Options:

Patient receiving Hospice Services, Patient Not Eligible:

Denominator Exclusion: G9687:

Hospice services provided to patient any time during the measurement period

OR

Most Recent Hemoglobin A1c Level > 9.0%

Performance Met: CPT II 3046F:

Most recent hemoglobin A1c level > 9.0%

OR

Hemoglobin A1c not Performed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 3046F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

Performance Met: 3046F *with* 8P:

Hemoglobin A1c level was not performed during the measurement period (12 months)

OR

Most Recent Hemoglobin A1c Level ≤ 9.0%

Performance Not Met: CPT II 3044F:

Most recent hemoglobin A1c (HbA1c) level < 7.0%

OR

Performance Not Met: CPT II 3045F:

Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0%

5. These documents also explain how often the denominator/numerator codes have to be included in a claim for the patient. The section describing this is called "Instructions." The "measure type" will determine how often the codes have to be included in claims.

INSTRUCTIONS:

This measure is to be reported 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 reported by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Claims Submission using the Test/Partial/Full Path

Test

For the Test path, you need one patient – so one Medicare Part B claim—to meet both the denominator and numerator, for one measure. Doing this will allow you to avoid a 2019 payment adjustment. You may want to submit more than one claim with the correct codes, just to ensure success.

Partial/Full

To earn more points in the quality category, you can follow the Partial or Full path. Partial and Full lie on a continuum – the difference between them is the effort you put in. Basically, the more measures you report on and the better you do on them, the more points you get. Your reporting period must be at least 90 days, though you can report on any continuous timeframe up to a full year. You can report two to six measures, or a measure set.

For every measure you report on for more than 90 days, you get 3 points right off the bat.

You can earn up to 10 points per quality measure reported, though. Earning those additional 7 points depends on the following three things:

- **The percentage of Medicare Part B patient you report on:** You must report on at least 50% of all the Medicare Part B patient you see for a date of service during the reporting period. (This is the **Data Completeness** Requirement)
- **The number of patients you report on:** At least 20 patients must count in the denominator. (This is the **Case Minimum** Requirement)
- **The percentage you get on the measure:** The better you do on a measure—called your performance rate—the more points earn

The percentage of Medicare Part B patients you report on: Data Completeness

The following equation has to be more than 50% for any measure you report on that you want more than 3 points for:

$$\frac{\text{Denominator Exclusion} + \text{Performance Met} + \text{Denominator Exceptions} + \text{Performance Not Met}}{\text{Denominator}}$$

The number of patients you report on: Case Minimums

The Denominator has to be at least 20.

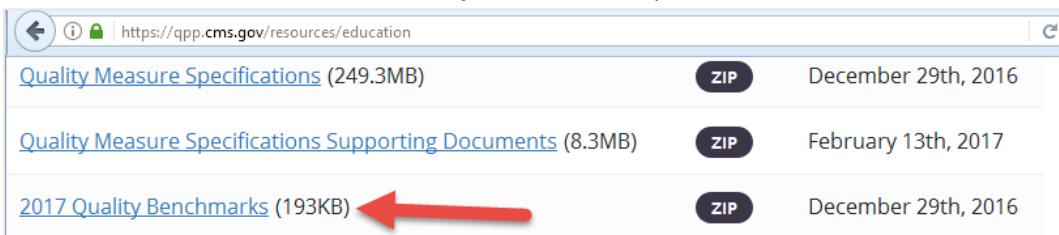
Your Performance Rate and the points you earn: Benchmarks

The percentage you get on a measure is calculated using the following equation:

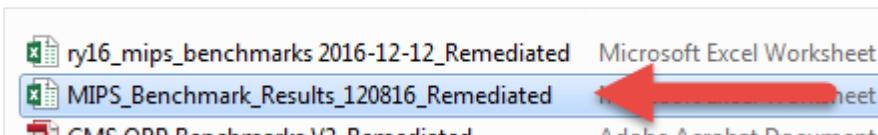
$$\frac{\text{Performance Met}}{\text{Data Completeness Numerator-Denominator} \times \text{Exclusion-Denominator} \times \text{Exception}}$$

Once you know your Performance Rate, you can see how many points you'll receive for that in the benchmark data.

1. Go to the <https://qpp.cms.gov/resources/education> page.
2. Scroll down to the **For Registries, Qualified Clinical Data Registries (QCDRs) & EHR Vendors** section and download the **2017 Quality Benchmarks** zip file.



3. Open the MIPS_Benchmark_Results file.



4. Find the measure in the spreadsheet and identify the row with the Submission_Method of Claims. Compare your performance rate to the ranges within the Decile columns.
 - If in Decile 3 range: you earn a total of 3-3.9 points per measure.
 - If in Decile 4 range: you earn a total of 4-4.9 points per measure.
 - If in Decile 5 range: you earn a total of 5-5.9 points per measure.
 - If in Decile 6 range: you earn a total of 6-6.9 points per measure.
 - If in Decile 7 range: you earn a total of 7-7.9 points per measure.
 - If in Decile 8 range: you earn a total of 8-8.9 points per measure.
 - If in Decile 9 range: you earn a total of 9-9.9 points per measure.
 - If in Decile 10 range: you earn a total of 10 points per measure.

Measure_Name	Measure_ID	Submission_Method	N
Diabetes: Hemoglobin A1c Poor Control	1	Claims	
Diabetes: Hemoglobin A1c Poor Control	1	EHR	
Diabetes: Hemoglobin A1c Poor Control	1	Registry/QCDR	

Decile 3	Decile 4	Decile 5	Decile 6	Decile 7
35.00 - 25.72	25.71 - 20.32	20.31 - 16.23	16.22 - 13.05	13.04 -
54.67 - 35.91	35.90 - 25.63	25.62 - 19.34	19.33 - 14.15	14.14 -
83.10 - 68.19	68.18 - 53.14	53.13 - 40.66	40.65 - 30.20	30.19 - 2