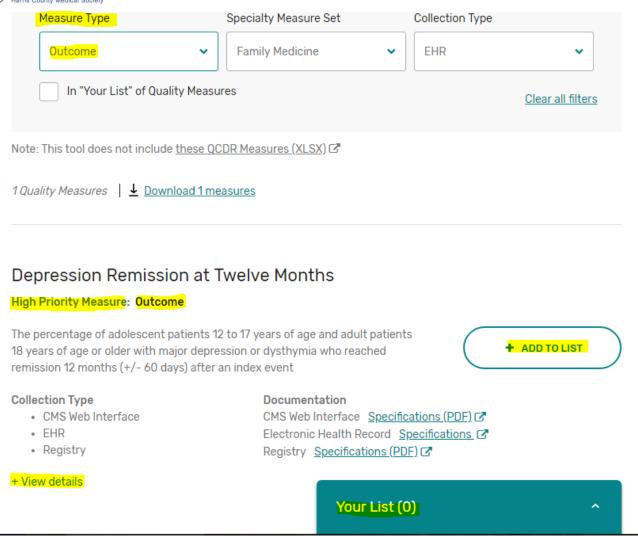# 2019 MIPS Step-by-Step Guide

Quality Category

Step 1: Review the MIPS quality measures here. Scroll down to the filter options and filter measures by "Collection Type". Select the method you will use to report your quality measures in the drop-down menu (for more information on submission methods click here). Now only the measures reportable by your selected method will be shown. Physicians are also able to filter measures related to their specialty under the "Specialty Measure Set" drop-down menu to help narrow down the list of measures.

Step 2: Review measures and choose **six quality measures** that suit the physician's practice/specialty. Review each measure details by clicking "View details" to expand. One of the six measures selected must be an "Outcome Measure". Outcome measure is a "Measure Type" which can be found underneath the title of each measure in smaller print or can be searched for by using the "Measure Type" filter. If an outcome measure is not available for your specialty, you may choose another high priority measure (cannot be filtered for under "Measure Type", but will be indicated under the title, see examples below).

*You can add your chosen measures to a list by click "Add to List" next to each measure which you can view at the bottom of your screen by clicking on "Your List", a CSV Excel File can be downloaded for personal record. Doing this is NOT a submission of measures or an attestation but is for organizational and personal use only.

Measure Type

Outcome ▼

Specialty Measure Set

Family Medicine ▼

Collection Type

EHR ▼

☐ In "Your List" of Quality Measures

Clear all filters

Note: This tool does not include these QCDR Measures (XLSX) ☑

1 Quality Measures | ↓ Download 1 measures

Depression Remission at Twelve Months

High Priority Measure: Outcome

The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event

+ ADD TO LIST

Collection Type
- CMS Web Interface
- EHR
- Registry

Documentation
CMS Web Interface Specifications (PDF) ☑
Electronic Health Record Specifications ☑
Registry Specifications (PDF) ☑

+ View details

Your List (0) ⌃

Step 3: For each of the six measures you have selected you will need to download its specifications. Measure specifications can be downloaded directly from the measure details found under "Documentation". Be sure to select and download the appropriate specifications document based on how you plan on reporting the measure (i.e. download the "Electronic Health Record Specifications" for measures you will report directly through your EHR).

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+ View details

Step 4: Once the PDF is open review the measures specifications. Within this document you will find information on patient requirements and case eligibility information (i.e. gender, age, diagnosis codes, encounter codes). This information can be found under "DENOMINATOR". Only if a patient/encounter meets this "Denominator Criteria" will it be eligible to count towards your quality measure reporting numbers. If you do not see any diagnosis requirements under "DENOMINATOR" then that measure does not have any. Not all measures will include a requirement for diagnosis but will include CPT/HCPCS requirements.

DENOMINATOR:

All visits for patients aged 18 years and older

> **DENOMINATOR NOTE:** *Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 90839, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96150, 96151, 96152, 97127*, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99236, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, 99281, 99282, 99283, 99284, 99285, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, G0101, G0108, G0270, G0402, G0438, G0439, G0515

Please note that EHR measure specification sheets are structured differently but contain the same information.

Step 5: Review the numerator requirements (found after the Denominator criteria) with the measure specification document. If reporting through claims, the numerator codes found in this section are what will be added to the CMS 1500 claim form with the corresponding denominator criteria found in Step 4. On claims, these numerator codes will be added in after the CPT/HCPCS codes under "Procedures, Services or Supplies" on the CMS 1500 form (each will have their own line). A 0.01 charge amount under "$ Charges" on the CMS 1500 form for each numerator code must be entered for proper submission. The rest of the CMS 1500 form will be entered in as usual and billed normally.

For an example of a completed CMS 1500 form please view the [CMS-1500 Claim MIPS Quality Example](#).

Please note that when reporting measures through claims you will only report on Medicare Part B (traditional Medicare) patients, but for all other methods you will be required to report on patients from all payers. Additionally, claims data submission is only available to physicians practicing in small groups (15 or fewer clinicians).

NUMERATOR:

MIPS eligible professional or MIPS eligible clinician attests to documenting, updating or reviewing a patient's current medications using all immediate resources available on the date of encounter. This list _**must**_ include ALL known prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND _**must**_ contain the medications' name, dosages, frequency and route of administration

Definitions:

Current Medications – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.

Route – Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical).

Not Eligible (Denominator Exception) – A patient is not eligible if the following reason is documented:
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status on the date of the encounter.

NUMERATOR NOTE: _The MIPS eligible clinician must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. MIPS eligible clinicians submitting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. By submitting the action described in this measure, the provider attests to having documented a list of current medications utilizing all immediate resources available at the time of the encounter._ **G8427** _should be submitted if the MIPS eligible clinician documented that the patient is not currently taking any medications._

Numerator Options:

Performance Met:	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications **(G8427)**
OR	
Denominator Exception:	Eligible clinician attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible clinician **(G8430)**
OR	
Performance Not Met:	Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given **(G8428)**

AUDIT CRITERIA: It is important to understand and report measures based upon their measure specifications incase CMS chooses to audit your practice after you have reported. CMS may request any records or data retained for the purposes of MIPS for up to 6 years, so it is recommended that documentation is kept for that length of time.

Step 6: **(QCDR Reporting Only)** If you are planning on reporting your quality measures through a Qualified Clinical Data Registry (QCDR), steps 1-5 do not include QCDR measures. Download the "2019 QCDR Measure Specifications" here. Click on the "Instructions" tab at the bottom of the downloaded Excel file to learn more or click on the "QCDR Specifications" tab and scroll to your specialty's available QCDR and associated measures. These measures are separate from those identified in the steps 1-5 because QCDRs can develop up to 30 special QCDR measures in addition to the MIPS measure set (i.e. the measures identified in steps 1-5).

Your QCDR will usually provide you with tailored instructions about your MIPS data submission. It is important to select your registry and contact them to see what format they will need your quality data in and if these codes will need to be noted (some registries will identify these codes for you based on your selected quality measures and type of encounter).

Step 7: **(DATA COMPLETENESS)** Each quality measure requires physicians to report at least 60% of applicable patients/encounters per measure within the performance year (ex. if there are 10 applicable encounters in 2019 for a measure, the physician/practice must report on at least 6 of them). Measures that do not meet the data completeness criteria will only earn 1 point, except for small practices (15 or fewer clinicians) who will earn 3 points.

Step 8: Submit your measures:

- Claims: Submit the CMS 1500 claim form with both the denominator and numerator codes and criteria. Please view this example. You should receive one of the following codes on your remittance advice/EOB to confirm receipt of your QDC codes – CARC 144 or 237, RARC N807, CO. **Claims submission will occur during the performance year from Jan. 1 through Dec. 31, 2019 along with a 60-day claims run out period after the performance period (Jan.1 – Mar. 1, 2019). All claims must be for dates of service within 2019.** This submission method is only available to small groups (15 or fewer clinicians).

- EHR – Speak with your EHR vendor regarding Quality submission capabilities for 2019. **Deadline to submit is March 31, 2020.**

- QPP Portal – CMS has created a QPP submission platform that can be used to submit your quality measures. The QPP portal will be open for 2019 data reporting **starting January 2, 2020. Deadline to submit is March 31, 2020.** To submit quality data through the portal physicians/groups will need to generate a report in either the new QPP file format or QRDA III file format and manually upload the file into the submission system (contact your EHR to generate this report). As data is entered into the system, eligible clinicians will see real-time initial scoring based on their submissions.

- Qualified Registry – By clicking this link an excel file titled "2019 Qualified Registry Posting" will open or download. This document has a full list of Qualified Registry vendors for 2019. Review which vendors can submit Quality under the "Performance Categories Supported" section. Also ensure your selected measures are reportable under the "Quality Measures Supported" section. **Submission through registries will begin January 1, 2020. The deadline to complete submission is March 31, 2020, although it is important to be aware of your registries individual submission/signup deadlines which typically precede CMS's set deadline of March 31.**
  * Excel file is split up into sheets in alphabetical order. Please review all sheets to see all vendors.
  * Not free, use of these vendors will most likely require payment to use their services.

- Qualified Clinical Data Registry (QCDR) – By clicking this link an excel file titled "2019 QCDR Qualified Posting" will open or download. This document has a full list of QCDR vendors for 2019. Review which vendors can submit Quality under the "Performance Categories Supported" section. Also ensure your selected measures are reportable under the "Quality Measures Supported" section. **Submission through QCDRs will begin January 1, 2020. The deadline to complete submission is March 31, 2019. Check with your QCDR to see if they have a submission or signup deadline that precedes this date.**
  * Excel file is split up into sheets in alphabetical order. Please review all sheets to see all vendors.
  * Not free, use of these vendors will most likely require payment to use their services.

- CMS Web Interface – Only groups of 25 or more may choose this reporting option and must register for this option. Registration to use this reporting method for 2019 begins on **April 1, 2019** and **ends June 30, 2019**. The reporting deadline for CMS Web Interface is **March 22, 2020**.

Contact HCMS's Quality Department for further assistance: quality@hcms.org or call (713) 524-4267

Additional Resources:

- 2019 Quality Performance Category Fact Sheet
- 2019 CMS Quality Measures Requirements
- HCMS General MIPS Guide/Education
- QPP Resource Library
- For additional free technical assistance contact the TMF Health Quality Institute.