Quality Payment PROGRAM

2023 Merit-based Incentive Payment System (MIPS) Payment Year Payment Adjustment User Guide

Introduction

In August 2022, each MIPS eligible clinician will receive a 2021 MIPS final score and 2023 MIPS payment adjustment information as part of their performance feedback. The 2023 MIPS payment adjustment, determined by the 2021 final score, will affect payments made for services in calendar year 2023, also referred to as the 2023 MIPS payment year.

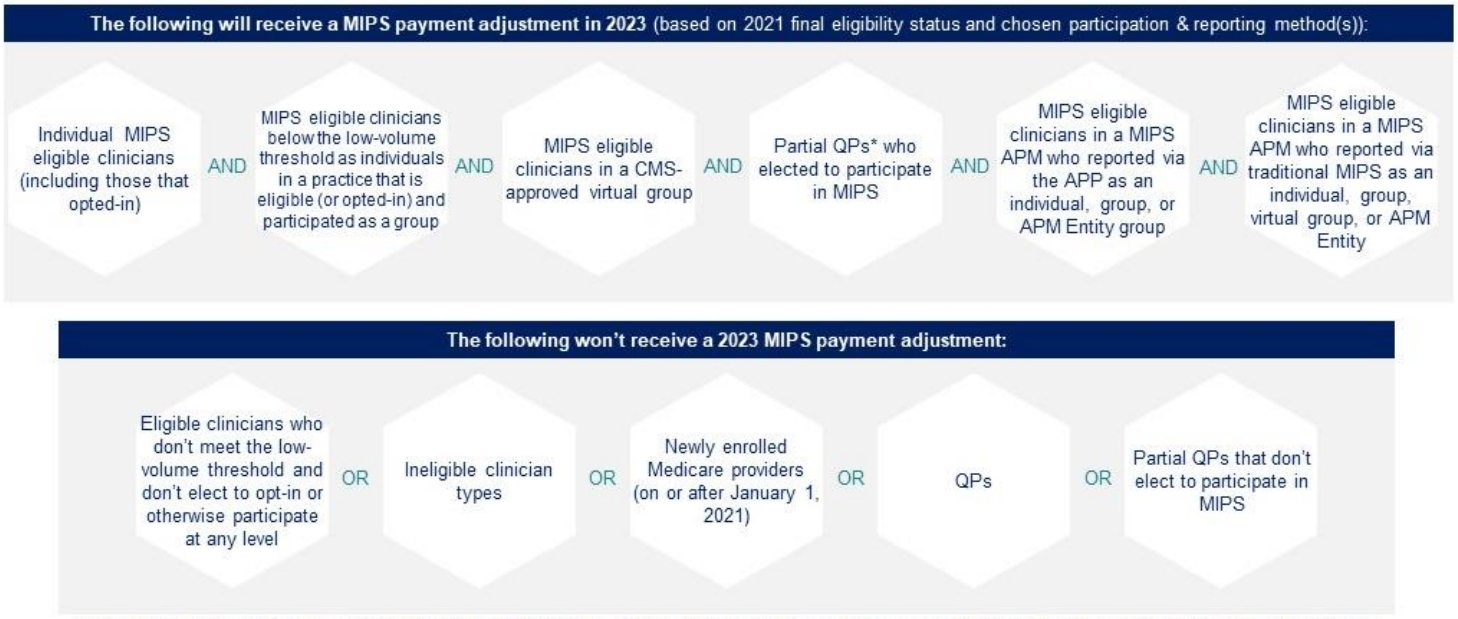
ACRONYMS

NPI = National Provider Identifier (unique identifier assigned to clinicians when they enroll as Medicare providers)

TIN = Taxpayer Identification Number, sometimes referred to as an Employer Identification Number (unique identifier assigned by IRS or SSA)

Type of Payment Adjustment	Impact to Payments in 2023
Positive	Each covered professional service you furnish in 2023 is **reimbursed more than 100%** – increase to paid amount
Neutral	Each covered professional service you furnish in 2023 is **reimbursed 100%** – no increase or decrease to paid amount
Negative	Each covered professional service you furnish in 2023 is **reimbursed less than 100%** – decrease to paid amount

Who Will Receive a MIPS Payment Adjustment in 2023?



* A Qualifying Alternative Payment Model Participant (QP) is an eligible clinician who has met or exceeded the payment amount or patient count thresholds based on participation in an Advanced APM.

A single clinician, identified by NPI, that billed Medicare under multiple TINs during 2021, can receive a separate 2021 MIPS Final Score for each of his/her unique TIN/NPI combinations.

Such clinicians may receive a different MIPS payment adjustment for covered professional services furnished and billed under each of their TIN/NPI combinations in the 2023 payment year.

Determining Your 2023 MIPS Payment Adjustment

If you meet the criteria above, the Final Score associated with your TIN/NPI combination determined your payment adjustment. Your Final Score was compared to performance thresholds to determine whether you'll receive a positive, negative, or neutral adjustment to payments for the covered professional services you furnish in the 2023 MIPS payment year.

1. **The performance threshold for the 2023 MIPS payment year is 60 points.** This means that MIPS eligible clinicians with a 2021 MIPS Final Score of 60 points or higher will avoid a negative payment adjustment in the 2023 MIPS payment year.

2. **The additional performance threshold for exceptional performance for the 2023 MIPS payment year is 85 points**. A MIPS eligible clinician with a Final Score of 85 points or higher will receive an additional payment adjustment factor for exceptional performance.

The MIPS payment adjustment factor(s) are determined by the MIPS eligible clinician's Final Score. Payment adjustment factors are assigned on a linear sliding scale and are based on an applicable percent defined by law.

Table 1: How 2021 MIPS Final Scores Relate to 2023 MIPS Payment Adjustments

Final Score Points	MIPS Payment Adjustment
0.00 – 15 points	• Negative MIPS payment adjustment of -9%
15.01 – 59.99 points	• Negative MIPS payment adjustment, between -9% and 0%, on a linear sliding scale
60.00 points (Performance threshold=60.00 points)	• Neutral MIPS payment adjustment (0%)
60.01 – 84.99 points	• Positive MIPS payment adjustment, greater than 0% (subject to a scaling factor to preserve budget neutrality) • **Not** eligible for an additional adjustment for exceptional performance
85.00 – 100.00 points (Additional performance threshold=85.00 points)	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) **AND** • Eligible for additional adjustment for exceptional performance (subject to a scaling factor to account for available funds)

Note: The Centers for Medicare & Medicaid Services (CMS) only displays payment adjustments to 2 decimal places in performance feedback.

How Do COVID-19 Relief Efforts Affect 2023 MIPS Payment Adjustments?

The following flexibilities, implemented as part of our COVID-19 relief efforts, affect 2021 final scores and the associated 2023 MIPS payment adjustments:

Relief Effort	How Did It Work?	Who Was It Available to?
MIPS Automatic Extreme and Uncontrollable Circumstances (EUC) Policy	Clinicians who didn't submit PY 2021 data automatically had all four performance categories reweighted to 0% and received a neutral payment adjustment in 2023, unless they had a higher score from group or APM Entity participation. MIPS eligible clinicians participating as individuals were only scored on performance categories for which data was submitted. All other performance categories were reweighted to 0% of their final score. Data submitted by individual clinicians voided reweighting for that performance category and the data was scored. Appendix A outlines performance category weights and payment adjustment implications based on data submission by individual clinicians.	**Individual MIPS eligible clinicians** **The MIPS automatic EUC policy didn't apply to groups, virtual groups, or APM entities**
Reweighted the Cost Performance Category from 20% to 0%	The 20% cost performance category weight was redistributed to other performance categories. This reweighting of the cost performance category applied in addition to the EUC policies. Clinicians who weren't covered by the automatic EUC policy or who didn't apply to request reweighting under the EUC policy still had their cost performance category weighted to 0%.	**Individuals, Groups and Virtual Groups**
Extreme and Uncontrollable Circumstances Application	Groups and virtual groups (or a third party) had the option to complete an application for one or more performance categories, citing they were impacted by the COVID-19 public health emergency. APM Entities were able to complete an application to request reweighting of all performance categories. If approved, all of the MIPS eligible clinicians in the APM Entity received a neutral MIPS payment adjustment in 2023.	**Groups, Virtual Groups and APM Entities**

Relief Effort	How Did It Work?	Who Was It Available to?
	Data submission by an APM Entity didn't override performance category reweighting. Groups and virtual groups weren't able to submit an EUC application to void previously submitted data.	
COVID-19 Clinical Data Reporting With or Without Clinical Trial Improvement Activity	To receive credit for the new *COVID-19 Clinical Data Reporting with or without Clinical Trial* improvement activity in 2021, clinicians had to attest that they participated in: 1) a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study or 2) the care of a patient diagnosed with COVID-19 and simultaneously submit relevant clinical data to a clinical data registry for ongoing or future COVID-19 research.	**Individuals, Groups, Virtual Groups and APM Entities**
Doubled Complex Patient Bonus	You could earn up to 10 bonus points for the Complex Patient Bonus for the 2021performance year (to be added to your 2021 MIPS final score).	**Individuals, Groups, Virtual Groups, and APM Entities**

Budget Neutrality and Scaling Factors

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires MIPS to be a budget neutral program, which means that the projected negative adjustments must be balanced by the projected positive adjustments.

- To achieve this, positive MIPS payment adjustment factors may be increased or decreased (or "scaled") by an amount called a "scaling factor." The scaling factor must be a number between 0 and 3, but the exact amount depends on the distribution of Final Scores across all MIPS eligible clinicians.
- For example, if the scaling factor that's applied to positive MIPS payment adjustment factors is less than 1.0, a clinician who received a Final Score of 100 points will still receive a positive payment adjustment, but the amount of the positive payment adjustment that clinicians will receive will be less than the applicable percent, which is 9% for 2023 (excluding the additional adjustment for exceptional performance).

Similarly, if the scaling factor is above 1.0, then the amount of the positive payment adjustment for a clinician who received a Final Score of 100 points will be more than 9% for 2023 (excluding the additional adjustment for exceptional performance).
A scaling factor is also applied to the additional adjustments for exceptional performance (i.e., Final Scores at or above 85 points). In this circumstance, the scaling factor is necessary to proportionally distribute the available funds to the clinicians who qualified.

The magnitude of the payment adjustment amount is influenced by 2 factors: the performance threshold and the distribution of Final Scores in comparison to the performance threshold in a given year. (The low-volume threshold, which is used to determine eligibility for the program, doesn't impact the magnitude of the payment adjustment.)

The modest positive payment adjustment you see for the 2023 payment year is a result of the following factors:

- A very small number of clinicians receiving a negative payment adjustment due to the flexibilities we introduced in response to COVID-19.
- High participation rates.
- A large percentage of Final Scores that were well above the relatively low performance threshold of 60 points.

With so many clinicians successfully participating, the distribution of positive adjustments is spread across many more people. This year's payment adjustment distribution was further affected because clinicians who didn't submit any data will receive a neutral payment adjustment instead of the maximum negative adjustment.

Multiple Final Scores for a Single TIN/NPI Combination

In some cases, there may be multiple Final Scores associated with your TIN/NPI combination. If this happens, we'll use the hierarchy described in the table below to assign the Final Score that will be used to determine your payment adjustment applicable to that TIN/NPI combination.

Beginning with PY 2021, if a TIN/NPI has a virtual group final score associated with it, we use the virtual group final score to determine the payment adjustment. If a TIN/NPI doesn't have a virtual group final score associated with it, we use the highest available final score associated with that TIN/NPI to determine the payment adjustment.

Table 2: Hierarchy for Assigning the 2021 MIPS Final Score when More Than One Final Score is Associated with a TIN/NPI Combination for a MIPS Eligible Clinician

Scenario	Final Score Used to Determine Payment Adjustments
TIN/NPI has a virtual group final score, an APM Entity final score, an APM Performance Pathway (APP) final score, a group final score, and/or an individual final score.	Virtual group Final Score.
TIN/NPI has an APM Entity Final Score, a group final score, and/or an individual final score, but is not in a virtual group.	The highest of the available final scores.

Multiple TIN/NPI Combinations/Establishing a New TIN/NPI Combination After the 2021 Performance Year

There may be instances when a MIPS eligible clinician, identified by NPI, billed Medicare under multiple TINs during 2021. In this situation, the clinician can receive a separate 2021 MIPS Final Score for each of his/her unique TIN/NPI combinations. Such clinicians may receive a different MIPS payment adjustment for covered professional services billed under each associated TIN/NPI combination in the 2023 payment year.

There may also be instances when a MIPS eligible clinician with a 2021 MIPS Final Score bills Medicare in the 2023 payment year under a TIN/NPI combination that they didn't use during the 2021 performance year. In such cases, we'll apply the payment adjustment associated with the highest 2021 Final Score associated with the NPI under any TIN during 2021.

Table 3: Which Payment Adjustment is Applied: New or Multiple TIN/NPI Combinations

Scenario	Payment Adjustment
Clinician has a 2021 Final Score under **TIN A.** Clinician continues to bill under **TIN A** in the 2023 payment year.	Clinician will receive a payment adjustment for covered professional services billed in 2023 under their **TIN A**/NPI combination based on 2021 Final Score attributed to that **TIN A**/NPI combination.
Clinician has a single 2021 Final Score, received at **TIN A**.	Clinician will receive a payment adjustment for covered professional services billed in

Scenario	Payment Adjustment
Clinician bills under **TIN B** in the 2023 payment year.	2023 under their **TIN B**/NPI combination based on 2021 Final Score attributed to their **TIN A**/NPI combination.
Clinician has a 2021 Final Score under **TIN A**. Clinician has a 2021 Final Score under **TIN B**. Clinician bills under **TIN C** in the 2023 payment year.	Clinician will receive a payment adjustment for covered professional services billed in 2023 under their **TIN C**/NPI combination based on their higher 2021 Final Score – either attributed to their **TIN A**/NPI combination or **TIN B**/NPI combination.
Clinician has a 2021 Final Score under **TIN A**. Clinician has a 2021 Final Score under **TIN B**. Clinician bills under **TIN A** and **TIN B** in the 2023 payment year.	Clinician will receive a payment adjustment for covered professional services billed in 2023 under their **TIN A**/NPI combination based on 2021 Final Score attributed to that **TIN A**/NPI combination Clinician will receive a payment adjustment for covered professional services under their **TIN B**/NPI combination based on 2021 Final Score attributed to that **TIN B**/NPI combination.

Please refer to the Frequently Asked Questions section for information about additional payment adjustment scenarios.

Application of MIPS Payment Adjustments in the 2023 Payment Year

MIPS payment adjustments are applied on a claim-by-claim basis, to payments made for covered professional services furnished by a MIPS eligible clinician.

- The payment adjustment is applied to the Medicare paid amount (not the "allowed amount").
- Payment adjustments don't impact the portion of the payment that a patient is responsible to pay.

A covered professional service is one which payment is made under, or based on, the Medicare Physician Fee Schedule (PFS). The PFS Look-Up Tool provides information on services covered by the PFS, including fee schedule status indicators. Definitions of these procedure status indicator codes (or "PROC STAT" codes) are found on pages 9-15 of the "PF22PC.pdf" document, part of the PFS National Payment Amount File. See also: The How to Use the MPFS Look-Up Tool Booklet

MIPS payment adjustments are applied only to assigned claims[1] for covered professional services furnished by MIPS eligible clinicians. Non-participating healthcare professionals may choose to have claims paid on an assignment-related basis.[2]

MIPS payment adjustments **aren't** applied to:

- Non-assigned claims for services.
- Covered professional services furnished during a year by a new Medicare-enrolled eligible clinician.
- Medicare Part B drugs or other items and services that aren't covered professional services.

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[1] Accepting assignment of the Medicare Part B payment means having the patient assign to the clinician their right to receive Medicare Part B payment for covered services. Under assignment, the Medicare-approved charge is the full charge for the Part B covered service. The participating clinician shall not collect from the patient or other person or organization for covered services more than the applicable deductible and coinsurance.

[2] Participating Health Care Professionals and Suppliers enrolled in Medicare and signed the Form CMS-460, Medicare Participating Physician or Supplier Agreement, agreeing to charge no more than Medicare-approved amounts and deductibles and coinsurance amounts. Participating professionals and suppliers submit assigned claims. Health professionals, suppliers and providers submit Assigned Claims on behalf of the beneficiary. Medicare issues payment to the submitter. Nonparticipating Health Care Professional and Suppliers enrolled in Medicare but decided not to sign the Form CMS-460. They accept assignment on a case-by-case basis. For services paid under the MPFS, Medicare reduces (5%) the Medicare-approved amounts for nonparticipants. Also, Medicare limits what the health care professional or supplier may charge the beneficiary (Limiting Charge) when they choose not to accept assignment on the claim.

Suppliers, such as independent diagnostic testing facilities (IDTFs), aren't included in the definition of a MIPS eligible clinician. In situations where a supplier bills for Part B covered professional services furnished by a MIPS eligible clinician, those services could be eligible to receive a MIPS payment adjustment based on the MIPS eligible clinician's performance during the applicable MIPS performance year. However, because those services are billed by suppliers that aren't MIPS eligible clinicians, they aren't subject to a MIPS payment adjustment. It isn't operationally possible for CMS to associate those services (in the form of billed allowed charges from a supplier) as originating from a MIPS eligible clinician.

Frequently Asked Questions & Answers

The following questions & answers illustrate how Final Scores are assigned in different scenarios and how MIPS payment adjustments are applied.

Q: I'm a MIPS eligible clinician who billed under multiple TINs during the 2021 MIPS performance year. Could I have multiple payment adjustments in 2023?

A: Yes. If you were MIPS eligible under multiple TIN/NPI combinations, you may receive a distinct MIPS payment adjustment for covered professional services furnished in 2023 and billed under each of those TIN/NPI combinations.

Q: We have a MIPS eligible clinician who started billing Medicare claims under our practice's existing TIN in October 2021. We participated as a group. Will this clinician receive a payment adjustment based on our group's Final Score?

A: Yes. MIPS eligible clinicians who started billing to a group's existing TIN between 10/1/2021 and 12/31/2021 will receive the group's Final Score and payment adjustment in the 2023 payment year, if the group's score is the highest score associated with that clinician's TIN/NPI. If the clinician (identified by the same TIN/NPI) is a virtual group participant, the clinician will receive a payment adjustment based on their virtual group score.

If the new practice didn't report as a group, then the MIPS eligible clinician will receive a neutral payment adjustment under this TIN/NPI combination in the 2023 payment year.

Q: We established a new TIN in October 2021, but our old TIN was eligible for MIPS as a group. We submitted MIPS data as a group under the old TIN, where it was billed and collected. What payment adjustment will our clinicians get?

A: MIPS eligible clinicians who started billing claims under this new TIN between 10/1/2021 and 12/31/2021 will receive a neutral payment adjustment under this TIN in the 2023 payment year.

MIPS eligible clinicians who start billing under this new TIN after 12/31/2021 (i.e., after the performance year) will receive the highest payment adjustment attributed to their NPI when billing under this new TIN in the 2023 payment year.

Q: If a QP is part of a group that submitted MIPS data on behalf of all the individual eligible clinicians in its group, will the QP receive a 2023 payment adjustment based on that group's 2021 Final Score?

A: No, the group's 2023 MIPS payment adjustment doesn't apply to clinicians in that group who were also determined to be a QP in 2021. Instead, clinicians in the group who are QPs are eligible to receive the 5% APM Incentive Payment.

Q: In 2021, I participated in an Advanced APM that was also considered a MIPS APM and was neither a QP nor a Partial QP in 2021. How does the payment adjustment work for me?

A: If you're in an Advanced APM but aren't a QP or a Partial QP, you're evaluated for MIPS eligibility just like any other clinician. Your MIPS eligibility status determines how the payment adjustment will work for you. See "Who Will Receive a MIPS Payment Adjustment in 2023?"

As a reminder, any MIPS eligible clinician who is identified on a participation list or affiliated practitioner list of any APM Entity participating in a MIPS APM on 1 of the 4 PY 2021 snapshot dates (March 31, June 30, August 31, December 31, 2021) may report via the APP. If they don't wish to report through the APP, then they are required to report via traditional MIPS

See: 2021 and 2022 Comprehensive List of APMs

Q: How are payment adjustments determined for virtual groups?

A: virtual group's performance is assessed and scored at the virtual group level across all 4 MIPS performance categories. Each clinician in a virtual group, as identified by a TIN/NPI combination, will receive a MIPS Final Score based on the virtual group's performance. Only MIPS eligible clinicians will receive a MIPS payment adjustment based on the virtual group's MIPS Final Score (clinicians in a virtual group that: aren't MIPS eligible clinician types, are newly Medicare-enrolled clinicians, are QPs, or are Partial QPs choosing not to participate in MIPS won't receive a MIPS payment adjustment).

If you participate as a virtual group, you'll receive a payment adjustment based on the virtual group's final score, even if you have additional final scores from other participation options.

For more information, please refer to the 2021 Virtual Groups Toolkit.

Q: Is the 2023 MIPS payment adjustment applied before or after sequestration?

A: Before sequestration. Sequestration is the automatic reduction in Medicare fee-for-service (FFS) payments to plans and providers, resulting from the Budget Control Act of 2011. The MIPS payment adjustment percentage is applied to the Medicare paid amount for covered professional services furnished by a MIPS eligible clinician after calculating deductible and coinsurance amounts but before sequestration.

UPDATE: The Protecting Medicare and American Farmers from Sequester Cuts Act impacts payments for all Medicare Fee-for-Service (FFS) claims as follows:

- No sequestration payment adjustment through March 31, 2022
- 1% sequestration payment adjustment April 1 – June 30, 2022
- 2% sequestration payment adjustment beginning July 1, 2022

Q: Is the MIPS payment adjustment applied to the Medicare paid amount or Medicare allowed amount?

A: The MIPS payment adjustment is applied to the Medicare paid amount for covered professional services (services for which payment is made under, or is based on, the Medicare Physician Fee Schedule) furnished by a MIPS eligible clinician.

Q. How is the MIPS payment adjustment applied to services that are "globally billed," meaning services are split into separate professional component (PC) and technical component (TC) services when the PC and TC are furnished by the same physician or supplier entity?

A: The MIPS payment adjustment is applied to all paid charges for both the TC and PC of a globally billed service.

Q: Are payments for radiology services subject to MIPS payment adjustments?

A: The professional component of radiology services furnished by a physician to an individual patient in all settings under the Medicare Physician Fee Schedule are subject to the MIPS payment adjustment. Radiology and other diagnostic services furnished to hospital outpatients are paid under the Outpatient Prospective Payment System (OPPS) to the hospital and aren't subject to MIPS payment adjustments.

Q: Are payment for anesthesiology services subject to MIPS payment adjustments?

A: Yes, anesthesiology services are subject to MIPS payment adjustments. The payment adjustment is not applied to any components of the anesthesia calculations. The adjustment is applied to the paid amount, not the allowed amount. After the system has applied the patient's deductible, coinsurance, and (if Medicare is secondary) the Medicare Secondary Payment Reduction to the claim, the system will apply the MIPS payment adjustment amount.

Q. Are payments for federally qualified health center (FQHC) and rural health center (RHC) benefits subject to MIPS payment adjustments?

A: No. All professional services in FQHC and RHC benefits are paid through the all-inclusive rate (AIR) system or the FQHC prospective payment system (PPS) for each patient encounter or visit. FQHC Healthcare Common Procedure Coding System (HCPCS) codes aren't priced by the Medicare PFS.

Q: Are payments for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) subject to MIPS payment adjustments?

A: No, payments for DMEPOS are made according to a separate fee schedule. They aren't considered covered professional services payable under the Medicare PFS.

Q: Do 2023 MIPS payment adjustments impact Medicare Advantage Organization (MAO) payments to non-contract providers? If so, how?

For guidance on when and how the MIPS payment adjustments apply to MAOs' payments to out-of-network MIPS eligible clinicians, please see the July 10, 2020, memorandum entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update." This memo is available here [See document entitled "2020 MIPS HPMS Memo 7.10.2020.pdf]

See also:

- February 4, 2022 HPMS Memo entitled: "Release of 2022 MIPS Payment Adjustment Data File" available here [see document entitled "2022_MIPS_Payment_Adj_Data_Rile_Release_Memo_02_04_2022_508.pdf"]

Q: Do MIPS payment adjustments impact Medicare Advantage payments to in-network/contracted providers? If so, how?

A: Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contracted clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contracted clinicians are governed by the terms of the contract between the MAO and the clinician.

Q: Are MIPS payment adjustments applied to items and services furnished by MIPS eligible clinicians in an Ambulatory Surgical Center (ACS), Home Health Agency (HHA), Hospice, and/or hospital outpatient department (HOPD)?

A: If a MIPS eligible clinician furnishes items and services in an ASC, HHA, Hospice, and/or HOPD and the ASC, HHA, Hospice and/or HOPD bills for those items and services under the facility's all-inclusive payment methodology or prospective payment system methodology, then the MIPS payment adjustment isn't applied to the facility payment itself.

If a MIPS eligible clinician furnishes covered professional services for which payment is made under or is based on the Medicare PFS in an ASC, HHA, Hospice and/or HOPD and bills for those services separately, then the MIPS payment adjustment is applied to payments for those services.

Q: How are MIPS payment adjustments applied to MIPS eligible clinicians practicing in Critical Access Hospitals (CAHs)?

A: For MIPS eligible clinicians who practice in Method II CAHs and have assigned their billing rights to the Method II CAH, the MIPS payment adjustment is applied to the Method II CAH payment.

For MIPS eligible clinicians who practice in Method II CAHs and haven't assigned their billing rights to the CAH, the MIPS payment adjustment is applied to payments for covered professional services billed by the MIPS eligible clinicians under PFS. The payment adjustment isn't applied to the facility payment to the Method II CAH itself.

For MIPS eligible clinicians who practice in CAHs that bill under Method I, the MIPS payment adjustment is applied to payments for covered professional services billed by MIPS eligible clinicians under the PFS. The MIPS payment adjustment wouldn't apply to the facility payment made to the Method I CAH itself.

Q: How will MIPS payment adjustments be reflected on remittance advice (RA) documents?

A: If a MIPS payment adjustment is applied to a payment made to a MIPS eligible clinician, the following codes will be displayed on the RA[3]:

Positive MIPS Payment Adjustments	**CARC[4] 144:** "Incentive adjustment, e.g., preferred product/service"	**RARC[5] N807:** "Payment adjustment based on the Merit-based Incentive Payment System (MIPS)."	**Group Code[6]: CO**. This group code is used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment.

[3] When you submit a claim to a MAC, you'll receive a RA that explains the payment and any adjustment(s) made to a payment during Medicare's adjudication of the claim. RAs provide itemized claims processing decision information regarding deductibles and co-pays, adjustments, denials, missing or incorrect data, claims withholding due to Medicare Secondary Payer situations, and more. For additional detailed information, please reference the Remittance Advice Booklet.

[4] Claim Adjustment Reason Codes (CARCs) provide financial information about claim decisions. CARCs communicate adjustments the MAC made and provide explanations when the MAC pays a claim or service line differently than what was on the original claim.

[5] Remittance Advice Remark Codes (RARCs) further explain an adjustment or relay informational messages that CARCs can't express.

[6] A group code is a code identifying the general category of payment adjustment. A group code is always used in conjunction with a CARC to show liability for amounts not covered by Medicare for a claim or service. For more information on group codes, visit the Medicare Claims Processing Manual, Chapter 22 (Remittance Advice), Section 60.1 (Group Codes).

Negative MIPS Payment Adjustments	**CARC 237**: "Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)"	**RARC N807:** "Payment adjustment based on the Merit-based Incentive Payment System (MIPS)."	**Group Code: CO**

Q: Will patients be notified if a claims payment made to one of their clinicians was adjusted due to that clinician's participation in MIPS?

A: Yes. Every 3 months, Original Medicare[7] patients receive a Medicare Summary Notice (MSN) in the mail for their Medicare Part A and Part B-covered services. MSNs show a patient all of his/her services or supplies that providers and suppliers billed to Medicare during the 3-month period, what Medicare paid, and the maximum amount the patient may owe the provider or supplier. For all the patients' claims for which the clinician who furnished the service received a positive or negative MIPS payment adjustment, the following MSN message will be displayed: "This claim shows a quality reporting program adjustment."

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. ET or by email at: qpp@cms.hhs.gov.
- To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.
- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.
- 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.

Version History

Date	Comment
08/22/2022	Original version.

[7] Original Medicare includes Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance)

Appendix A: Performance Category Weights and Payment Adjustment based on Individual Data Submission

The table below illustrates the 2021 performance category reweighting policies that CMS will apply to individual clinicians under the MIPS automatic extreme and uncontrollable circumstances policy. The automatic policy (and the reweighting below) doesn't apply to clinicians who participate in MIPS as a group, virtual group or APM Entity.

Note: Participants in APMs are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category, which will override reweighting of this performance category.

Data Submitted	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No data	0%	0%	0%	0%	Neutral
Submit Data for One Performance Category					
Quality Only[8]	100%	0%	0%	0%	Neutral
Promoting Interoperability Only[8]	0%	100%	0%	0%	Neutral
Improvement Activities Only	0%	0%	100%	0%	Neutral
Submit Data for 2 Performance Categories					
Quality **and** Promoting Interoperability[8]	70%	30%	0%	0%	Positive, Negative, or Neutral
Quality **and** Improvement Activities	85%	0%	15%	0%	Positive, Negative, or Neutral

[8] Participants in APMs are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category.

Data Submitted	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
Improvement Activities **and** Promoting Interoperability	0%	85%	15%	0%	Positive, Negative, or Neutral
Submit Data for 3 Performance Categories					
Quality **and** Improvement Activities **and** Promoting Interoperability	55%	30%	15%	0%	Positive, Negative, or Neutral