

MACRA FAQ: Merit-Based Incentive Payment System (MIPS)

General Information

What is MIPS?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created a new quality payment program (QPP) for Medicare part B. The QPP established 2 ways for providers to participate in quality improvement programs under MACRA: (1) the Merit-Based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (APMs) (see APTA's APM FAQ). The MIPS program begins in 2017 and combines a number of previous quality-reporting programs, including the Physician Quality Reporting System (PQRS) and the Meaningful Use (MU) program for electronic health records (EHRs). Physical therapists are not formally included in MIPS initially, but they may be added to the program in 2019.

Does this mean I can stop reporting quality measures data in 2017?

No, APTA and CMS strongly recommend that PTs voluntarily report in MIPS in 2017 to gain experience with the new quality program. Similar to mandated participants, if you submit data in 2017 you will receive a feedback report allowing you to see how your performance may affect your payment in future years. You should participate in 2017 by reporting the quality measures you have been submitting under PQRS via either claims-based reporting or electronic reporting through a registry or EHR vendor.

Is PQRS going away?

Yes. 2016 is the last reporting year of PQRS, with the last PQRS penalty year being 2018 (based on the 2016 data). MIPS takes over in 2017.

How is MIPS different from PQRS?

Success in the PQRS program was based on the percentage of Medicare patients for which you submitted data. MIPS is a more complex program, and providers will be scored on 4 categories.

 <p>Quality</p>	 <p>Improvement Activities</p>	 <p>Advancing Care Information</p>	 <p>Cost</p>
<p>Replaces PQRS.</p>	<p>New category.</p>	<p>Replaces the Medicare EHR Incentive Program also known as Meaningful Use.</p>	<p>Replaces the Value-Based Modifier.</p>

If I voluntarily participate in MIPS, do I report in the Quality (old PQRS) category, or do I need to participate in the other 3 categories (Improvement Activities, Advancing Care Information and Cost), too?

APTA is encouraging PTs to participate in the Quality category to begin with in 2017. Participation in the improvement activities and advancing care information categories will require electronic data submission to CMS via a certified EHR or a registry. APTA is working on additional member resources and educational materials in the additional categories to prepare PTs to voluntarily report in all of them beginning in 2018. If added formally to the program in 2019, PTs will be required to report in all 4 categories.

How can I learn more about MIPS?

CMS has [created a QPP website](#) to help providers such as PTs understand MIPS. Additionally, APTA will continue to develop member-specific resources.

What else do I need to do to prepare for inclusion in MIPS in 2019?

For now, continue to report PQRS measures (the Quality category) into MIPS to gain reporting experience. In addition, given the complexity of the MIPS program, you should invest in technology to support the transition into MIPS and APMs; this investment includes certified EHRs and participation in registries.

Does APTA have recommendations for EHRs?

APTA has online resources on its [EHR webpage](#) for determining the best EHR product for your clinic. Additionally, the [Office of the National Coordinator \(ONC\) has online resources](#) for providers on EHRs.

If you already have an EHR and want to determine if your current vendor is certified, visit [ONC's lookup list](#).

Does APTA have a registry?

APTA has a registry. [For more information please see the registry website](#).

Quality Measures

What quality measures should I report?

PTs can submit 6 quality measures via claims in 2017:

- Measure 128 - Preventive Care and Screening BMI
- Measure 130 - Documentation of Current Medications
- Measure 131 - Pain Assessment and Follow Up
- Measure 154 - Falls Risk Assessment
- Measure 155 - Falls Plan of Care
- Measure 182 - Functional Outcome Assessment

For more information on these measures, [please see our PQRS webpage](#).

What resources are available to help facilitate the workflow processes associated with participating in PQRS?

APTA has created [data collection tools for the claims based measures](#) (#128, 130, 131, 154, 155, and 182).

If I am reporting quality measures via a registry, should I report on the same 6 measures?

There are additional quality measures available for reporting via registry. Please speak with your registry vendor about the measures they offer.

If I report these measures, how will I know that CMS has accepted our report information?

You will be able to tell if your quality reporting data has been accepted when you see the remittance advice from Medicare. Remittance advice denial code N620, found on the Explanation of Benefits (EOB) form, is your indication that the PQRS codes are valid.

If I do not get the code N620 on my remittance advice and instead get a different denial code, what should I do?

If you are not getting N620 remittance advice codes, there is a problem with your claims submission, such as putting the GP modifier on the same line item as the quality code. You will need to investigate what might be causing the problem and work to correct it.

What information will I receive on my MIPS feedback report?

MIPS feedback information will be broken out into the 4 program categories. In 2017, because you will report measures only under the quality category, you will get information about your performance in that category.

How will I access my MIPS feedback report?

As this is the first year of the program, APTA doesn't yet have that information. As soon as it becomes available, the association will share it with members, including through updates to this FAQ.

Eligibility of Outpatient Therapy Settings to Participate in MIPS

Are any outpatient therapy settings able to participate in MIPS in 2017?

In 2017, physical therapists in private practices that submit claims to Medicare carriers using the 1500 claim form or 837-P are the **only** settings that are able to formally participate in MIPS. Each physical therapist in private practice obtains his or her NPI number, which is placed on the claim form. This NPI number is then used to track performance on the quality measures.

Which outpatient therapy settings are NOT able to participate in the MIPS in 2017? Why are these settings unable to participate?

In 2017, the following settings in which outpatient therapy services are furnished will **NOT** be able to participate, per the final MACRA rule:

1. Professionals paid under or based upon the PFS [physician fee schedule] billing Medicare Carriers/Medicare Administrative Contractors (MACs) who do not bill directly, and
2. Professionals paid under the PFS billing Medicare fiscal intermediaries (FIs) or MACs. The FI/MAC claims processing systems currently cannot accommodate billing at the individual physician or practitioner level:
 - Critical access hospital (CAH), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the regular FI for the professional services provided by the physician or practitioner.
 - All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.