Quality Payment PROGRAM

Merit-based Incentive Payment System (MIPS) Payment Adjustment Remittance Advice FAQ

The following information and related questions and answers are meant to help MIPS eligible clinicians understand how to identify and interpret the application of positive, neutral and/or negative MIPS payment adjustments to be applied to payments for certain claims submitted for services furnished in calendar year (CY) 2019 based on clinicians' 2017 MIPS final scores.

First, please review a few key points regarding Medicare claims processing and payment:

- When you submit a claim to a Medicare Administrative Contractor (MAC), you will receive a Remittance Advice (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 Medicare Learning Network's (MLN) Remittance Advice Overview Fact Sheet.
- An RA contains codes that communicate detailed payment information about a health care claim(s) and, if applicable, describes why Medicare has not paid the total original charges in full. RA codes help health care providers understand the actions the MACs took while processing the claim(s) and identify any additional action that may be necessary.
- Three code types will be used to communicate information about MIPS payment adjustments on RAs. A clinician receiving a positive or a negative MIPS payment will see three types of codes indicative of this adjustment displayed on their RAs:
    1. *Claim Adjustment Reason Codes (CARCs)*- 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.
    2. *Remittance Advice Remark Codes (RARCs)*- RARCs further explain an adjustment or relay informational messages that CARCs cannot express.
    3. *Group Code*: 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).

Questions & Answers:

Question #1: Based on my 2017 MIPS final score, I will receive a positive MIPS payment adjustment in 2019. How will I know if/when my positive MIPS payment adjustment has been applied to payment for a claim?

Answer #1: If a positive MIPS payment adjustment is applied to a payment made to a MIPS eligible clinician, as identified by a unique TIN-NPI combination, for a service furnished by a MIPS eligible clinician for which payment is made under or based on the Medicare Physician Fee Schedule (PFS) then the following codes will be displayed on the RA:

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

For more information about the determination of MIPS payment adjustments, identification of MIPS eligible clinicians, and other detailed payment adjustment scenarios, please refer to the 2019 MIPS Payment Adjustment based on 2017 MIPS Final Scores Fact Sheet.

Question #2: Based on my 2017 MIPS final score, I will receive a negative MIPS payment adjustment in 2019. How will I know if/when a negative MIPS payment adjustment has been applied to payment for a claim?

Answer #2: If a negative MIPS payment adjustment is applied to a payment made to a MIPS eligible clinician, as identified by a unique TIN-NPI combination, for a service furnished by a MIPS eligible clinician for which payment is made under or based on the Medicare PFS, then the following codes will be displayed on the RA:

- 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. This group code is used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment.

For all list of *all* CARCs and RARCs please see the following resources:

- Claim Adjustment Reasons Codes (CARCs)
- Remittance Advice Remark Codes (RARCs)

Question #3: Will beneficiaries be notified if a claims payment made to one of their clinicians was adjusted due to that clinician's participation in MIPS?

Answer #3: Yes. Every three months, Original Medicare beneficiaries receive a Medicare Summary Notice (MSN) in the mail for their Medicare Part A and Part B-covered services. MSNs show a beneficiary 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 beneficiary may owe the provider or supplier. For all the beneficiary's 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." In Spanish: "Esta reclamación le muestra un ajuste del programa de informes sobre la calidad." A sample Part B MSN is available here.