MIPS Program: 2017 Data Validation and Auditing

On October 14, 2016, CMS released the final rule on the Quality Payment Program, which includes both the Merit-Based Incentive Payment Program (MIPS) and Advanced Alternative Payment Models (APMs). The final rule requires CMS to release criteria the agency will use to validate data submitted as part of the MIPS program in 2017. The validation criteria will be used as an element of future audits on 2017 MIPS performance. This guide summarizes the criteria CMS has released and information about potential audits.

Validation Criteria

For 2017, the first performance year of MIPS, CMS has begun releasing validation criteria for each of the categories of MIPS that require data submission from physicians: Quality, Improvement Activities, and Advancing Care Information.

Quality: The data validation process will apply for claims and registry submissions to validate whether physicians submitted all applicable measures when submitting fewer than six measures or if the required outcome measure or high-priority measure was not submitted.

Improvement Activities: CMS has released a list of suggested documentation examples for each of the 92 available improvement activities. For high-weighed activities many ophthalmic practices plan on submitting, CMS suggests the following documentation. For extended practice hours, CMS suggests retaining documentation of claims or patient records indicating the patient was seen outside of regular business hours. For use of a Qualified Clinical Data Registry (QCDR), such as IRIS, CMS suggests retaining documentation of feedback reports from the QCDR. For full credit in the category, practices with 15 or fewer Medicare providers only need to submit one high-weighted or two medium-weighted activities. Practices of 16 or more providers are required to submit two high-weighted, four medium-weighted, or a combination of one high-weighted and two medium-weighted activities.

Advancing Care Information: CMS recommends retaining documentation related to the practice's data submission for this category.

Potential Audits

CMS indicates that the data validation criteria will be used as an element of forthcoming audits on MIPS data submissions. If a practice is contacted with an audit request, it has 10 business days to respond to CMS.

For 2017 performance, CMS has stated that only the data submitted in the Quality category will be subject to audits.

CMS notes that the MIPS program requires submission of all payer data for the Advancing Care Information category and for some submission methods of the Quality category (registry and EHR). CMS will use this all-payer data to improve future data validation efforts and will include it in audits, but will not make a final determination on whether a practice passes the validation solely on the basis of non-Medicare Part B data submitted.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.