ANATOMY IT

2023 MIPS

Avoid a Penalty Guide

Anatomy IT
10 New King St Suite 215
White Plains, NY 10604

(888) 816-9272
support@anatomyit.com
anatomyit.com

ANATOMY IT

Reporting Matters

MIPS evaluates Medicare clinicians on Quality, Promoting Interoperability, Improvement Activities, and Cost performance categories. To avoid a 9% penalty on all Medicare Part B physician service payments in 2025, you must achieve a total 2023 MIPS score of 75 points. This guide walks you through how to avoid the MIPS penalty based on your 2023 performance.

Contents

1 Will You Be Scored on Cost?

2 Avoiding the Penalty: Small Practices (≤15

3 Avoiding the Penalty: Large Practices (16+ clinicians)

4 Appendices

C. Cost Measure Case Minimums

D. Quality Measures Benchmarks

ANATOMY IT

Will You Be Scored on Cost?

If you meet the case minimum on at least one Cost measure, you will receive a Cost performance category score. The case minimum ranges from 10 to 35 (Appendix A).

For a patient to count toward the case minimum, they must meet the measure's attribution criteria. The way a measure is attributed varies based on the measure type.

Facility-based scoring may be applied to facility-based clinicians, groups, and virtual groups.[1]

Episode-Based Cost Measures Attribution

Procedural

- Attributed to any clinician or TIN that bills the measure's trigger code(s).

Acute Inpatient Medical Condition

- Attributed to the TIN billing at least 30% on the inpatient E&M services on Part B physician/supplier claims during the inpatient stay.
- Attributed to any clinician in the attributed TIN who billed at least one inpatient E&M service during the inpatient stay.

Chronic Condition

- Attributed to the TIN that renders services that make up a trigger event. A trigger event is identified by the occurrence of 2 claims billed in close proximity (defined by the measure) by the same clinician group. Both claims must have a diagnosis code for the chronic disease captured by the measure.
    - The first claim must have an E&M code for outpatient services as identified in the measure specification.
    - The second claim must have either another E&M for outpatient services *or* a condition-related HCPCS/CPT code related to the treatment or management of the chronic condition.
- Attributed to any clinician within the attributed TIN who renders at least 30% of qualifying services during the episode.

---

[1] Facility-based scoring will be used for your quality and cost performance category scores when all the following conditions are met:

- You're identified as facility based.
- You're attributed to a facility with a fiscal year 2024 Hospital Value-Based Purchasing (VBP) Program score.
- The facility-based scoring methodology using your Hospital VBP Program score results in a higher final score than your final score calculated without the application of facility-based measurement.

Total Per Capita Cost Measure Attribution

- Attributed to TINs that have a candidate event:
  - A clinician bills an initial E&M primary care service, AND
  - Any clinician bills another primary care service within 3 days, OR a clinician from the same TIN bills a second E&M primary care service or another primary care service within 90 days.
- Attributed to the clinician within the attributed TIN that is responsible for the largest share of candidate events provided to the patient within the TIN.
- Exclusions for candidate events of clinicians (TIN-NPIs) who meet either:
  - Any of the service category exclusion thresholds
    - billed 10-day or 90-day global surgery services during 15% or more of their candidate events.
    - billed anesthesia services during 5% or more of their candidate events.
    - billed therapeutic radiation services during 5% or more of their candidate events.
    - billed chemotherapy services during 10% or more of their candidate events. OR
  - Are designated as one or more of the 56 specialties unlikely to be responsible for primary care services (e.g., dermatology, emergency medicine, and ophthalmology).

Medicare Spending Per Beneficiary (MSPB) Measure Attribution

Medical MSPB

- Attributed to the TIN billing at least 30% on the inpatient E&M services on Part B physician/supplier claims during the inpatient stay.
- Attributed to any clinician in the TIN who billed at least one inpatient E&M service during the inpatient stay.

Surgical MSPB

- Attributed to the clinician(s) who performed any related surgical procedure during the inpatient stay as well as to the TIN under which they billed the procedure.

ANATOMY IT

Avoiding a Penalty Small Practices

Small Practices Not Scored on Cost or PI

Cost and PI category weight will be redistributed to the Quality and IA categories.

Quality (50% of Score)

Fully report 6 measures, including 1 outcome measure.

Each measure must:

- Be reported on at least 70% of denominator-eligible patients AND with at least 20 patients in the denominator.
- Average at least 4 out of 10 points

Improvement Activities (50% of Score)

Perform 1 high-weighted OR 2 medium-weighted activities for 90+ consecutive days.
If group reporting, at least 50% of eligible clinicians must complete the same activity or activities.

Promoting Interoperability (0%)

If you're a small practice without 2015 Edition Cures Update certified EHR, you can choose not to report PI data and allow the automatic small practice PI hardship to apply.

If you do report 2023 data, PI will comprise 30% of your MIPS final score; Quality would be 55% and IA 15%.

ANATOMY IT

Small Practices Not Scored on PI

PI category weight will be redistributed to the Quality and IA categories.

Quality (50% of Score)

Fully report 6 measures, including 1 outcome measure.

Each measure must:

- Be reported on at least 70% of denominator-eligible patients AND with at least 20 patients in the denominator
- Average at least 6.5 out of 10 points*

Improvement Activities (30% of Score)

Perform 1 high-weighted OR 2 medium-weighted activities for 90+ consecutive days.
If group reporting, at least 50% of eligible clinicians must complete the same activity or activities.

Cost (30% of Score)

If you meet the case minimum for any of the Cost measures, you will be scored on Cost.

Keep in mind that, if you have NPs or PAs billing under your TIN, you will likely be scored on TPCC at the group level.

*All cost scores are unpredictable; the Quality calculation assumes a 50% score in Cost.

Promoting Interoperability (0%)

If you're a small practice without 2015 Edition Cures Update certified EHR, you can choose not to report PI data and allow the automatic small practice PI hardship to apply.

If you do report 2023 data, PI will comprise 25% of your MIPS final score.

ANATOMY IT

Small Practices Not Scored on Cost

Cost category weight will be redistributed to the Quality and PI categories.

Quality (55% of Score)

Fully report 6 measures, including 1 outcome measure.

Each measure must:

- Be reported on at least 70% of denominator-eligible patients AND with at least 20 patients in the denominator
- Average at least 5.6 out of 10 points*

Improvement Activities (15% of Score)

Perform 1 high-weighted OR 2 medium-weighted activities for 90+ consecutive days.

If group reporting, at least 50% of eligible clinicians must complete the same activity or activities.

Promoting Interoperability (30% of Score)

If you're a small practice without 2015 Edition Cures Update certified EHR, you can choose not to report PI data and allow the automatic small practice PI hardship to apply.

If you choose not to report 2023 PI data, Quality and IA will both be 50%.

*Quality calculation assumes a score of 80 out of 100 in PI.

ANATOMY IT

Small Practices Scored on All Categories

Quality (30% of Score)

Fully report 6 measures, including 1 outcome measure.

Each measure must:

- Be reported on at least 70% of denominator-eligible patients AND with at least 20 patients in the denominator
- Average at least 6.5 out of 10 points*

Improvement Activities (15% of Score)

Perform 1 high-weighted OR 2 medium-weighted activities for 90+ consecutive days.

If group reporting, at least 50% of eligible clinicians must complete the same activity or activities.

Cost (30% of Score)

If you meet the case minimum for any of the Cost measures, you will be scored on Cost.

Keep in mind that, if you have NPs or PAs billing under your TIN, you will likely be scored on TPCC at the group level.

*All cost scores are unpredictable; the Quality calculation assumes a 50% score in Cost.

Promoting Interoperability (25% of Score)

If you're a small practice without 2015 Edition Cures Update certified EHR, you can choose not to report PI data and allow the automatic small practice PI hardship to apply.

If you choose not to report 2023 PI data, PI category weight will be redistributed to Quality and IA.

ANATOMY IT

Avoiding a Penalty Large Practices

Large Practices Not Scored on Cost or PI

Cost and PI category weight will be redistributed to the Quality categories.

Quality (85% of Score)

Fully report 6 measures, including 1 outcome measure.

Each measure must:

- Be reported on at least 70% of denominator-eligible patients AND with at least 20 patients in the denominator
- Average at least 7.1 out of 10 points

Improvement Activities (15% of Score)

Perform 2 high-weighted OR 4 medium-weighted OR 1 high-weighted and 2 medium-weighted activities for 90+ consecutive days.

If group reporting, at least 50% of eligible clinicians must complete the same activity or activities.

Promoting Interoperability (0%)

If you do not have a 2015 Edition Cures Update certified EHR, apply for the PI hardship reweighting by Dec. 31, 2023.

If you do not receive a hardship, PI will comprise 30% of your MIPS final score; Quality would be 55% and IA 15%.

ANATOMY IT

Large Practices Not Scored on PI

PI category weight will be redistributed to the Quality category.

Quality (55% of Score)

Fully report 6 measures, including 1 outcome measure.

Each measure must:

- Be reported on at least 70% of denominator-eligible patients AND with at least 20 patients in the denominator
- Average at least 8.2 out of 10 points*

Improvement Activities (15% of Score)

Perform 2 high-weighted OR 4 medium-weighted OR 1 high-weighted and 2 medium-weighted activities for 90+ consecutive days.

If group reporting, at least 50% of eligible clinicians must complete the same activity or activities.

Cost (30% of Score)

If you meet the case minimum for any of the Cost measures, you will be scored on Cost.

Keep in mind that, if you have NPs or PAs billing under your TIN, you will likely be scored on TPCC at the group level.

*All cost scores are unpredictable; the Quality calculation assumes a 50% score in Cost.

Promoting Interoperability (0%)

If you do not have a 2015 Edition Cures Update certified EHR, apply for the PI hardship reweighting by Dec. 31, 2023.

If you do not receive a hardship, PI will comprise 25% of your MIPS final score.

Large Practices Not Scored on Cost

Cost category weight will be redistributed to the Quality and PI categories.

Quality (55% of Score)

Fully report 6 measures, including 1 outcome measure.

Each measure must:

- Be reported on at least 70% of denominator-eligible patients AND with at least 20 patients in the denominator
- Average at least 6.6 out of 10 points*

Improvement Activities (15% of Score)

Perform 2 high-weighted OR 4 medium-weighted OR 1 high-weighted and 2 medium-weighted activities for 90+ consecutive days.

If group reporting, at least 50% of eligible clinicians must complete the same activity or activities.

Promoting Interoperability (30% of Score)

If you do not have a 2015 Edition Cures Update certified EHR, apply for the PI hardship reweighting by Dec. 31, 2023.

If you receive a hardship, Quality will be 85%.

*Quality calculation assumes a score of 80 out of 100 in PI.

ANATOMY IT

Large Practices Scored on All Categories

Quality (30% of Score)

Fully report 6 measures, including 1 outcome measure.

Each measure must:

- Be reported on at least 70% of denominator-eligible patients AND with at least 20 patients in the denominator
- Average at least 8.33 out of 10 points*

Improvement Activities (15% of Score)

Perform 2 high-weighted OR 4 medium-weighted OR 1 high-weighted and 2 medium-weighted activities for 90+ consecutive days.

If group reporting, at least 50% of eligible clinicians must complete the same activity or activities.

Cost (30% of Score)

If you meet the case minimum for any of the Cost measures, you will be scored on Cost.

Keep in mind that, if you have NPs or PAs billing under your TIN, you will likely be scored on TPCC at the group level.

*All cost scores are unpredictable; the Quality calculation assumes a 50% score in Cost.

Promoting Interoperability (25% of Score)

If you do not have a 2015 Edition Cures Update certified EHR, apply for the PI hardship reweighting by Dec. 31, 2023.

If you do receive a hardship, Quality will be 55%.

*Quality calculation assumes a score of 80 out of 100 in PI.

ANATOMY IT

Appendix A

2023 Cost Measures and Case Minimums

Measure Name	Measure Type	Case Minimum
Total Per Capital Cost (TPCC)	Population-based. Assesses the overall cost of care delivered to a Medicare patient with a focus on primary care received.	20 Medicare patients (Medicare Parts A and B)
Medicare Spending Per Beneficiary (MSPB)	Episode-based Cost of care for services related to qualifying inpatient hospital stays (immediately prior to, during, and after) for a Medicare patient.	35 episodes (Medicare Parts A and B)
Acute Kidney Injury Requiring New Inpatient Dialysis	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Episode-based Chronic Condition	20 episodes (Medicare Parts A, B, and D)
Colon and Rectal Resection	Episode-based Procedural	20 episodes (Medicare Parts A and B)
Diabetes	Episode-based Chronic Condition	20 episodes (Medicare Parts A, B, and D)
Elective Outpatient Percutaneous Coronary Intervention	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Elective Primary Hip Arthroplasty	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Femoral or Inguinal Hernia Repair	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Hemodialysis Access Creation	Episode-based Procedural	10 episodes (Medicare Parts A and B)

Inpatient COPD Exacerbation	Episode-based Acute Inpatient Medical Condition	20 episodes (Medicare Parts A and B)
Intracranial Hemorrhage or Cerebral Infarction	Episode-based Acute Inpatient Medical Condition	20 episodes (Medicare Parts A and B)
Knee Arthroplasty	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Lower GI Hemorrhage (applies to groups only)	Episode-based Acute Inpatient Medical Condition	20 episodes (Medicare Parts A and B)
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Lumpectomy Partial Mastectomy, Simple Mastectomy	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Melanoma Resection	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Non-Emergent Coronary Artery Bypass Graft	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Renal or Ureteral Stone Surgical Treatment	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Routine Cataract Removal with IOL Implantation	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Screening/Surveillance Colonoscopy	Episode-based Procedural	10 episodes (Medicare Parts A and B)
Sepsis	Episode-based Acute Inpatient Medical Condition	20 episodes (Medicare Parts A, B, and D)
Simple Pneumonia with Hospitalization	Episode-based Acute Inpatient Medical Condition	20 episodes (Medicare Parts A and B)
STEMI with Percutaneous Coronary Intervention	Episode-based Acute Inpatient Medical Condition	20 episodes (Medicare Parts A and B)

ANATOMY IT