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MIPS Extreme and Uncontrollable circumstances Application for Program Year 2019 for Payment Year 2021



MIPS-eligible clinicians who are impacted by extreme and uncontrollable circumstances may submit a request for reweighting of the Quality, Cost, Promoting Interoperability and Improvement Activities performance categories. "Extreme and uncontrollable circumstances" are defined as rare events (highly unlikely to occur in a given year) entirely outside your control and the facility in which you practice.

Group, Individual, or Virtual Group Application

-- None --

Submit

Individual:

Group, Individual, or Virtual Group Application

Individual

* Clinician NPI

* Clinician First Name

* Clinician Last Name

* Group Practice Name

-- None --

Individual- 'Group Not Listed' selected:

Group, Individual, or Virtual Group Application

Individual

* Clinician NPI

* Clinician First Name

* Clinician Last Name

* Group Practice Name

Group NOT Listed

* Group TIN

Group:

Group, Individual, or Virtual Group Application

Group ▼

* Group TIN

Virtual Group:

Group, Individual, or Virtual Group Application

Virtual Group ▼

* Virtual Group ID

Submitter/Third Party Intermediary:

Section 1: Submitter/Third Party Intermediary Information

▼ More information

Provide the information below for the person working on behalf of the clinicians.

All return correspondence will be sent to the contact listed in section 1 (Fields marked with * are required.)

* Submitter/Third Party Intermediary First Name

* Submitter/Third Party Intermediary Last Name

Company or Organization Name

* Submitter/Third Party Intermediary Email (This is how we will communicate with you.)

* Submitter/Third Party Intermediary Business Telephone Number (Include Area Code)

Extension

* Submitter/Third Party Intermediary Relationship

-- None -- ▼

* I certify that I am authorized by the clinician or group identified above to submit this application on behalf of the clinician or group

Form:

Extreme and Uncontrollable Circumstances

▼ More information

In order to be approved, the clinician(s) must attest to facing extreme and uncontrollable circumstances that impacted the availability and applicability of measures for the impacted performance category or categories.

On behalf of the clinician(s) listed in this application, I am requesting this exception and attest that the clinician(s) faced extreme and uncontrollable circumstances as described below.

Period of time of the extreme and uncontrollable event (MM/DD/YYYY) to (MM/DD/YYYY).

Disaster

Start Date

End Date

Please describe the type of event and other pertinent details that impacted the availability and applicability of measures for impacted performance categories

Performance Categories

▼ More information

Please select all performance categories impacted by an extreme and uncontrollable event

- Quality
- Improvement Activities
- Promoting Interoperability
- Cost

CERTIFICATION STATEMENT FOR QPP APPLICATION

▼ GENERAL NOTICE

Failure to provide information necessary for clinician identification may result in processing delays or denial of the Quality Payment Program MIPS Extreme and Uncontrollable Circumstance Application.

CERTIFICATION OF CLINICIAN or CLINICIAN REPRESENTATIVE: By submitting this application, I certify that the information contained in this application is true, accurate, and complete to the best of my knowledge, information and belief. If I become aware that any information contained in this application is not true, accurate, and complete, I will inform CMS promptly. I understand that:

- Approval of this MIPS Extreme and Uncontrollable Circumstance Application for the Quality Payment Program may result in a change in the amount the clinician will be paid from Federal funds.
- Any person who knowingly files a claim or statement containing any false, incomplete, or misleading information, including the concealment of a material fact, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil penalties

I hereby agree to keep all records related to this MIPS Extreme and Uncontrollable Circumstance Application and to furnish them upon request by the Department of Health and Human Services or to a contractor acting on its behalf.

CERTIFICATION OF THIRD PARTY INTERMEDIARY AUTHORIZED TO SUBMIT DATA ON BEHALF OF CLINICIAN(S): By submitting this application, I certify that I am submitting this MIPS Extreme and Uncontrollable Circumstance Application on behalf of the clinician(s) that has (have) given me authority to act as agent. I certify that the information contained herein is true, accurate, and complete to the best of my knowledge, information, and belief. If I become aware that any information contained in this application is not true, accurate, and complete, I will inform CMS promptly. I understand that any person who knowingly files a claim or statement containing any false, incomplete, or misleading information, including the concealment of a material fact, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil penalties. I hereby agree to keep all records related to this MIPS Extreme and Uncontrollable Circumstance Application and to furnish them upon request by the Department of Health and Human Services or to a contractor acting on its behalf.

NOTICE: Under section 1128J of the Social Security Act, a person or entity must tell us if it believes it has been overpaid by Medicare, including under the Quality Payment Program. Failure to make such a disclosure may result in liability under the False Claims Act (31 U.S.C. § 3729 et seq.) and other Federal laws.

* Certify

Date

* Name of individual completing form

Submit

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1314 (Expiration date: XX/XX/XXXX). The time required to complete this information collection is estimated to average 0.25 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact QPP at qpp@cms.hhs.gov.