MIPS Claims-based Reporting

2019

The **Medicare Access and CHIP Reauthorization Act (MACRA)** of 2015 established the Quality Payment Program, which includes the **Merit-based Incentive Payment System (MIPS)**. Eligible clinicians (ECs) who are in a small practice (15 or fewer clinicians), are not part of an alternative payment model (APM) and do not have an electronic health record (EHR) or have a non-certified EHR, can report MIPS Quality data to CMS via claims. Reporting the minimum required data of 30 points will enable that EC to avoid a negative payment adjustment on Medicare Part B revenue in 2021.

1 Determine Claims-based Measure(s) to Report

Your Quality Plan

Using the search function, choose at least six quality measures from the 2019 Measures List in the CMS Resource Library at this link.

https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2019#measures

- Sort the list by **Measure Type** and **Specialty Measure Set**
- Select **Claims** for the Collection Type and the 2019 measure list will populate
- Download your favorites to a list by clicking on **+ ADD TO LIST**

2 Find the Measure Specification Sheets for Your Measures

Quality Measure Specifications

Locate the measure specification sheet for each measure you have selected by searching **specification** in the QPP Full Resource Library search tool at https://qpp.cms.gov/about/resource-library and selecting **2019 Medicare Part B Claims Measure Specifications and Supporting Documents.** From the **Specifications** file, select the specifications you need by Quality ID#.

Important: Thoroughly read the **Quality Measure specification sheet(s)** and **Measures Guide** which is in the 2019 supporting documents folder.

- Identify the patient populations to include (for claims, this is **Medicare Part B** patients only)
- Abstract all the codes and descriptors assigned to each measure you will report
- Create a **Quality Coding Summary** using all of the codes listed (see sample next page). Review your summary carefully and check for accuracy, any errors will result in a lack of data submission and may affect your payment adjustment.
- Identify what documentation is required in the medical record to support each measure

3 Enlist Your Billing Company and Staff Into Your Quality Plan

Staff/Billing Readiness and Documentation

If you code manually: Create a **quality coding sheet** or add the codes and descriptors to your **encounter form/superbill**. Share the code list with your billing vendor so they can activate the codes.

If you code in your EHR: Work with your vendor to activate and/or map these codes into your EHR

- CMS strongly suggests a **$.01 fee amount** to enable quality codes to populate claims.
- Run some test claims to make sure the codes are dropping to the **electronic** CMS 1500 claim form & check your EOMB for quality code processing.
- Educate all providers and staff to engage them in capturing and recording quality data , which includes documenting in the medical record to support the *met* and *excluded* codes reported.

Quality Improvement Organizations
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Administered By Healthcentric Advisors in Partnership with Qualidigm

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2019 Claims-based Quality Measure Coding Summary – SAMPLE

Breast Cancer Screening #112 Mammogram at least once in 27 months for Women 51-74	☐ G9708 – bilateral mastectomy (excluded) ☐ G9709 – Hospice services during measure period (excluded) ☐ **G9898 -** Patients age 65 or older in Institutional (Special Needs Plans) SNP or residing in long term care with POS code 32, 33, 34, 35 or 56 any time during the measurement period (excluded) ☐ **G9899 -** Screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammography results documented and reviewed (met) ☐ **G9900 -** Screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammography results were not documented and reviewed, reason not otherwise specified (unmet)
Colon Cancer screening #113 Patients 50-75 with one or more colon cancer screenings per performance period	☐ G9710 - Hospice services during measure period (excluded) ☐ G9711 –Past history of colorectal cancer or total colectomy (excluded) ☐ **G9901 -** Patients age 65 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54 or 56 during the measurement period (excluded) ☐ 3017F – Colon cancer screening results documented & reviewed (met) ☐ 3017F 8P – Colon ca screening not documented without reason (unmet)
Diabetes Eye Exam #117 Patients 18 - 75 years with diabetes who had a retinal or dilated eye exam or a negative retinal or dilated eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period	☐ 2022F - Dilated retinal eye exam with interpretation performed (met) ☐ 2024F - Seven standard field stereoscopic photos with interpretation performed (met) ☐ 2026F - Eye imaging validated to match diagnosis from seven standard field stereoscopic photos (met) ☐ 3072F - Low risk for retinopathy (no evidence of retinopathy in the prior year)* ☐ 2022F, 2024F, 2026F with modifier 8P - Dilated eye exam was not performed, reason not otherwise specified (unmet) ☐ G9714 - Patient is using hospice services any time during the measurement period (exempt) Include the diabetes diagnosis (ICD-10) on the claim along with any other diagnoses.
BMI #128 Patients 18+ with a BMI outside normal parameters (+/-) with a f/u plan (minimum of once per performance period)	☐ G8422 – BMI not documented; patient excluded (pregnant/ Hospice, etc) ☐ G8938 – abnormal BMI documented; patient excluded ☐ G8420 – BMI normal (met) ☐ G8417 –BMI above normal; f/u plan documented (met) ☐ G8418 – BMI below normal; f/u plan documented (met) ☐ G9716 – abnormal BMI; f/u plan not done for specified reason (met) ☐ G8421 – BMI not documented; no reason given (unmet) ☐ G8419 – abnormal BMI documented; no plan; no reason given (unmet)
Documentation of current medications in the medical record #130 Document all known prescriptions, OTC, herbals, vitamins with dosage & route for patients 18+	☐ G8427 – Current medications with name, dosage, frequency and route documented; or patient on no medications (met) ☐ G8430 – Current medications not documented; patient excluded i.e., emergent medical issue (excluded) ☐ G8428 – Current medications with name, dosage, frequency and route not documented; reason not given (unmet) Report at each visit except post-surgical CPT 99024
Pain Assessment & Follow-Up #131 Patients aged 18+ years with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	☐ G8730 - Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented (met) ☐ G8731 - Pain assessment using a standardized tool is documented as negative, no follow-up plan required (met) ☐ G8442 - Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool (exempt) ☐ G8939 - Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible (exempt) ☐ G8732 - No documentation of pain assessment, reason not given (unmet) ☐ G8509 - Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given (unmet)

Unsure of how you should prepare to report or what you need to do now?

Contact the NE QIN-QIO for personalized support at: http://neqpp.org/ask-question/support-team/

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