MIPS Reporting for Skilled Nursing Facilities 2018

The **Medicare Access and CHIP Reauthorization Act (MACRA)** of 2015 established the Quality Payment Program, which includes the **Merit-based Incentive Payment System (MIPS)**. In MIPS Performance Year 2, clinicians and groups who submit more than $90,000 in Medicare Part B claims and care for 200 or more Medicare Beneficiaries annually are eligible to report. Clinicians working in Skilled Nursing Facilities who are eligible for MIPS reporting can take the steps below to prepare and report for MIPS Performance Year 2.

1

Determine Quality Measure Selection

Your Quality Measure Selection

ECs and groups are encouraged to select the quality measures that are most appropriate for their practice and patient population.
Be sure to check the measure specification (instructions below) to see if…

- It can be reported using the chosen data submission method
- Meets the requirement for an outcome or high priority measure
- EC or group sees patients that fall within the specified population

** Please note that on Page 2 of this document, you will find quality measures along with encounter codes and applicable data submission methods.

2

Find the Measure Specification Sheets for Your Measures

Quality Measure Specifications

Once a quality measure(s) have been selected, review the Quality Measure Specification zip file on the CMS website resources webpage, https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html. On this webpage you will find a set of **Claims-Registry-Measure** sheets. Locate the measure specification sheet(s) by Quality ID #, being sure to select the sheet(s) specific to **claims if reporting via claims or select registry if reporting via registry or EHR.**

- The quality measure specification sheets assist in identifying the appropriate documentation required to support the measure selected to report. The measure specification sheets also define the numerator and denominator patient population for each measure differently.
- If you are reporting via claims, the measure specification sheets identify the eligible encounter codes (CPT/HCPCS) and applicable G-Codes for the measures being reported.

3

Other SNF reporting requirements

Other SNF Reporting Requirements

For Skilled Nursing Facilities, the performance category weighting is as follows:

- **Quality – 50%**
- **Advancing Care Information (ACI) – 25%**
- **Improvement Activities (IA) – 15%**
- **Cost – 10%**

Hospital based clinicians , which are those who furnish at least 75% of their eligible services in POS 21, 22, 23, do not have to report for the Advancing Care Information performance category. However, clinicians who provide a significant amount of services (>25%) to patients in skilled nursing facilities (SNF – POS 31) will be required to report Advancing Care Information performance category.

NEW ENGLAND QUALITY INNOVATION NETWORK
Administered By Healthcentric Advisors in Partnership with Qualidigm

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2018 SNF SAMPLE Measures with Codes and Submission Methods

Diabetes #1 Patients 18-75 with DM ; hemoglobin A1c > 9.0%	☐ G9687 - Hospice services during measure period (excluded) ☐ 3046F - HbA1c > 9.0 % (met) ☐ 3046F 8P - HbA1c not performed during performance period (not met) ☐ 3044F – Most recent HbA1c less than 7.0% (not met) ☐ 3045F – Most recent HbA1c 7.0 to 9.0% (not met)	Evaluation and Management Codes: ✓ Initial visit – 99304-99306 ✓ Subsequent visit – 99307-99310, 99315, 99316, 99318 Data Submission Methods: ☐ Claims ☐ EHR
Care Plan: Advanced Care Planning #47 Patients 65+ with ACP or surrogate, or did not wish to provide	☐ 1123F – ACP discussed and documented (met) ☐ 1124F – ACP discussed and documented; patient declined (met) ☐ 1123F 8P – ACP not documented; no reason specified (unmet)	Evaluation and Management Codes: ✓ Initial visit – 99304-99306 ✓ Subsequent visit – 99307-99310 Data Submission Methods: ☐ Claims ☐ Registry
Influenza Vaccination #110 Patients 6mos+ flu shot Oct 1st – Mar 31st or previously done	☐ G8482 – Flu shot administered/previously received (met) ☐ G8483 – Flu shot not given; reason documented (met) ☐ G8484 – Flu shot not given; reason not documented (unmet)	Evaluation and Management Codes: ✓ Initial visit – 99304-99306 ✓ Subsequent visit – 99307-99310, 99315, 99316 Data Submission Methods: ☐ Claims ☐ EHR
Elder Maltreatment #181 Patients 65+ with documented elder maltreatment screen using a screening tool and documented follow-up plan	☐ G8535- screening not documented; patient not eligible (excluded) ☐ G8941- screening documented as positive, follow up plan not documented; patient not eligible (excluded) ☐ G8733 –screening documented as positive AND follow up plan documented (met) ☐ G8734- screening documented as negative, follow up not required (met) ☐ G8536- No screening, reason not given (unmet) ☐ G8735- screening documented as positive, follow up plan not documented, reason not given (unmet)	Evaluation and Management Codes: ✓ Initial visit – 99304-99306 ✓ Subsequent visit – 99307-99310, 99318 Data Submission Methods: ☐ Claims ☐ Registry
Falls: Risk Assessment #154 Fall risk assessment for patients 65+ who have a history of falls (1 fall with injury or 2 falls w/o injury within the past year)	☐ G9718 - Hospice services during measure period (excluded) ☐ 1101F – One fall w/o injury or no falls within 1 year reported (excluded) ☐ 1101F 8P – Fall status not documented (excluded) **For Patients with Fall Risk - one fall with injury or two+ falls within 1 year** (two codes needed) ☐ 3288F – Fall risk assessed (met) ☐ 3288F 1P - Fall risk not assessed; medical reasons (excluded) ☐ 3288F 8P – Fall risk not assessed; no reason (unmet) ✓ + 1100F – one fall with injury or two+ falls within 1 year *Also document falls plan of care status below:*	Evaluation and Management Codes: ✓ Initial visit – 99304-99306 ✓ Subsequent visit – 99307-99310, Data Submission Methods: ☐ Claims ☐ Registry
Falls: Plan of Care #155 For all patients 65+ with a history of falls (in measure 154)	☐ G9720 - Hospice services during measure period (excluded) ☐ 0518F – Falls plan of care documented (met) ☐ 0518F 1P – Falls plan of care not done, medical reasons (excluded) ☐ 0518F 8P – Falls plan of care not documented, no reason (unmet)	Evaluation and Management Codes: ✓ Initial visit – 99304-99306 ✓ Subsequent visit – 99307-99310 Data Submission Methods: ☐ Claims ☐ Registry