A Review of MIPS (PQRS, Value-Based Modifiers, & MU) For 2017 and beyond

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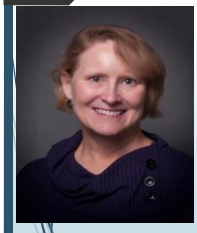
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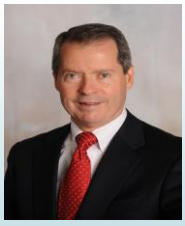
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What We Will Cover

- Brief overview
- MIPS 2017 and beyond
- MIPS 2017 +vs Previous PQRS 2016
- MIPS 2017 + vs Previous EHR & CQM 2016
- MIPS 2017 + vs Previous Value Based Modifiers 2016
- Successes and Penalties
- Other related information
- Resources

Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

The Merit-based Incentive Payment System (MIPS) or **Advanced Alternative Payment Models (APMs)**

- ✓ First step to a fresh start
- ✓ We're listening and help is available
- ✓ A better, smarter Medicare for healthier people
- ✓ Pay for what works to create a Medicare that is enduring
- ✓ Health information needs to be open, flexible, and user-centric

Merit-based Incentive Payment System

- ✓ **MIPS is a new program**
  - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
  - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**

Quality — PQRS

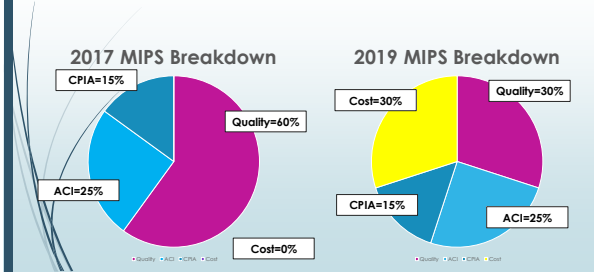
Resource use — Value Based Modifier

Clinical practice improvement activities — New

Advancing care information — EHR Incentive

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Merit-based Incentive Payment System



MIPS Reporting Options

First option –

- Report some data
  - One measure in the quality performance category

  OR
  - One activity in the improvement activities performance category
- **Avoid negative MIPS payment adjustment**

OR

- Choose to **not report even one measure** or activity and receive full negative 4% adjustment

MIPS Reporting Options

Second option

- Report MIPS for < full 2017 performance period but >/= 90day period
- Report > 1 quality measure

OR

- Report > 1 improvement activity

OR

- Report > required measures in advancing care information performance category

Avoid negative adjustment and MAY receive modest bonus

MIPS Reporting Options

Third option -

- Report fully => 90-day period full year to maximize chances to qualify for positive adjustment
- If exceptional are eligible for an additional positive adjustment

Report for full year provides = "moderate" positive payment adjustment

Incentive to participate fully during transition year:

IF achieve final score of 70 or higher = eligible for exceptional performance adjustment (funded from a pool of $500 million)

MIPS Reporting Options

Fourth option

- Advanced APM participation = qualify for 5% bonus in 2019
- Not really viable option for most Optometrist

MIPS Exclusions

Exclusions

Can report voluntarily to reporting but won't receive any money

Newly enrolled Medicare clinicians	Low threshold	APM participants
Has not submitted claims under any group prior to performance period	<$30k in Medicare billing ***OR*** <100 Part B patients	Qualifying participants (QPs) Partial qualifying participants who opt not to report MIPS

NOTE: MIPS does not apply to hospitals or facilities

Low Volume Exclusions

- $30,000 or fewer than 100 Medicare patients
- Two evaluation periods:
  - September 1, 2015 to August 31, 2016
  - September 1, 2016 to August 31, 2017
- CMS estimates that 67% of OD's may be exempt
- NPI look-up:
  - Mechanism to see if an given NPI is exempt

When does the Quality Payment Program start?

JAN 1 → OCT 2

If you're ready, you can begin January 1, 2017 and start collecting your performance data. If you're not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you'll need to send in your performance data by March 31, 2018.

The first payment adjustments based on performance go into effect on January 1, 2019.

2018: **90% of Medicare** payments tied to quality.

2020: **75% of commercial** plans will be value-based.

U.S. Department of Health & Human Services

Jan 2015: http://www.hhs.gov/news/press/2015pres/01/20150126a.html

AOA MORE Participation

- Free to AOA members
- Works via your EHR, if one listed on AOA MORE website
- Eases this process

HOWEVER

- Can still participate in MIPS if not EHR
- Can still participate on MIPS if not using EHR contracted with AOA MORE
- Can still participate in MIPS even if exempt- important for practice
  - No way to know how long exemptions will last

Let's dive into how to participate for those with and without Certified EHR Technology (CEHRT)

For MORE information:

Visit www.aoa.org/MORE

AOA MORE
MEASURES AND OUTCOMES REGISTRY FOR EYECARE
BY PROMETHEUS | RESEARCH

MIPS Quality Reporting

- PQRI/PQRS Began 2007 - Pay for Reporting Paying 2% bonus
- Now participate to avoid 2% reduction in 2018
- PQRS ended in 2016
- **Stand alone PQRS program penalties ending in 2018**
- **MIPS participation/reporting begins 2017**
  - **Penalties begin - 2019**
- MIPS incorporating many PQRS requirements in Quality portion
- **Quality portion of MIPS counts 60%**

Quality Reporting Options

1. **Claims based reporting**
2. **Qualified Clinical Data registry reporting**

   AOA MORE Qualified Clinical Data registry – Ability to submit data depends on your EHR's status with AOA MORE
3. **Qualified Registry**
4. **Certified Electronic Health Records Reporting (CEHRT)**
5. **Group practice reporting**
   a) Web interface (25+ EPs in Group)
   b) Group registry reporting (2+ EPs)
   c) CMS-certified survey vendor reporting (2+ EPs)
   d) EHR – direct or data submission (2+ EPs)

Quality Reporting Options

- **Electronic Health Records**
  - Click on the correct boxes per patient
  - Run report Quality Measures Report
  - Submit through CMS portal
- **AOA MORE Registry**
  - Through registry step by step process
- **Claims based reporting**
  - Report Quality Codes on 50%+ of applicable Medicare patients via claim

Quality Reporting AOA MORE

- Automatic reporting but patient minimums for Quality Measures
  - Minimum of 20 patients per Quality Measure
    - To achieve highest MIPS scores, 20+ patients
    - Can still acquire some points if < 20 patients
- Do not have minimum number of patients for a specific measure?
- Consider choosing a different measure

Quality Reporting AOA MORE

Required 5 measures + 1 outcome
Bonus:
1 extra Outcomes =2 point
1extra High Priority =1 point

Regular measures
! High priority measures
!! Outcomes measures

- DM eye exam (no retinopathy)*
- Diabetic Retinopathy
- Diabetic Ret letter to PCP!
- POAG*
- AMD exam*
- AMD AREDS counseling*
- Document meds!
- BMI measure
- BP Screening
- Close the referral loop!
- Tobacco Screening/Cessation*
- POAG 15% reduction!!
- BP control!!
- A1c control!!

Pick 1 High Priority

Pick 1 Outcomes

Pick 5 others

AMERICAN OPTOMETRIC ASSOCIATION

AOA MORE

2017 Quality Eye Care Measures

- **Measure 12** –Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation – *Claims, Registry, EHR*
- **Measure 14** – Age-Related Macular Degeneration (AMD): Dilated Macular Examination – *Claims, Registry*
- **Measure 19** – Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care - *Claims, Registry, EHR* ***High Priority-bonus eligible***
- **Measure 117** – Diabetes mellitus: Dilated Eye Exam in Diabetic Patient – *Claims, Registry, EHR, Web Interface*
- **Measure 140** – Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement – *Claims, Registry*
- ***Measure 141** – Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care – *Claims, Registry*

* ***Outcomes Measure***

2017 Quality Eye Care Measures

- **Measure 18** – Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

** EHR reporting Only still, not claims based

- 8 Other Eye care measures for registry or EHR
  - BUT surgeons only
  - 6 for cataract & 2 for retina
- Do not allow use of -55 modifier

2017 Quality Eye Care Measures

5 Measures that allow use with 92000/99000 codes

- **Measure 130** Documentation of Current Medications in the Medical Record – *Claims, Registry, EHR* ***High Priority-bonus eligible***
- **Measure 131** Pain Assessment and Follow up – *Claims, Registry*
- **Measure 226** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention – *Claims, Registry, EHR, Web Interface*
- **Measure 317** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented – *Claims, Registry, EHR*

Report as diagnosis indicates or on every claim when not linked to diagnosis

2017 Quality Eye Care Measures

Other possibilities BUT NOT allowed with 92000

- **Measure110** Preventive Care and Screening: Influenza Immunization – *Claims, Registry, EHR, Web Interface*
- **Measure111** Pneumonia Vaccination Status for Older Adults – *Claims, Registry, Web Interface*
- **Measure128** Preventive Care and Screening: Body Mass Index (BMI) Screening &FU – *Claims, Registry, EHR, Web Interface*
- **Measure 236** Controlling High Blood Pressure – *Claims*
  High Priority- bonus eligible

Other Measures …BUT NOT Allowed with Claims Reporting

- **Measure 1** Diabetes: Ha1c Poor Control – *Registry*
  High Priority-bonus eligible
- **Measure 173** Preventive Care and Screening: Unhealthy Alcohol Use Screening – *Registry*
- **Measure 374** Closing the Referral loop: Receipt of specialist Report – *EHR* ***High Priority-bonus eligible***

Just for clarification, these measures are **NOT** available for claims only reporting but would be available for Registry and/or EHR reporting

2017 MIPS Quality Performance Category

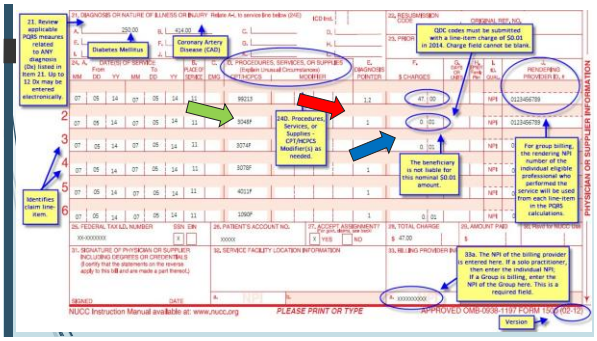
- Self reported
- Six (6) measures including **1 outcome measure**
- **Report on 50% or more of appropriate claims**
  - #236 Controlling HTN may be an option (99000 only)
  - No domain requirements
  - Population measures automatically calculated
  - Extra bonus if report extra outcome or high priority measure
- Will Count **60%** of total MIPS score in 2017

Claims: Quality Reporting Hints

- Track all claims submitted with quality codes
- Look for quality code line item denial codes
- Ensure Provider NPI attached to each line item including quality code line items
- If need to submit corrected claims-include quality codes
  - BUT cannot re-file only to add quality codes
- More details later BUT:
- Use 8P modifier judiciously – do not use this modifier just to avoid performing the measure requirements!

Claims - Quality Reporting Hints

- Current CMS 1500 form has 12 diagnosis places
- Current electronic claim has 12 diagnosis places
- **Link only 1 diagnosis per quality code even if more Dx apply**
- CMS analyzes claims data using ALL diagnoses from the base claim and service codes for each individual claim and provider (if multiple providers on one claim)



Claims Quality Reporting

Claims Reporting with Quality Data Codes (QDCs)

- CPT II codes
  - Performance codes developed by CPT
  - If implemented before published in CPT book – posted on line
  - Not all published CPT II codes utilized for Quality Reporting (2022F, 4177F, 2019F, 2027F, 5010F, 0517F etc)
- HCPCS G codes used when:
  - Measures without published CPT II codes
  - Measures required to share CPT II codes (G8397, G8398, etc)

Claims Quality Reporting Basics

- Numerator
  - Appropriate QDC(s)
    - CPT II codes
    - HCPCS G codes
- Denominator
  - CPT I codes (E&M; General Ophthalmic codes)
  - Any appropriate diagnosis indicated
  - Additional factors such as age and frequency

Exceptions Modifiers

What if measure cannot be completed?

- When you file one of the appropriate diagnoses along with one of the appropriate E&M codes, you must still report to be counted or it will count against you
- **Use modifiers**
  - **1P: medical reason**
  - **2P: patient reason**
  - **8P: other reason**
- Important to use these exception modifiers judiciously and not just to avoid performing measure, especially 8P

Claims Quality Reporting

- If you report an evaluation & management code – 99201-99205 or 99212-99215

OR

- If you report a general ophthalmic service code – 92004, 92014, 92002, 92012

ANY OF THESE CODES - THINK Quality Reporting

No other procedure codes are considered

Nursing Home/Rest Home and other E&M codes eligible as well but will not discuss today.

Claims Quality Reporting

- Three Conditions To Think About:
  - Age Related Macular Degeneration
  - Primary Open Angle Glaucoma
  - Diabetes: Insulin and Non-insulin Dependent
- ANY OF THESE … THINK MIPS Quality Reporting
- Only a few changes to measures from previous PQRS reporting

Claims Quality Reporting

If you have the diagnosis and examination code:

The only step left is to add the QDC

Must add QDC to every Medicare claim WHEN the diagnosis and examination code is appropriate for the measure

Currently traditional Medicare and Railroad Medicare claims only

HOWEVER, many private payor, including Medicare Advantage plans may be rolling out their version of MIPS so ensure you know the requirements for the plans in your area!

If you do this consistently, you will not be penalized and could earn a bonus!

Claims Quality Reporting

Rule of thumb:

- Use QDC every time you have diagnosis and encounter code (with modifiers if needed) or will count against you!

AND

- If chose an additional measure high priority or outcomes measure, add when appropriate to standard Medicare or Railroad Medicare claims
- Pay close attention to the diagnosis, procedure codes and age for each measure since diagnosis code and age were two major areas for error in previous years

Claims Quality Reporting 2017 Recommendations

- **Measure 12** –Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
- **Measure 14** – Age-Related Macular Degeneration (AMD): Dilated Macular Examination
- **Measure 19** – Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care ***High Priority-bonus eligible***
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- ***Measure 141** – Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

  * ***Outcomes Measure***
- **Measure 130** Documentation of Current Medications in the Medical Record

  High Priority-bonus eligible
- **Measure 226** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Claims Quality Reporting 2017

Discussion of the details!!

Age Related Macular Degeneration

- Any of diagnosis codes for Non-exudative or exudative ARMD: H35.3110 to H35.3233
- Patient age **50 and older**
- Two PQRS measures to use

- USE **2019F (measure #14)**
- USE **4177F (measure #140)**

ARMD

- **2019F**:
  - **Dilated** view of macula
  - **Document** +/- macular thickening and +/- hemorrhages and level of severity-mild moderate severe
    - You must dilate and record finding
    - Report at least once per reporting period

Exclusions:

- **1P** Medical reason for no dilated macula view
- **2P** Patient reason for no dilated macula view
- **8P** Other reason for no dilated macula view

AOA Advice:

REPORT EVERY TIME USE ARMD DIAGNOSIS CODES AND EXAMINATION CODE

ARMD

4177F:

- Discussed pros and cons of AREDS
- Made proper recommendations for individual
- Documented discussion

Discuss and record your recommendation at least once per reporting period for each unique patient …

Exclusions - 8P No reason for not discussing AREDS

AOA ADVICE:

REPORT EVERY TIME you use ARMD diagnosis and examination code
If already on AREDS, assumption is you have already discussed

ARMD Exceptions and Summary

SUMMARY FOR ARMD

Report 2019F and 4177F on every claim when the diagnosis code is ARMD and the examination code is 92000 or 99000 code

Link only to ONE of your ARMD codes if you have more than one on claim.

For Example:

a. H35.3111 b. H35.3123

92014 Link to a AND b

2019F Link only to a OR b <u>but NOT both</u>

4177F Link only to a OR b <u>but NOT both</u>

Glaucoma – Primary Open Angle

- Two PQRS measures to be used
  - Use **2027F** (optic nerve evaluation)(Measure #12)
  - Use **3284F <u>or</u> 0517F+3285F** (control or uncontrolled)(Measure #141) **(OUTCOME measure)**
- Will discuss these two measures together (subcategories)
  - **Only the following glaucoma types**
    1. **Primary open angle glaucoma**
    2. **Low tension glaucoma**
    3. **Residual stage open angle glaucoma**
- H40.1111to H40.1234, H40.151to H40.153
- Patient age **18 years and older**

Glaucoma – Primary Open Angle

Two different reporting options

- Controlled IOP
  - **2027F and 3284F**
- Uncontrolled IOP
  - **2027F and 0517F & 3285F**

Glaucoma POA: Controlled

- **2027F -** Viewed optic nerve **(With or without dilation)**
- **3284F -** IOP reduced 15% or more from pre-intervention

<u>Outcome measure</u>

Report at least one every reporting period

2027F

- **1P** Medical reason for not viewing optic nerve
- **8P** Mo reason for not viewing optic nerve

3284F

- **8P** IOP not documented, no reason given

<u>AOA Advice</u>:

Report every time you use diagnosis and exam code

Glaucoma POA: Uncontrolled

- **2027F-** Viewed optic nerve
  - **1P** Medical reason for not viewing optic nerve
  - **8P** No reason for not viewing optic nerve

AND

- **3285F**- IOP NOT reduced 15% from pre-intervention levels
  - No exceptions – use 3284F 8P if No IOP measure

AND

- **0517F**- Plan of care to get IOP reduced
  - **8P** No plan of care to reduce IOP documented

Report at least once per reporting period

AOA Advice:
Report every time you use diagnosis & exam code

Glaucoma POA: Uncontrolled

- **0517F Plan of care examples**
  - Recheck of IOP at specified time
  - Change in therapy
  - Perform additional diagnostic evaluations
  - Monitoring per patient decisions
  - Unable to achieve due to health system reasons
  - Referral to a specialist
  - Other reasons documented/inferred

Diabetes – 2 Measures

Diabetes with retinopathy only (HIGH PRIORITY)

Use **5010F + G8397 or G8398 alone** (Measure #19)

Communication of macular edema and retinopathy to physician responsible for DM care (ONLY WITH RETINOPATHY)

New:G9714: Patient is using hospice services any time during the measurement period – not eligible for measure)

Age 18 and up

Diabetes with or without retinopathy

Use **2022F or 3072F (or 2024F or 2026F)** (Measure#117)

Dilated eye examination

Ages 18-75

Report at least once per reporting period

AOA Advice:
Report every time you use diagnosis and exam code

Diabetes with or without retinopathy
2022F or 3072F (2024F 2026F G9714)

- Diabetes diagnoses (not complete list Includes E13 and others)

E10.10 to E10.9, **E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3219, E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, E11.3312, E11.3313, E11.3319, E11.3391, E11.3392, E11.3393, E11.3399, E11.3411, E11.3412, E11.3413, E11.3419, E11.3491, E11.3492, E11.3493, E11.3499, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533, E11.3539, E11.3541, E11.3542, E11.3543, E11.3549, E11.3551, E11.3552, E11.3553, E11.3559, E11.3591, E11.3592, E11.3593, E11.3599, E11.36, E11.37X1, E11.37X2, E11.37X3, E11.37X9, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9**

- Patients **age 18-75** years old

Diabetes with or without retinopathy

2022F Dilated eye exam in diabetic patient **OR**

2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed OR

2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed

8P No reason for not performing dilated eye exam

OR

3072F Low risk of DR (normal exam last year)

No exceptions for this measure

OR

G9714: Patient is using hospice services any time during the measurement period (not eligible for measure)

(2 codes for imaging views of retina exist for this measure, 2024F and 2026F, we are making it simple)

Dilation is the recommended clinical care guideline

Diabetes with retinopathy HIGH PRIORITY

- 18+ years of age
- Diagnosis(with retinopathy only):
- E10.311to E10.3599, **E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3219, E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, E11.3312, E11.3313, E11.3319, E11.3391, E11.3392, E11.3393, E11.3399, E11.3411, E11.3412, E11.3413, E11.3419, E11.3491, E11.3492, E11.3493, E11.3499, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533, E11.3539, E11.3541, E11.3542, E11.3543, E11.3549, E11.3551, E11.3552, E11.3553, E11.3559, E11.3591, E11.3592, E11.3593, E11.3599** Also E08, E09 and E13 included

Diabetes with retinopathy High Priority

- **5010F** - Communicated presence or absence of macular edema and the level of DR to physician responsible for the diabetic care ages 18 and up (Must file with G8397 or only file G8398 alone
  - **1P** Medical reason for not communicating
  - **2P** Patient reason for not communicating
  - **8P** No reason for not communicating

AND

G8397 Dilated macular exam performed

OR

G8398 Dilated macular exam not performed

Diabetes Examples

1. **DM –no DR** age 18-75: **2022F** (dilated eye exam)
2. **DM + DR** age 18-75: **2022F, 5010F, G8397** (dilated eye exam and communication)
3. **DM – no DR** over age 75: **no PQRS codes** (over 75 without retinopathy)
4. **DM + DR** over age 75: **5010F, G8397** (over 75 with retinopathy)

Combined Examples

1. **ARMD + DM** age 52: **2019F, 4177F, 2022F**
2. **ARMD + G (controlled)** age 35: **2027F, 3284F**
3. **ARMD + G (uncontrolled) + DM** age 72:
   2019F, 4177F, 2027F, 0517F, 3285F, 2022F
4. **G (uncontrolled) + DM with DR** age 72:
   2027F, 0517F, 3285F, 2022F, 5010F, G8397
5. **ARMD + G (controlled) + DM** age 78:
   2019F, 4177F, 2027F, 3284F

Documentation of Current Medications in the Medical Record (Measure#130)

HIGH PRIORITY

- Not related to any specific diagnosis codes
- Report on EACH visit in a 12 month period
- Will use on Medicare and Railroad Medicare patients
- Age 18+
- Use if you report an evaluation & management code
  - 99201-99205 or 99212-99215
- If you report a general ophthalmic service code
  - 92004, 92014, 92002, 92012

Nursing Home/Rest Home, other E&M codes eligible - will not discuss today
Again, no other procedure codes or "testing" codes apply

#130 (NQF 0419) Documentation of Current Medications in the Medical Record

MUST include name, dosage, frequency and route of administration for

1. All prescription medications
2. All over-the-counters medications
3. All herbals
4. All vitamin/mineral/dietary (nutritional) supplements

- **Route -** Documentation of way medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical
- **Not Eligible** - A patient is not eligible if the following reason is documented:

  Urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

#130 (NQF0419) Documentation of Current Medications in the Medical Record

G8427: List of current medications documented by the provider, including drug name, dosage, frequency and route

OR

G8430: Provider documentation that patient is not eligible for medication assessment

OR

G8428: Current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) with drug name, dosage, frequency and route **not** documented by the provider, reason not specified

Controlling High Blood Pressure (Measure#236) (99000 codes only) HIGH PRIORITY

- 18-85 years of age
- Diagnosis of hypertension and adequately controlled (< 140/90 mmHg) during measurement period
- Report at least once in 12 month reporting period
- Use if you report an evaluation & management code 99201-99205 or 99212-99215

NOTE: 92002 -92014 are NOT included with this measure

- Systolic & diastolic values **must be reported separately**

Use lowest systolic & diastolic readings if multiple readings take on any specific date

Controlling High Blood Pressure (Measure #236)

High Priority

- *Do not include blood pressure readings that meet following criteria:*

1. *Blood pressure readings from patient's home (including readings directly from monitoring devices)*
2. *Taken during an outpatient visit which was for sole purpose of having diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole)*
3. *Obtained same day as major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy)*

- *If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled"*

Controlling High Blood Pressure (Measure#236)

High Priority

- **G9740:** Hospice services given to patient any time during measurement period

OR

- **G9231:** *Documentation of end stage renal disease (ESRD), dialysis, renal transplant before or during measurement period or pregnancy during measurement period*

OR

- **G8752:** Most recent systolic blood pressure < 140 mmHg **OR**
- **G8753:** Most recent systolic blood pressure ≥ 140 mmHg

AND

- **G8754:** Most recent diastolic blood pressure < 90 mmHg **OR**
- **G8755:** Most recent diastolic blood pressure ≥ 90 mmHg

OR

- **G8756:** No documentation of blood pressure measurement, reason not given

Controlling High Blood Pressure (Measure#236) Examples

- No BP taken: **G8756**
- 165/86 : **G8753 and G8754**
- 139/89: **G8752 and G8754**
- 128/94: **G8752 and G8755**
- Hospice patient: **G9740**
- ESRD: **G9231**

MIPS Quality Summary

- 60% of total MIPS score
- **Report 6 measures including 1 outcome measure**
  - 6 eye care specific measures meet this goal
- **Bonus of reporting additional high priority (1 bonus point) or additional outcome measure (2 bonus points)**
  - Documentation of Current Medications (92 & 99 codes) (HP)
  - Controlling HTN (99 only) (outcome)
  - Diabetes: Ha1c Poor Control (registry only) (outcome)

AOA Advice

Report consistently as appropriate to ensure you meet the 50% of time goal for 6 eye care measures and report Documentation of Current Medications on every claim!

MIPS Quality Summary

- 0 points if you report NOTHING
- 3 points if you report even 1 measure one time
- 4-10 points if you report 6 measures 50% of time including the outcome measure – properly reported
- 2 bonus points for extra outcome measure properly reported
- 1 bonus point for extra high priority measure properly reported
- May report more than one extra high priority or outcome measure
- Can report via claims or EHR or AOA MORE

MIPS Advancing Care Information (ACI)

- **Advancing Care Information Performance Category**
  - **Counts for 25% of total MIPS score**

Base score + performance score + bonus point = composite score

Base (50 points) + Performance (90 points) + Bonus (15 point) =>

100 points or more → 25% total MIPS score

The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points Or MORE

MIPS ACI

- Replacing Meaningful Use
- No stand alone CQM reporting
- CQM were partly incorporated into ACI performance category and some measures put into new category of clinical practice improvement (CPI)
- Dropped some requirements and lessened others from MU

ACI: Advancing Care Information

Base Score: Performed each measure for at least one patient
Yes/No **OR** Numerator/Denominator
Earn 50 points from 4 categories (5 measures)

Performance Score: How well you performed each measure from Basic and how well performed additional measures from Performance
Earn up to 90 points from 6 categories (15 measures)

MUST BE USING A CEHRT

ACI Basic Score

1. Protect Patient Health Information (PHI)
   Security Risk Assessment
2. Electronic Prescribing –eRx
3. Provide patient access
4. Health Information Exchange
   a) Send Summary of Care
   b) Request/Accept Summary of Care

Must indicate yes or no on these measures – CEHRT
If done or not – not on how well you performed

ACI Performance Score

- Health Information Exchange
  a) Send Summary of Care 10%
  b) Request/Accept Summary of Care 10%
- Patient Electronic Access
  - Provide patient access 10%
  - Patient view download transmit information 10%
- Patient specific information provided 10%
- Secure messaging 10%
- Medication reconciliation 10%
- Immunization registry reporting 10%

Graded on how WELL performed

ACI Measure Specifics
Basic Requirement/No Performance

Protect Patient PHI – Security Risk Analysis

Conduct/review security risk analysis which includes

1. Addressing security (including encryption) of ePHI data created or maintained by certified EHR

and

2. Implement security updates as necessary

and

3. Correct identified security deficiencies as part of MIPS eligible clinician's risk management process

ACI Measure Specifics
Basic Requirement/No Performance

- Electronic Prescribing
- At least one permissible prescription written by MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology

ACI Measure Specifics
Basic Requirement/ Performance Earned

- **Patient Electronic Access - Provide Access**

At least one unique patient or representative provided timely access to view online, download, and transmit his or her health information

and

PHI is available for access using application of patient choice

and

Access meets technical specifications of Application Programing Interface (API) for certified EHR technology

Performance Credit: Up to 10%

Numerator/Denominator Reporting

ACI Measure Specifics
Basic Not Required/Performance Earned

Patient Specific Education

- Must use clinically relevant information from CEHRT to identify patient-specific educational resources

and

- Provide electronic access to those materials to at least one unique patient seen by the MIPS eligible clinician

Performance Credit: Up to 10%

Numerator/Denominator Reporting

ACI Measure Specifics
Basic Not Required/Performance Earned

- **Patient Electronic Access - View, Download and Transmit (VDT)**

At least one unique patient (or authorized representatives) actively engages with EHR made accessible by MIPS eligible clinician

Can meet measure by

1. View, download or transmit PHI to third party **OR**
2. Access PHI via patient chosen applications through CEHRT

OR

3. Combination of (1) and (2)

Performance Credit Up to 10%

Numerator/Denominator Reporting

ACI Measure Specifics
Basic Not Required/Performance Earned

Secure Messaging

At least one secure message sent using electronic messaging function of CERHT to patient (or authorized representative)

or

Response to secure message sent by patient (or authorized representative)

Performance Credit Up to 10%

Numerator/Denominator Reporting

ACI Measure Specifics
Basic Not Required/ Performance Earned

Patient Generated Health Data

- Patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for at least one unique patient seen by MIPS clinician

- **Performance Credit** Up to 10%
- Numerator/Denominator Reporting

ACI Measure Specifics
Basic Requirement/ Performance Earned

Send Summary of Care

- For at least one transition of care or referral, the transitioning clinician who refers their patient to another setting of care or health care provider:

1. Creates a summary of care record using certified EHR technology

AND

2. Electronically exchanges the summary of care record

Performance Credit Up to 10%

Numerator/Denominator Reporting

ACI Measure Specifics
Basic Requirement/ Performance Earned

Requests/Accepts Summary of Care

- For at least one new transition of care or new referral received or new patient encounter, the MIPS eligible clinician receives or retrieves and incorporates into the patient's record an electronic summary of care document

- **Performance Credit** Up to 10%
- Numerator/Denominator Reporting

ACI Measure Specifics
Basic Not Required/Performance Earned

- **Clinical Information Reconciliation**

  For at least one:

  Transition of care **or** Referral received **or** New patient encounter

  1. Medication: Review of medication - name, dosage, frequency, and route
  2. Medication allergy: Review of known medication allergies
  3. Current Problem list: Review current and active diagnoses

Performance Credit Up to 10%

Numerator/Denominator Reporting

ACI Measure Specifics
Basic Not Required/Performance Earned

- **Pubic Health And Clinical Data Registry Reporting Category**
- 5 Measures
  - Immunization Registry Reporting
  - Syndromic Surveillance Reporting
  - Electronic Care Reporting
  - Public Health Registry Reporting
  - **Clinical Date Registry Reporting (AOA MORE)**

- **Performance Credit** Immunization = 0 or 10% All others=Bonus
- Yes and No Reporting

ACI Measure Specifics
Basic Not Required/Performance Earned

- Using AOA MORE – 5%
  - Active engagement to submit data to clinical data registry (beyond Immunization Registry Reporting)
- Report improvement activities through CEHRT – 10%

ACI TOTAL POINTS

- TOTAL - 100 points (can over achieve to ensure maximum performance)
- Minimum required – 70 points
- All 50 Base Points + 20 Performance Points minimum

ACI Submission

- **Electronic Health Record**
  - Run report through CEHRT
  - Submit through CMS portal
- **AOA MORE –**
  - Counts as bonus only, not submitted via AOA MORE
- **Claims** –
  - Cannot report via claims
  - Can request Hardship exemption

ACI Exemptions for Hardships

If no EHR availability –similar to Exemptions for Meaningful Use

ACI component would not be counted

- **Insufficient Internet Connectivity**
  The applicant would have to demonstrate that the doctor lacked sufficient internet access, during the performance period, and that there were insurmountable barriers to obtaining such infrastructure, such as a high cost of extending the internet infrastructure to their facility
- **Extreme and Uncontrollable Circumstances**
  Such as natural disaster in which an EHR or practice building are destroyed
- **Lack of Control over the Availability of CEHRT**
  Doctors would need to submit an application demonstrating that a majority (50 percent or more) of their encounters occur in locations where they have no control over the health IT decisions of the facility
- **Lack of Face-to-Face Patient Interaction**

MIPS Clinical Practice Improvement

- Could include care coordination, shared **decision** making, safety checklists, expanded practice access
- Goal of improved public health activities of practice

Summary:

- ✓ **To not receive a zero score, a minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities**
- ✓ **Full credit for patient-centered medical home**
- ✓ **Minimum of half credit for APM participation**
- ✓ **Key Changes from Current Program:**
  - **Not applicable (new category)**
  - **Year 1 Weight: 15%**

MIPS Clinical Practice Improvement-CPIA

- Total score needed = 40 points maximum
- Geared toward Qualified Clinical Data Registry (QCDR)Participation

AOA MORE participation = 40 points

COUNTS 15% of total MIPS Score

Groups 1-15 providers →1 high weight or 2 medium weight activities

(small groups get double credit compared to large groups)

Groups > 15 providers →2 high **or** 1 high + 2 medium weight **or** 4 medium weight activities

(Group size based on Tax ID#)

MIPS CPIA Reporting

- **Attestation model for reporting** – think MU attestation
- **Submit chosen CPIA measure via CMS portal**
  - Yes or no response for each
  - Need to be able to prove in event of audit
- **Calculate total CPIA score**
  - Which activities did you achieve?
  - Did total add up to 40 points?
  - Remember double points for small practices

MIPS Clinical Practice Improvement-CPIA

More in depth details not yet known:

1. Use **AOA MORE** to report local practice patterns (High-20 points)
2. *24/7 access to clinicians (High-20 points)* **
3. Use **AOA MORE** for ongoing practice assessment & improvements in patient safety (Medium-10 points)
4. Use **AOA MORE** for quality improvement (Medium-10 points)
5. Use **AOA MORE** to access patient engagement tools (Medium-10 points)
6. Use **AOA MORE** for collaborative learning opportunities (Medium-10points)

MIPS Clinical Practice Improvement-CPIC

7. Use **AOA MORE** to show outcome comparisons across specific population (Medium-10 points)
8. Use **AOA MORE** to promote standard practice uses (Medium-10 points)
9. Use **AOA MORE** to track patient safety (microbial keratitis) (Medium-10 points)
10. *Close referral loop: provide reports to referred from physicians (Medium-10 points)* **
11. *Timely communication of test results (Medium-10 points)* **
12. *Engage patients and families in decision making (Medium-10 points)* **

CPIA Measures - Details

1. Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record

Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations

Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management

High weight – 20 points

2. Tobacco use

Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence

Medium weight -10 points

CPIA Measures

3. Implementation of use of specialist reports back to referring clinician or group to close referral loop

Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the certified EHR technology

Medium weight – 10 points

4. Care transition standard operational improvements

Establish standard operations to manage transitions of care that could include one or more of the following: Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or Partner with community or hospital-based transitional care services

Medium weight – 10 points

CPIA Measures

5. Implementation of documentation improvements for practice/process improvements

Implementation of practices/processes that document care coordination activities (documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure)

Medium weight – 10 points

6. Annual registration in the Prescription Drug Monitoring Program with 6 months active participation

Annual registration by eligible clinician or group in the prescription drug monitoring program of the state where they practice. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups must participate for a minimum of 6 months

Medium weight – 10 points

CPIA Measures

7. Measurement and improvement at the practice and panel level

Measure and improve quality at the practice and panel level that could include one or more of the following: Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or MIPS eligible clinician or group(panel); and/or Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.

Medium weight – 10 points

8. Unhealthy alcohol use

Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including screening and brief counseling (refer to NQF #2152) for patients with co-occurring conditions of behavioral or mental health conditions.

Medium weight – 10 points

CPIA Measures

9. Use of decision support and standardized treatment protocols

Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs

Medium weight – 10 points

10. Use of toolsets or other resources to close healthcare disparities across communities

Take steps to improve healthcare disparities, such as Population Health Toolkit or other resources identified by CMS, the Learning and Action Network, Quality Innovation Network, or National Coordinating Center. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund

Medium weight - 10 points

CPIA Measures

11. Use of patient safety tools

Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of the Surgical Risk Calculator

Medium weight – 10 points

12. Participation in private payer CPIA

Participation in designated private payer clinical practice improvement activities

Medium weight – 10 points

13. Participation in a 60-day or greater effort to support domestic or international humanitarian needs

Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater

High weight – 20 points

CPIA Measures

14.Improved practices that engage patients pre-visit

Provide a pre-visit development of a shared visit agenda with the patient

Medium weight – 10 points

15.Collection and follow-up on patient experience and satisfaction data on beneficiary engagement

Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan

Medium weight – 10 points

- Multiple other activities available and will be detailed on AOA website – 90+

MIPS Resource Use - Cost

- Final category to consider is cost replacing current Value Based Modifier program
- CMS will calculate based on claims
- Provider does not submit anything
- CMS takes the average of all cost measures available
- **Cost will be tracked but not counted for the final performance weighted score in 2017**

COSTS

2017

- CMS will compare costs of care with other physicians
- Provide feedback on performance
- Performance will not factor into score for the 2017 performance year

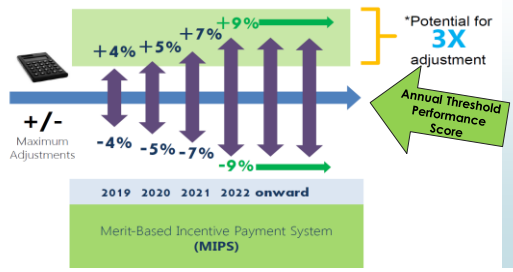
2018

- Cost Scores will contribute to 10 percent of total score

2019 and beyond

- Cost Scores will account for 30 percent of score
- Look for more information on the cost category in future AOA publications

Real impact of MIPS on reimbursement



How about a Hug

AOA Input

- CMS →36,385 ODs in Medicare, ~ 2/3 will be excluded from MIPS in 2017
- CMS predicts of 12,000 ODs (averaging $75K in Medicare income) included in MIPS - only about 10% will be penalized
- CMS predicts about 2x bonus dollars will flow to optometry than penalties, resulting in $4-5 million net for optometry
- Some bonus amounts may be small, like PQRS

CMS branded 2017 a "transition year"

- **Fee schedule update for 2017 and 2018 is +0.5% by law**
- **Fee-for-service payments not enough to offset rising costs of providing care**
- **CMS will maintained 12month performance period for maximum incentive**

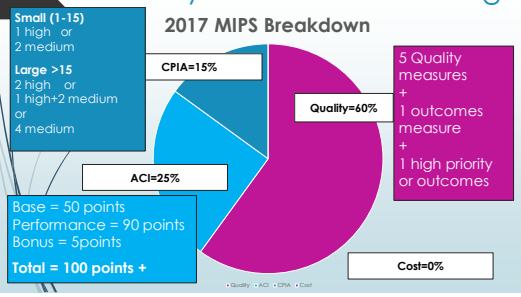
Scoring: minimum requirements

- **Clinical Practice Improvement Activities (NEW)**
  - 15% of score
  - Most providers only need to attest that completed up to 4 improvement activities for a minimum of 90 days
  - Groups 1-15 participants and rural or health professional must attest completion of 2 activities for a minimum of 90 days
- **Advancing Care Information (~Meaningful Use)**
  - 25% of Score
  - Fulfill the required measures for a minimum of 90 days
  - Choose to submit up to 9 measures for a minimum of 90 days for additional credit

Scoring: minimum requirements

- **Costs Category** (~VBMS)-Will *not* be required in 2017
- **Quality Performance Measure** (~PQRS):
  - 60% of score
  - For a minimum of 90 days with three options for full participation:
    - Report 6 quality measures
    - One specialty-specific measure set or
    - One Subspecialty-specific measure set
  - One Outcomes measure required in the 6 total measures

Summary of Total MIPS Scoring



Resources

CMS Quality Resources

https://qpp.cms.gov/resources/education

AOA Meaningful Use Resources

http://www.aoa.org/optometrists/tools-and-resources/medical-records-and-coding/mu

AOA MORE Resources

http://www.aoa.org/more

AOA Coding Resources

http://www.aoa.org/coding

Contacts and Websites

- Most material referenced on web
- Use available tools
  - CPT, ICD-10-CM, HCPCS
- Use AOACodingToday.com
  - Instant updates
  - Extra coding tools
  - Notes
  - Clarifications

www.aoa.org/coding

Thank You!