AMERICAN OPTOMETRIC ASSOCIATION

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

UPDATED FOR 2019 RULES

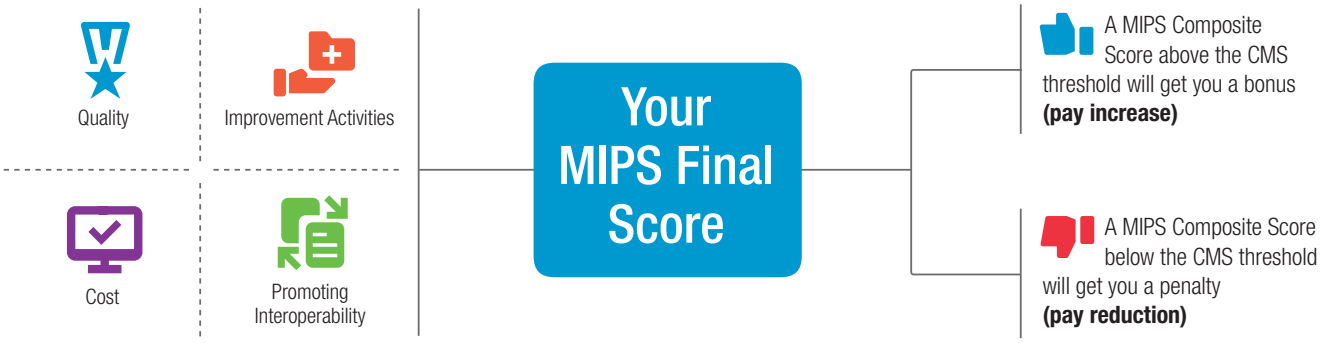
2019 MIPS Guidebook

A Road Map to Success for Doctors of Optometry

The Centers for Medicare & Medicaid Services (CMS) has changed the way it pays doctors. This new system is called the Merit-Based Incentive Payment System (MIPS), and will directly influence Medicare reimbursement amounts moving forward. MIPS requires doctors to more robustly report their quality, electronic health record (EHR) use, and practice improvement activities to get paid at the highest levels. This information release from the AOA assists you in leveraging the power of **AOA MORE** and learning how to become a successful MIPS participant.

The Lay of the Land

A single MIPS **Final Score** will factor in performance in **4 Weighted Performance Categories:**



MIPS Made Easy

Quality: Think PQRS! Reporting "quality" is paramount.

Cost: How much does it cost CMS for you to provide care.

Improvement Activities: Think about your role in overall public health.

Promoting Interoperability: Formerly known as Advancing Care Information. Think Meaningful Use!

0-100: CMS will grade you on a scale of 0-100 to determine your payment for providing services. This is known as your Final MIPS Score and is based on your use of four key components: Quality Reporting, Cost, Improvement Activities and Promoting Interoperability (use of an electronic health record - EHR)

The AOA thanks the Quality Improvement and Registries Committee and the Coding Committee for their guidance and input in developing this resource.

MIPS Made Easy. Follow these 3 steps.

1. Review program requirements. Know the exclusions!
2. Follow the recommendations in the check list.
3. Know the minimum requirements for protecting your income and avoiding penalties.

REPORTING REQUIREMENTS

Quality

- Requires you to include 60% of your patients for the entire calendar year (but do recommend reporting on 100%)

Promoting Interoperability (PI)

- Requires you to report for 90+ days

Improvement Activities (IA)

- Requires you to report for 90+ days

Cost

- Nothing for you to report. It is calculated by CMS

INDIVIDUAL V. GROUP REPORTING

Individual v. Group Reporting: Doctors in group practices can choose to participate in MIPS as a group. A "group" is defined as 2 or more CMS clinicians in the same tax ID number. If the group makes this decision, the low volume exclusion will be assessed at the group level. If you participate in MIPS as a group, the total of your group's Medicare billings must be more than $90,000 and your group must see more than 200 Medicare patients total and you must collectively provide more than 200 covered services to Medicare beneficiaries. CMS will accept voluntary group reporting and determine if your practice will receive a BONUS, PENALTY or NEUTRAL adjustment in your overall CMS payables for 2021.

KNOW THE EXCLUSIONS!

Doctors who qualify for an exclusion from MIPS, will not be required to meet program criteria if they meet any of the following:

Exclusion 1: New Medicare-enrolled physicians
If 2019 is your first year submitting claims to Medicare.

Exclusion 2: Low-Volume Threshold
If you have Medicare allowable charges less than or equal to $90,000 or if you provide care for 200 or fewer Part B-enrolled Medicare beneficiaries or you provide less than or equal to 200 covered professional services.

Exclusion 3: Qualifying APM Participants (QP) and Partial Qualifying APM Participant (Partial QP)
If you participate in a qualifying advanced alternative payment model (Think ACO).

NEW FOR 2019! MIPS OPT IN

If you meet one of the three low volume threshold criteria, you can opt into the MIPS program and be eligible for an incentive, or at risk for a penalty. You must complete the CMS process for indicating you would like to opt in to the program. This process will be completed during attestation in 2020.

QUALITY IN 2019: 45% of your 0-100 MIPS score

Doctors of Optometry need to report **6 QUALITY** measures. You must include one "Outcomes" measure; however, if you are unable to report an outcomes measure, then one "High Priority" measure must be selected as one of your 6 Quality measures. You must report on 60 percent of your patients across **all** payers, if you are reporting through AOA MORE or your EHR.

Below are recommended quality measures for reporting. Some measures are only available for reporting for certain reporting methods (e.g. claims or AOA MORE) Certain measures are "topped out" and therefore have a point cap.

Measure	CMS Number	Type	Recommended Reporting Method(s)	Topped Out
Controlling High Blood Pressure	CMS165v5 / 236	Outcome Measure	AOA MORE/EHR	NO
Diabetes: Hemoglobin A1c Poor Control	CMS122v5 / 1	Outcome Measure	AOA MORE/EHR	NO
Documentation of Current Medication	CMS68v6 / 130	High Priority Measure	AOA MORE/EHR Claims	**YES (7 point cap for AOA MORE and claims)**
Closing the Referral Loop: Receipt Measure of Specialist Report	CMS50v5 / 374	High Priority Measure	AOA MORE/EHR	NO
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	CMS142v5 / 19	High Priority Measure	AOA MORE/EHR Claims	NO (not topped out for AOA MORE) **YES (7 point cap for claims)**
Diabetes: Eye Exam	CMS131v5 / 117	Process Measure	AOA MORE/EHR Claims	NO (not topped out for AOA MORE) **YES (7 point cap for claims)**
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	CMS143v5 / 12	Process Measure	AOA MORE/EHR Claims	NO (not topped out for AOA MORE) **YES (7 point cap for claims)**
Preventive Care and Screening: Tobacco Use	CMS138v5 /226	Process Measure	AOA MORE/EHR Claims	**3 point cap for claims and AOA MORE**
Age-Related Macular Degeneration: 14 Dilated Macular Examination	14	Process Measure	Claims	**YES (7 point cap for claims)**
Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% OR Documentation of a Plan of Care	141	Outcome Measure	Claims	**YES (7 point cap for claims)**

For a listing of appropriate quality reporting data codes to report on claims and additional measure specification information on claims based reporting review the information in Appendix A.

COST IN 2019: 15% of your 0-100 MIPS score

Cost, or Resource Use, is an attempt to measure how much you cost CMS to provide care to patients. There is nothing for doctors of optometry to submit when the Cost score is analyzed. This score is derived from calculations based on claims data. Certain conditions, i.e., diabetes, are emphasized when calculating Cost, or Resource Use, scores.

IMPROVEMENT ACTIVITIES IN 2019: 15% of your 0-100 MIPS score

AOA members who use an EHR system that is not yet integrated with **AOA MORE** can still participate in IA's through the registry! Visit www.aoa.org/MORE and select the ENROLL button. On the EHR selection page, select OTHER and scroll down to find your vendor. Complete the enrollment and start earning MIPS points!

SELECT YOUR IA PATH:

Your IA requirements depend on how large your practice is (by Tax ID#)
IA's must be completed for a period of 90+ days.

IA Path 1

I am an OD in practice with **15 or fewer** CMS Clinicians → **"Small Practice" Select 1 high weighted or 2 medium weighted IAs**

IA Path 2

I am an OD in practice with **Greater than 15** CMS Clinicians → **"Large Practice" Select 2 high weighted IAs or 1 high and two medium weighted IAs, or 4 medium weighted IAs.**

AOA MORE Supports the following IAs. You can also use AOA MORE to report completion of all other CMS approved improvement activities during the attestation process.

Activity	CMS Reference Number	Weight	Additional Guidance For Meeting IA Reporting Requirements
Participation in a Qualified Clinical Data Registry (QCDR) (AOA MORE), that promotes use of patient engagement tools.	CMS Reference Number IA_BE_7	Medium weight	Login to AOA MORE to obtain and review patient engagement tools. An email will be sent from AOA when new tools are made available. Retain this email for documentation along with the date you accessed materials.
Participation in a QCDR (AOA MORE), that promotes collaborative learning network opportunities that are interactive.	CMS Reference Number IA_BE_8	Medium weight	AOA MORE has access to links to online learning opportunities. Access these resources throughout the year and document your participation in any online learning programs.
Participation in a QCDR (AOA MORE) for quality improvement.	CMS Reference Number IA_PM_10	Medium weight	Check your progress on quality measures throughout the year and review AOA guidance on how to improve your quality scores. Document your efforts to improve as necessary.

PROMOTING INTEROPERABILITY

NEW FOR 2019! You must use EHR technology certified to the 2015 Edition certification (stage 3) criteria! The new scoring methodology for 2019 only has four objectives:

- e-Prescribing
- Health Information Exchange
- Provider to Patient Exchange (portal access)
- Public Health and Clinical Data Exchange (registry)

You will be required to report certain measures from each objective, with performance-based scoring at the individual measure-level. Each measure will be scored based on the performance for that measure, which is based on the submission of a numerator and denominator, except for the measures associated with the Public Health and Clinical Data Exchange (registry) objective, which requires "yes or no" submissions. The score for each individual measure will be added together to calculate the PI performance score of up to 100 possible points for each MIPS eligible clinician.

Failure to report any required measure, or reporting a "no" response on a "yes or no" response measure, unless an exclusion applies would result in a score of zero for PI.

Objectives	Measures	Exclusion	Maximum Points
e- Prescribing	e-Prescribing *Bonus:* Query of Prescription Drug Monitoring Program (PDMP) 5 point bonus -Your EHR must be integrated with state PDMP -Requires one prescription for a schedule II medicine. Use clinical judgment and do not issue a prescription solely for the purpose of obtaining a bonus	**If you write fewer than 100 permissible prescriptions during the performance period.**	10 points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	**If you transfer a patient to another setting or refer a patient fewer than 100 times during the performance period.**	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	**If you are unable to implement the measure for a MIPS performance period in 2019 would be excluded from having to report this measure. Or if you receive fewer than 100 transitions of care or referrals or have fewer than 100 encounters with patients never before encountered during the performance period.**	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information "Through EHR online portal"		40 points
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: • Immunization Registry Reporting** • Electronic Case Reporting** • Public Health Registry Reporting** • Clinical Data Registry Reporting** • Syndromic Surveillance Reporting** You can register for AOA MORE as your "Clinical Data Registry." If another registry is available to you (e.g. state syndromic surveillance) you may register for that registry as your second registry. If no additional registry is available to aside from AOA MORE, you may claim an exclusion for the second required registry. AOA Members can register for AOA MORE and receive MIPS credit, even if their EHR is not yet integrated.	**For these measures you may claim an exclusion if you don't administer vaccinations; or if there is no registry available to accept data at start of the reporting period, OR if there is no registry that has declared readiness to accept data six months prior to the reporting period.**	10 points

CHANGES FOR 2019

Removed measures

- Patient-Specific Education
- Secure Messaging
- View, Download or Transmit
- Patient-Generated Health Data

New measures

- Query of Prescription Drug Monitoring Program (PDMP) (bonus)
- Verify Opioid Treatment Agreement (bonus)
- Support Electronic Referral Loops – Receiving and Incorporating Health Information

Security Risk Analysis (SRA) Change!

- **Security Risk Analysis requirement is retained for 2019, but will not be scored. Do not complete your SRA until you are using 2015 certified (stage 3) EHR**

Scoring and Exclusions

- If an exclusion is claimed for the e-Prescribing measure for 2019, the 10 points for this measure will be redistributed equally among the measures associated with the Health Information Exchange objective.
- Anyone who is unable to implement the Support Electronic Referral Loops (by receiving and incorporating) measure for the 2019 performance period will be excluded from reporting this measure; the 20 points would be redistributed to the Support Electronic Referral Loops by Sending Health Information and that measure would be worth 40 points. CMS will address in future rulemaking how the points will be redistributed if exclusions are claimed for both measures.
- For the public health objective, if an exclusion is claimed for one measure, but then you submit a "yes" response for another measure, you will earn the 10 points for the Public Health and Clinical Data Exchange objective. If you claim exclusions for both measures you select to report on, the 10 points would be redistributed to the Provide Patients Electronic Access to Their Health Information measure under the Provider to Patient Exchange objective.

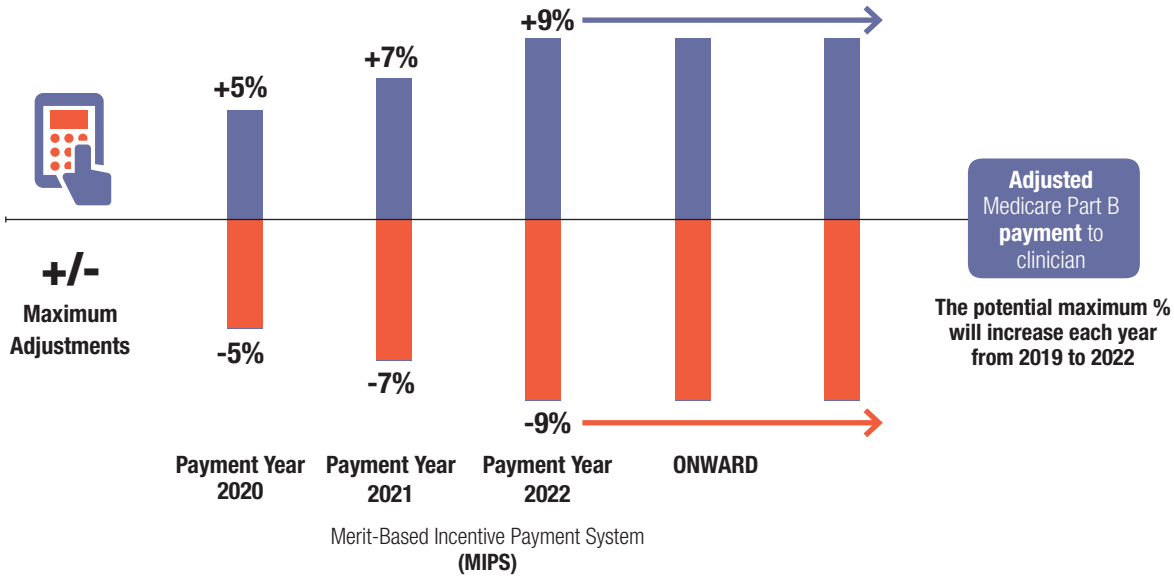
OVERALL FINAL MIPS SCORE

Your final MIPS score is calculated by your performance on each of the 4 Performance Categories. Your final score determines if you receive a **BONUS**, **PENALTY** or **NEUTRAL** adjustment in your overall **CMS** payables. The threshold to determine **BONUS** and **PENALTY** will be determined by **CMS** each year. If your score is above the **CMS**-derived threshold, you will get a bonus. If your score is below the threshold, you will get a penalty (pay reduction).

Quality Score + **Cost Score** + **IA Score** + **PI Score** = **Your 0-100 MIPS Final Score**

How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive +/- **or neutral** adjustments **up to** the percentages below.



Let AOA MORE Be Your Guide to MIPS

Follow the **Physician Check List** on the following page to assure you are meeting all of the requirements for successful MIPS reporting.

AOA MORE can be used to report all of your **QUALITY** measures, **IAs** and help you earn **PI** points.

Reporting **QUALITY** measures with **AOA MORE** earns you bonus points.

Additional Notes/Disclaimers: There are other potential quality measures and IAs that a doctor of optometry could report to meet the program objectives. This is simply an overview of one way a doctor of optometry may engage with the program.

Physician Check List for Meeting QUALITY Reporting Requirements via AOA MORE:

☐ Login to AOA MORE and check your progress on measures throughout the year. Updates are made weekly to your AOA MORE dashboard.

☐ After reviewing your progress in AOA MORE, if measures seem lower than expected, please contact your EHR vendor for support on how to properly document the measures to ensure your **QUALITY** is being recorded in the appropriate fields to submit to AOA MORE.

☐ At the end of the reporting year, you will need to give AOA MORE permission to submit **QUALITY** data to CMS on your behalf. A step-by-step process is designed to assist you and information on attestation will be provided on the AOA MORE website.

☐ Not all EHR systems are set up to report the **QUALITY** measures that AOA MORE collects, so you may not be able to .report on all measures through your EHR. Check with your EHR vendor to see which **QUALITY** measures it can track.

Physician Check List for Meeting QUALITY Reporting Requirements via EHR:

☐ If your EHR vendor is not fully integrated with AOA MORE and you will attest through the Quality Payment Plan (QPP) portal, make sure that you apply for an HCQIS Access Roles and Profile System (HARP) account early in the year!

☐ Check with your EHR vendor to determine how to export a QRDA III file of your quality measures performance. During the reporting period (first 90 days of 2020), visit https://www.qpp.cms.gov and login to the QPP portal with your EIDM account credentials mentioned above. Follow the instructions to upload the QRDA III file. Additional information will be available on the AOA MORE website to assist you with this method of reporting.

Physician Check List for Meeting IA Reporting Requirements:

☐ Follow the **IA** guidance on page 4 and complete the activities for a 90-day period.

☐ At the end of the reporting year, you will be able to attest directly from the AOA MORE Attestation Portal on the completion of **IAs**. Step-by-step instructions will be provided to show you how to authorize AOA MORE to submit these activities to CMS on your behalf. We recommend you keep a record of your improvement activities, in case of an audit.

Physician Check List for Meeting PROMOTING INTEROPERABILITY Reporting Requirements:

☐ Work with your EHR vendor to get periodic feedback on your performance.

☐ Audits for Security Risk Assessments were common under Meaningful Use. The Department of Health and Human Services makes a risk assessment tool available to no charge at: https://www.healthit.gov/providers-professionals/security-risk-assessment-tool.

☐ At the end of the reporting year, you will have the option to attest to meeting the **PI** program requirements through the AOA MORE Attestation Portal (if your EHR vendor supports this interface) or through the QPP Attestation Portal. Detailed instructions will be provided.

APPENDIX A
2019 MIPS Quality Measures for Claims Based Reporting

Measure	CPTII	Code Description	Age	ICD.10	CPT I	Modifiers
12 (NQF 0086) **POAG:** ON Evaluation Primary Open-Angle Glaucoma: Optic Nerve Evaluation (Effective Clinical Care)	**2027F**	**POAG:** Optic Nerve Evaluation Performed	**18 +**	H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.1110, H40.1111, H40.1112, H40.1113, H40.1114, H40.1120, H40.1121, H40.1122, H40.1123, H40.1124, H40.1130, H40.1131, H40.1132, H40.1133, H40.1134, H40.1190, H40.1191, H40.1192, H40.1193, H40.1194, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.151, H40.152, H40.153,	92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 *Signifies that this CPT code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for claims-based measures.	**1P:** Medical Reason **8P:** Reason NOT Specified
14 (NQF 0087) **AMD:** DFE Age-Related Macular Degeneration: Dilated Macular Examination **(Effective Clinical Care)**	**G9974** **G9975** **G9892** **G9893**	**AMD:** Dilated Macular Examination Performed including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity **AMD:** No Dilated Macular Examination Performed Medical Reason **AMD:** No Dilated Macular Examination, Patient reason **AMD:** No dilated Macular examination, No Reason	**50 +**	H35.3110, H35.3111, H35.3112, H35.3113, H35.3114, H35.3120, H35.3121, H35.3122, H35.3123, H35.3124, H35.3130, H35.3131, H35.3132, H35.3133, H35.3134,H35.3210, H35.3211, H35.3212, H35.3213, H35.3220, H35.3221, H35.3222, H35.3223, H35.3230, H35.3231, H35.3232, H35.3233	92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337	

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APPENDIX A
2019 MIPS Quality Measures for Claims Based Reporting *(continued)*

Measure	CPTII	Code Description	Age	ICD.10	CPT I	Modifiers
19 (NQF 0089) **DR:** Diabetic Retinopathy: Communication with Physician Managing Ongoing Diabetes Care and Care Coordination)	**G8398** **OR** **5010F** **and** **G8397**	Dilated Macular or Fundus Exam NOT Performed Diabetic Retinopathy: Findings of dilated macular or fundus exam communicated with the physician or other qualified health care professional responsible for managing ongoing diabetes care Dilated Macular or Fundus Exam Performed including documentation of the presence or absence of macular edema AND level of severity of retinopathy	**18 +**	E08, E09 and E10 series as well as the following:, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3219, E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, 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, E11.3593, E11.3599, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3219, E13.3291, E13.3292, E13.3293, E13.3299, E13.3311, E13.3312, E13.3313, E13.3319, E13.3391, E13.3392, E13.3393, E13.3399, E13.3411, E13.3412, E13.3413, E13.3419, E13.3491, E13.3492, E13.3493, E13.3499, E13.3511, E13.3512, E13.3513, E13.3519, E13.3521, E13.3522, E13.3523, E13.3529, E13.3531, E13.3532, E13.3533, E13.3539, E13.3541, E13.3542, E13.3543, E13.3549, E13.3551, E13.3552, E13.3553, E13.3559, E13.3591, E13.3592, E13.3593, E13.3599	92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 *Signifies that this CPT code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for claims-based measures.	**1P:** Medical Reason **2P:** Patient Reason **8P:** Reason NOT Specified

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APPENDIX A
2019 MIPS Quality Measures for Claims Based Reporting *(continued)*

Measure	CPTII	Code Description	Age	ICD.10	CPT I	Modifiers
117 (NQF 0055) Diabetes: Eye Exam **(Effective Clinical Care)**	**2022F** **or 2024F** **or 2026F** **or 3072F*** **or G9714**	Retinal or Dilated Eye Exam Performed by an Eye Care Professional (documented and reviewed) 7 standard field stereoscopic photos with interpretation (documented and reviewed) Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos results (documented and reviewed) Low risk retinopathy (no retinopathy in previous year)* * Note: This code can only be used if the claim/encounter was during the measurement period because it indicates that the patient had "no evidence of retinopathy in the prior year." Not eligible due to Hospice status	**18 - 75**	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, E11.3593, E11.3599, E11.36, E11.37X1, E11.37X2, E11.37x3E11.37X9, 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	92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439	**8P:** Reason NOT Specified * Note: 8P modifier NOT used with 3072F
141 (NQF 0563) **POAG:** IOP Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% OR Documentation of a Plan of Care (Communication and Care Coordination)	**3284F** **OR** **3285F** **and 0517F** **OR** **3285F** **and** **0517F** **OR** **3284F**	**POAG:** Reduction of IOP >/= 15% Pre-Intervention Level Reduction of IOP < 15% Pre-Intervention Level Glaucoma Plan of Care Documented Reduction of IOP < 15% Pre-Intervention Level Glaucoma Plan of Care NOT Documented, Reason NOT Otherwise Specified IOP Measurement NOT Documented, Reason NOT Otherwise Specified		H40.1111, H40.1112, H40.1113, H40.1114, H40.1121, H40.1122, H40.1123, H40.1124, H40.1131, H40.1132, H40.1133, H40.1134, H40.1211, H40.1212, H40.1213, H40.1214, H40.1221, H40.1222, H40.1223, H40.1224, H40.1231, H40.1232, H40.1233, H40.1234, H40.151, H40.152, H40.153	92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337	**8P:** Reason NOT Specified

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APPENDIX A
2019 MIPS Quality Measures for Claims Based Reporting *(continued)*

Measure	CPTII	Code Description	CPT I	Modifiers
130 (NQF 0419) Documentation of Current Medications in the Medical Record **(Patient Safety)** Documentation of Current Medications in the Medical Record **(Patient Safety)** **226(NQF 0028)** Preventive Care & Screening: Tobacco Use: Screening and Cessation Intervention **(Community / Population Health) (Communication and Care Coordination)**	G8427 or G8430 or G8428 **Criteria 1** **G9903** or **G9902** or **G9904** or **G9905** **Criteria 2** **G9906** or **G9907** or **G9908** **Criteria 3** **4004F** or **1036F** or **v4004F 1P** or **G9909 Or 4004F 8P**	Current Medications Documented (with Name, Dosage, Frequency, or Route Documented) Current Medications NOT Documented, Patient not Eligible (emergency situations only) Current Medications with Name, Dosage, Frequency, Route NOT Documented, Reason NOT Specified/Given **All patients** Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco Patient Screened for Tobacco Use and Identified as a Tobacco User Patient Not Screened for Tobacco Use, Medical Reason Patient Not Screened for Tobacco Use, No reason given **Tobacco Users** Patient Screened and Received Cessation Counselling Patient Screened, No Cessation Counselling, Medical Reason Patient Screened, No Cessation Counselling, No reason given Tobacco User Screened and Received Counselling Screened and Non-Tobacco User Tobacco Use Not Screened Medical Reason for Not Screening Tobacco User, Medical Reason for Not Providing Cessation Counselling No Tobacco Screening Performed No Cessation Counselling Provided, No Reason	92002, 92004, 92014, 92014, 92507, 92508, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96151, 96152, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439 **Examples:** Tobacco Non-user: G9903 and 1036F Tobacco User Screened and Cessation Counselling: G9902, G9906, 4004F Tobacco User Screened NO Cessation Counselling, Medical: G9902, G9907, 9909F Tobacco User Screened NO Cessation Counselling, No Reason: G9902, G9908, 4004F-8P Tobacco User Not Screening+No Cessation Counselling, Medical: G9904, G9907, 4004F-1P Tobacco User Not Screening+No Cessation Counselling, No Reason: G9905, 4004F-8P	None