MIPS 2019
What’s new for claims based reporting?

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What We Will Cover

- Brief overview
- MIPS 2019
- MIPS Quality 2019
- MIPS Promoting Interoperability (PI) 2019
- MIPS Improvement Activities (IA) 2019
- Successes and Penalties
- Other related information
- Resources
2018 Final MIPS Reporting

- Jan 2, 2019 to April 2, 2019 attestation period
- Failure to attest by 4/2/19, will see reductions to 2020 Medicare payments
- Deadline for submitting all 2018 claims is April 2, 2019
- Even without Promoting Interoperability measures (EHR), can submit data Quality and Improvement Activities performance categories and perform well for 2018
- You must earn a minimum of 15 points in 2018 to avoid negative reimbursement adjustment in 2020
- Additional data submitted could equal positive adjustment in 2020
- NOTE: Check with your EHR vendors for deadline for data submission from 2018
- AOA MORE last data push from EHR to AOAMORE is February 15, 2019 – AOA MORE must have the extra time to get data to CMS
- PROVIDERS WILL THEN HAVE TO REVIEW AND ATTEST PRIOR TO DATA BEING SUBMITTED TO CMS THROUGH AOA More
CMS Quality Program Considerations - 2019

- Improve beneficiary outcomes
- Increase adoption of Advanced APMs
- Improve data and information sharing
- Reduce burden on clinicians
- Maximize participation
- Ensure operational excellence in program implementation
- Deliver IT systems capabilities that meet the needs of users
Merit-based Incentive Payment System

MIPS Performance Categories for Year 3 - 2019

- Quality: 45%
- Cost: 15%
- Improvement Activities: 15
- Promoting Interoperability: 25

100 Possible Final Score Points

- Comprised of four performance categories in 2019
- So what? The points from each performance category are added together to give you a MIPS Final Score.
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a positive, negative, or neutral payment adjustment.
MIPS 2019

Quality = 45%
12 months

PI = 25%
≥ 90 days

Cost = 15%
12 months

IA = 15%
≥ 90 days
MIPS 2019 Changes

Must meet the following or you will be exempt under the Low-Volume Threshold

If bill:
- >$90,000 in Medicare Part B allowed charges
- >200 Medicare patients per year
- Provide >200 professional services per year

If NOT, then you are exempt and cannot receive bonus but no penalty

NEW for 2019:

If you meet or exceed 1 or 2 of the above, then you can OPT IN

Note: No way to accidentally Opt In, must actively Opt In

And BEFORE YOU GET TOO EXCITED - Consider:
- Practice makes perfect….and if you have been participating DO NOT GET OUT OF THE HABIT
- No one knows when participation requirement will change to require you to participate
MIPS Exclusions 2019

Exclusions

- Newly enrolled Medicare clinicians
  - New to Medicare in 2018
  - Have not submitted claims under any group prior to performance period

- Low threshold
  - <$90k in Medicare billing and
  - <200 Part B patients and
  - < 200 Professional services

- APM participants
  - Qualifying participants (QPs)
  - Partial qualifying participants who opt not to report MIPS

May voluntarily report without bonus or penalty for reporting experience
Must actively Opt In if exempt from MIPS but meet 1 or 2 of the above criteria and will be subject to bonus or penalty
2018: 90% of Medicare payments tied to quality.

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

AOA MORE Participation

- An AOA member benefit
- Works via EHR, if yours is integrated with AOA MORE
- Eases this process

AND

- Will be able to participate in AOA MORE Improvement Activities if not using an EHR or not using an AOA MORE integrated EHR
- Will be able to participate even if exempt - important for practice
  - No way to know how long exemptions will last
For MORE information:

Visit www.aoa.org/MORE

The 2019 MIPS webinar was presented January 15, 2019 and is available at www.aoa.org/advocacy/webinars
MIPS 2019 Dates to Remember

**Performance period**
- Performance period opens January 1, 2019
- Closes December 31, 2019
- Clinicians care for patients and record data during the year.

**Submit**
- Deadline for submitting data is March 31, 2020
- Clinicians are encouraged to submit data early.

**Feedback available**
- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

**Adjustment**
- January 1, 2021
- Payment Adjustment
  - MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2021.
MIPS Participation Options 2019

OPTIONS

1. Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. As a Group
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year

*Deadline Past for 2019 Oct to Dec 2018
Details for Quality
Don’t fall asleep!
MIPS Quality Reporting History

- PQRI/PQRS Began 2007 - Pay for Reporting Paying 2% bonus
- PQRS ended in 2016
- Stand alone PQRS program penalties ending in 2018
- MIPS participation/reporting began in 2017
  - Penalties begin in 2019
- MIPS incorporating many PQRS requirements in Quality portion
- Quality portion of MIPS counts 45% for 2019
- Small practice bonus is 6 points added to quality scoring
Quality Reporting Options

- **Electronic Health Records**
  - Click on the correct boxes per patient
  - Specific instructions through your EHR vendor
  - Run report Quality Measures Report
  - Submit through CMS portal

- **AOA MORE Registry**
  - Through registry step by step process – NOT AUTOMATIC
  - AOA MORE attestation portal and tutorial available soon

- **Claims Based Reporting**
  - Report Quality Codes on 60%+ of applicable Medicare patients via claim (minimum of 20 cases reported for each measure)
2019 Quality Eye Care Measures

- **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*

- **Measure 117** – Diabetes mellitus: Dilated Eye Exam in Diabetic Patient
- **Measure 140** – Age-Related Macular Degeneration (AMD): Antioxidant Supplement
- **Measure 141** – Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

*Outcomes Measure*

**DELETED IN 2019**
2019 Quality Eye Care Measures

4 Measures that allow use with 92000/99000 codes

- **Measure 130** Documentation of Current Medications in the Medical Record – *High Priority-bonus eligible*

- **Measure 131** Pain Assessment and Follow up

- **Measure 226** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

- **Measure 317** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

*Report as diagnosis indicates or on every claim if not linked to diagnosis*
2019 MIPS Quality Performance Category

- Self reported
- Six (6) measures including 1 outcome measure
- Report on 60% or more of appropriate claims
- Report on a minimum of 20 patients for each measure
  - #1 Diabetes: Ha1c Poor Control may be an option (99000 only)
  - #236 Controlling HTN may be an option (99000 only)
  - Extra bonus if report extra outcome or high priority measure
- Will Count 45% of total MIPS score in 2019
Quality Measures Claims Reporting

- Filed just like previous PQRS measures
- Paper-based CMS 1500 claims
- Quality measures must be reported on the same claim as CPT I
  - Sample CMS 1500 form will be reviewed
- No registration is required to participate
21. Review applicable PQRS measures related to ANY diagnosis (Dx) listed in item 21. Up to 12 Dx may be entered electronically.

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**Diabetes Mellitus**

**Coronary Artery Disease (CAD)**

QDC codes must be submitted with a line-item charge of $0.01 in 2014. Charge field cannot be blank.

24D. Procedures, Services, or Supplies - CPT/HCPCS Modifier(s) as needed.

The beneficiary is not liable for this nominal $0.01 amount.

For group billing, the rendering NPI number of the individual eligible professional who performed the service will be used from each line-item in the PQRS calculations.

33e. The NPI of the billing provider is entered here. If a solo practitioner, then enter the individual NPI; if a Group is billing, enter the NPI of the Group here. This is a required field.

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**NUCC Instruction Manual available at: www.nucc.org**

Please print or type

Approved OMB-00938-1197 Form 1500 (02-12)
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, 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 with CPT II codes only
  - 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 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
- 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 **payers**, including Medicare Advantage plans **may** be rolling out their version of MIPS so ensure you know the requirements for the plans in your area!

Report consistently so will not be penalized and could earn 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 choosing to report additional high priority measure 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 2019

Minimum 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]
- **Measure 117** – Diabetes mellitus: Dilated Eye Exam in Diabetic Patient
- **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

Can also consider
Measure 131 Pain Assessment
Measure 317 HTN Screening
Claims Quality Reporting 2019
Discussion of the details!!
Age Related Macular Degeneration

- Any of diagnosis codes for Non-exudative or exudative ARMD
  

- Patient age 50 and older
- One Quality Measures to use

#14 (NQF 0087) – USE G9974, G9975, G9892, G9893

Note: ARMD now only has ONE quality measure to report. Measure 140: AREDS was deleted for 2019

These QDC’s have changed again in 2019
ARMD

- **G9974:**
  - Dilated view of macula
  - Document Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage **AND** level of macular degeneration severity (mild moderate severe)

  - **Macular Thickening** – Acceptable synonyms for “macular thickening” include: intraretinal thickening, serous detachment of the retina, pigment epithelial detachment or macular edema.

  - **Severity of Macular Degeneration** – Early, intermediate and advanced.

  - **Geographic Atrophy** – the advanced form of non-neovascular AMD, will have one or more zones of well-demarcated retinal pigment epithelial and/or choriocapillaris atrophy

You must dilate and record finding

**Must report at least once per reporting period**

**AOA Advice:**

REPORT EVERY TIME use ARMD diagnosis and appropriate exam code
ARMD Exceptions

- **G9975** Medical reason for no dilated macula view
- **G9892** Patient reason for no dilated macula view
- **G9893** Other reason for no dilated macula view
Glaucoma – Primary Open Angle

- Two PQRS measures to be used
  - #12 Use 2027F (optic nerve evaluation)
  - #141 Use 3284F or 0517F+3285F (controlled or uncontrolled) (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
- 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

*Outcome measure*

Report at least one every reporting period

**AOA Advice:**

REPORT EVERY TIME use POAG diagnosis & appropriate exam code
Glaucoma POA: Controlled

Exceptions

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

3284F
- 8P IOP not documented, no reason given
Glaucoma POA: Uncontrolled

- **2027F**: Viewed optic nerve

PLUS

- **3285F**: IOP NOT reduced 15% from pre-intervention levels

AND

- **0517F**: Plan of care to get IOP reduced

Report at least once per reporting period

**AOA Advice:**

**REPORT EVERY TIME** use POAG diagnosis & appropriate 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
Glaucoma POA: Uncontrolled Exceptions

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

3285F
- No exceptions – use 3284F 8P if No IOP measure

0517F
- 8P No plan of care to reduce IOP documented
Diabetes – 2 Measures

**Diabetes with retinopathy only**

#19 (NQF 0089) 5010F + G8397 or G8398 alone

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

Age 18 and up  **High Priority**

**Diabetes with or without retinopathy**

#117 NQF 0055 2022F or 3072F (or 2024F or 2026F)

Dilated eye examination

Ages 18-75

**G9714:** Patient on hospice services any time during measurement period – not eligible for measure)
Diabetes with or without retinopathy  
2022F or 3072F (2024F 2026F G9714)

- Patients age 18-75 years old

- Diabetes diagnoses
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 OR

3072F Low risk of DR (normal exam last year) 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 for diabetes
Diabetes with or without retinopathy

Exceptions

2022F 2024F 2026F

8P No reason for not performing dilated eye exam

3072F

No exceptions for this measure

G9714 Patient is using hospice services any time during the measurement period are not eligible
Diabetes with retinopathy

18+ years of age

Diagnosis (with retinopathy only):


NOTE: All the unspecified eye codes were deleted for 2019
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

Exceptions

- 1P Medical reason for not communicating
- 2P Patient reason for not communicating
- 8P No reason for not communicating
Diabetes with retinopathy

G8397 Dilated macular exam performed
OR
G8398 Dilated macular exam not performed

MUST be coded along with 5010F QDC for this measure to be complete

Report at least once per reporting period

AOA Advice:
REPORT EVERY TIME you use DR diagnosis and appropriate exam code
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: G9974, 2022F
2. ARMD + G (controlled), age 35: 2027F, 3284F
3. ARMD + G (uncontrolled) + DM, age 72:
   G9974, 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:
   G9974, 2027F, 3284F
#130 (NQF 0419) Documentation of Current Medications in the Medical Record  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
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
#226 (NQF 0028): Tobacco Use: Screening and Cessation Intervention

18 years and older

Seen at least two visits or at least one preventive visit during measurement period

Screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Submitted once per performance period for patients seen during performance period

90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 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

92000 & 99000 codes are NOT considered preventative visits for this measure
#226 (NQF 0028): Tobacco Use: Screening and Cessation Intervention

There are three submission criteria for this measure:

1. % screened for tobacco use one or more times within 24 months
2. % screened for tobacco use and identified as tobacco user who received tobacco cessation intervention
3. % screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as tobacco user
Tobacco Use – Includes any type of tobacco

**Tobacco Cessation Intervention** Includes brief counseling (3 minutes or less), and/or pharmacotherapy. (minimal and intensive advice/counseling interventions conducted both in person and over the phone) qualifies …**BUT**…

Written self-help materials (e.g., brochures, pamphlets), complementary/alternative therapies do not qualify for the numerator.
#226 (NQF 0028): Tobacco Use: Screening and Cessation Intervention

**Criteria 1 Numerators**

Use one of these codes for all patients at least once in 24 months

- **G9902**: Patient screened for tobacco use & a **tobacco user**
- OR
- **G9903**: Patient screened for tobacco use & a **tobacco non-user**
- OR
- **G9904**: Documented medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)
- OR
- **G9905**: Patient not screened for tobacco use, reason not given
#226 (NQF 0028): Tobacco Use: Screening and Cessation Intervention

**CRITERIA 2 Numerators** – Use one of these codes for All tobacco users

Must report with G9902 from Criteria 1

- **G9906**: Patient received tobacco cessation intervention (counseling and/or pharmacotherapy)
- **OR**
- **G9907**: Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)
- **OR**
- **G9908**: Patient did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given
CRITERIA 3 Numerators:

ALL PATIENTS SCREENED FOR TOBACCO USE & IF TOBACCO USER, RECEIVED TOBACCO CESSATION INTERVENTION OR IDENTIFIED AS A TOBACCO NON-USER

4004F: Patient screened for tobacco use AND received tobacco cessation intervention tobacco user

OR

1036F: Current tobacco non-user

OR

4004F 1P: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

OR

G9909 Documentation of medical reason(s) for not providing tobacco cessation intervention if tobacco user (e.g., limited life expectancy, other medical reason)

OR

4004F with 8P: Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise specified
#226 (NQF 0028): Tobacco Use: Screening and Cessation Intervention

Examples:

- **Non-tobacco user:**
  
  G9903 and 1036F

- **Tobacco user screened and counselled:**
  
  G9902, G9906, 4004F

- **Tobacco user screened but not counselled (medical reasons):**
  
  G9902, G9907, G9909

- **Tobacco user not screened and not counselled (medical reasons):**
  
  G9904, 4004F-1P

- **Tobacco user screened but not counselled (no reason):**
  
  G9902, G9908, 4004F-8P

- **Tobacco user not screened and not counselled (no reason):**
  
  G9905, 4004F-8P
#131 (NQF 0420) Pain Assessment & Follow up

- Not related to any specific diagnosis codes
- Report on **EACH visit** in a 12 month period
- Use on Standard 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

Other E&M codes eligible as well but will not discuss today
Again, no other procedure codes or “testing” codes apply
Must use **standardized Pain Assessment Tool**

- Documentation of pain assessment using standardized tool(s) on each visit

AND

- Documentation of follow-up plan when pain is present
  - Follow-up plan must be related to presence of pain:
    - “Patient referred to pain management specialist for back pain”
    - “Return in two weeks for re-assessment of pain”
  - May include pharmacologic and/or educational interventions
#131 (NQF 0420) Pain Assessment & Follow up

Standardized Tool - appropriately normalized and validated for population in which it is used (Reference AOA website)

1. Brief Pain Inventory (BPI)
2. Faces Pain Scale (FPS)
3. McGill Pain Questionnaire (MPQ)
4. Multidimensional Pain Inventory (MPI)
5. Neuropathic Pain Scale (NPS)
6. Numeric Rating Scale (NRS)
7. Oswestry Disability Index (ODI)
8. Roland Morris Disability Questionnaire (RMDQ)
9. Verbal Descriptor Scale (VDS)
10. Verbal Numeric Rating Scale (VNRS)
11. Visual Analog Scale (VAS)
Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:

1. Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others
2. Patient in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status

#131 (NQF 0420) Pain Assessment & Follow up
#131 (NQF 0420) Pain Assessment & Follow up

- **G8730**: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented

- **OR**

- **G8731**: Pain Assessment Documented as Negative, No Follow-Up Plan Required

- **OR**

- **G8442**: Pain assessment NOT documented, documentation patient not eligible for pain assessment using a standardized tool

- **OR**

- **G8939**: Pain assessment documented as positive, follow-up plan not documented, documentation patient is not eligible

- **OR**

- **G8732**: No documentation of pain assessment, reason not given

- **OR**

- **G8509**: Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given
Screened for high blood pressure AND recommended follow-up plan is documented based on current blood pressure (BP) reading as indicated

- Age 18 years and older
- Once per reporting period

Must **perform the blood pressure screening** at qualifying visit

**May not** obtain measurements from external sources

Recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive

Documented follow up plan must be related to the current BP reading as indicated, example:

“Patient referred to primary care provider for BP management.”
#317: Preventive Care and Screening: Screening for HTN & FU Documented

Definitions:

- **BP Classification** - BP is defined by four BP reading classifications.
- **Recommended BP Follow-Up** - BP screening intervals, lifestyle modifications and interventions based on the current BP reading.
- **Lifestyle Modifications** - Weight Reduction, Dietary Approaches to Stop Hypertension (DASH) Eating Plan, Dietary Sodium Restriction, Increased Physical Activity, or Moderation in Alcohol (ETOH) Consumption.
- **Second Hypertensive Reading** - Requires a BP reading of Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg during the current encounter AND a most recent BP reading within the last 12 months Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg.
- **Second Hypertensive Reading Interventions** - Anti-Hypertensive Pharmacologic Therapy, Laboratory Tests, or Electrocardiogram (ECG).
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<tr>
<td>Normal BP Reading</td>
<td>&lt; 120</td>
<td>AND &lt; 80</td>
<td>• No Follow-Up required</td>
</tr>
<tr>
<td>Pre-Hypertensive BP Reading</td>
<td>≥ 120 AND ≤ 139</td>
<td>OR ≥ 80 AND ≤ 89</td>
<td>• Rescreen BP within a minimum of 1 year AND Lifestyle Modifications OR Referral to Alternative/Primary Care Provider</td>
</tr>
<tr>
<td>First Hypertensive BP Reading</td>
<td>≥ 140</td>
<td>OR ≥ 90</td>
<td>• Rescreen BP within a minimum of ≥ 1 day and ≤ 4 weeks AND Lifestyle Modifications OR Referral to Alternative/Primary Care Provider</td>
</tr>
<tr>
<td>Second Hypertensive BP Reading</td>
<td>≥ 140</td>
<td>OR ≥ 90</td>
<td>• Lifestyle Modifications AND 1 or more of the Second Hypertensive Reading Interventions (see definitions) OR Referral to Alternative/Primary Care Provider</td>
</tr>
</tbody>
</table>
**Not Eligible** – A patient is not eligible if one or more of the following reason(s) are documented:

1. Patient has an active diagnosis of hypertension
2. Patient refuses to participate (either BP measurement or follow-up)
3. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated
#317: Preventive Care and Screening: Screening for HTN & FU Documented

- **G8783**: Normal blood pressure documented, follow-up not required
- **OR**
- **G8950**: Pre-Hypertensive or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented
- **OR**
- **G9745**: Documented reason for not screening or recommending a follow-up for high blood pressure
- **OR**
- **G8785**: Blood pressure reading not documented, reason not given
- **OR**
- **G8952**: Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given
- **OR**
- **G9744**: Patient not eligible for due to active diagnosis of Hypertension
MIPS Quality Summary

- 45% of total MIPS score
- Report 6 measures reported on at least 60% applicable claims
  6 eye care specific measures meet this goal with outcome measure #141
- Bonus of reporting additional high priority (1 bonus point) or additional outcome measure (2 bonus points)

1. Documentation of Current Medications (92 & 99 codes) (High Priority)
2. Controlling HTN (99 only) (Outcome)
3. Diabetes: Ha1c Poor Control (99 only) (Outcome)

AOA Advice
Report consistently as appropriate to ensure you meet 60% of time goal for 6 eye care measures and report
Documentation of Current Medications and Tobacco on every claim!
MIPS Quality Summary

- 0 points if you report NOTHING
- 1 point (large practice) or 3 points (small practice) for reporting 1 measure
- 3-10 points possible for each of 6 + measures reported on 60% of patients, 20+ cases each (Includes required outcome measure!)
- ALL CLAIMS MEASURES (Except #317) ARE TOPPED OUT - only 3-7 points possible rather than the 10 possible for non-topped out measures
- 2 bonus points for Outcomes measures properly reported
- 1 bonus point for High Priority measures properly reported
- May report more than one High Priority or Outcomes measure
- Can report via claims or EHR or AOA MORE
- CMS will use the highest score of any reporting method
- Check with your EHR for supported measures and how to properly document
ARE YOU EXCITED YET??
MIPS Promoting Interoperability (PI) (formerly Advance Care Information-ACI)

- Counts for 25% of total MIPS score
- Report of 90 or more consecutive days in year
- Must use 2015 Certified EHR
- Consider an exemption application if no EHR or non-certified EHR and reporting via claims
- Must perform Security Risk Analysis (not scored)
- No longer broken down into Base-Performance-Bonus scoring system
- Must report in 4 categories
  - eRx
  - Patient access to portal
  - Health Information Exchange
  - Registry
PI Categories and Scoring

1. eRx = 10%
   Bonus opportunities x 2 @5% = 10%
2. Patient access to portal = 40%
3. Health Information Exchange
   Sending =20%
   Receiving and incorporating = 20%
4. Registry = 10%

Total = 110% but capped at 100%

See AOA MORE MIPS Webinar for more details
PI Exemptions for Hardships

If no EHR availability:
ACI component would not be counted; however, applications were due by December 31, 2018: **Keep Deadline in mind for 2019 if needed**

- **Insufficient Internet Connectivity**
  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**
  Submit an application demonstrating that a majority (>/>=50%) of their encounters occur in locations where they have no control over the health IT decisions of the facility including MIPS eligible in a small practice and using non-CEHRT EMR

- **Lack of Face-to-Face Patient Interaction**
NOW WE ARE REALLY EXCITED!!
MIPS Improvement Activities (IAs)

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

**Number of Activities:**

- No change in the number of activities that MIPS eligible clinicians must report to achieve a total of 40 points.

- **Burden Reduction Aim:** MIPS eligible clinicians in small practices and practices in a rural areas will continue to report on no more than 2 activities to achieve the highest score.

**Maximum 40 Points**
Each activity is 10 or 20 points
MIPS Improvement Activities (IAs)

- Total score needed = 40 points maximum
- Includes many options geared toward Qualified Clinical Data Registry (QCDR) Participation

AOA MORE participation = 40 points
If using AOA MORE for IA's, must complete activities through AOA MORE

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 IA Reporting

- Attestation model for reporting – think MU attestation
- Submit chosen IAs via CMS portal by April 2, 2019
  or
- Via AOA MORE even without EHR integration

(AOA MORE Portal opens Feb 25, 2019 - Closes at 5pm on April 2, 2019)

- Yes or no response for each
- Need to be able to prove in event of audit

- Calculate total IA score
  - Which activities did you achieve
  - Remember double points for small practices
  - Did total add up to 40 points?
IA Measures - Details

1. Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record
   High weight – 20 points

2. Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
   Medium weight – 10 points

3. Use of toolsets or other resources to close healthcare disparities across communities
   Medium weight - 10 points

4. Use Of QCDR for feedback reports that incorporate population health (AOA MORE supported)
   High weight = 20 points
IA Measures

5. Use of QCDR data for quality improvement such as comparative analysis reports across patient populations (AOA MORE supported)
   Medium weight = 10 points

6. Regular Review Practices in place on targeted patient population needs
   Medium weight = 10 points

7. Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop
   Medium weight = 10 points

8. Implementation of improvements that contribute to more timely communication of test results
   Medium weight = 10 points
IA Measures

9. Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities
   Medium weight = 10 points

10. Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
    High weight = 20 points

11. Participation in a QCDR, that promotes use of patient engagement tools *(AOA MORE supported)*
    Medium weight = 10 points

12. Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive *(AOA MORE supported)*
    Medium weight = 10 points
IA Measures

13. Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms
   Medium weight = 10 points

14. Improved Practices that Engage Patients Pre-Visit
   Medium weight = 10 points

15. Annual registration in the Prescription Drug Monitoring Program
   Medium weight = 10 points

16. Consultation of the Prescription Drug Monitoring Program
   High weight = 20 points
17. Participation in private payer CPIA
   Medium weight = 10 points

18. Use of decision support and standardized treatment protocols
   Medium weight = 10 points

19. CDC Training on CDC’s Guideline for Prescribing Opioids for Chronic Pain
   Medium weight = 10 points

20. Engagement of New Medicaid Patients and Follow-up
   High weight = 20 points
IA Measures

21. Participation on Disaster Medical Assistance Team, registered for 6 months
   Medium weight = 10 points

22. Participation in a 60-day or greater effort to support domestic or international humanitarian needs
   High weight = 20 points

23. Tobacco use
   Medium weight = 10 points
IA Measures 2019

- New This Year!!

- Comprehensive Eye Examinations Medium Weight=10 points
  - Promote importance of comprehensive eye exam
    - Providing literature
    - Promoting conversation using resources: “Think About Your Eyes” campaign
    - Referring patients to resources providing no-cost eye exams – American Optometric Association’s VISION USA
  
Measure targeted at underserved/high-risk populations who would benefit from engagement regarding their eye with aim of improving their access to comprehensive eye exams.

https://qpp.cms.gov/about/resource-library
Curious about the cost factor?
MIPS Resource Use - Cost

- Final category is Cost
- Replaced 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 tracked by CMS for 15% weighted score in 2019
In 2017
- CMS compared costs of care with other physicians
- Provide feedback on performance
- Performance was not factored into score for the 2017 performance year

2018
- Cost Scores was 10 percent of total score

2019
- Cost Scores will contribute 15% of total score

Beyond 2019
Was predicted to be 30% BUT Budget vote allows this to be changed ...may be lower
Factors Considered for Determination Period in 2018

1. Medicare Spending Per Beneficiary (MSPB); and
2. Total Per Capita Costs for All Attributed Beneficiaries (TPCC)
3. Episode Based Cost Measures
   - Routine Removal of Cataract with IOL Episode of Care - applicable 1 of 8 measures - trigger is cataract surgery
Are you exhausted yet?
Scoring: minimum requirements

- Improvement Activities
  - 15% of score
  - Providers only need to attest that completed up to 4 improvement activities for a minimum of 90 days **BUT**
  - Groups 1-15 participants and rural or health professional must attest completion of 2 activities for a minimum of 90 days

- Promoting Intraoperability
  - 25% of Score
  - Fulfill the required measures for a minimum of 90 days
Scoring: Minimum Requirements

Costs Category 15% 12 months

Quality Performance Measure

45% of score
12 months

- Report 6+ quality measures at least 60% of applicable time
- One Outcomes measure required in the 6 total measures
  - Eye care measures detailed in presentation include outcome measure
- And can report additional Outcome measures or High Priority measures for more points
MIPS Payment Adjustments 2019

- 2017: +4%
- 2018: +5%
- 2019: +7%
- 2020: +9%

Lowest 25% = maximum reduction

- 2017: -4%
- 2018: -5%
- 2019: -7%
- 2020: -9%

Additional Performance Threshold: 75 points
Performance Threshold for 2019: 30 points
Resources

CMS Quality Resources
https://qpp.cms.gov/about/resource-library

AOA Meaningful Use Resources

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 !!!!!

www.AOA.org/coding
www.aoa.org/more