Claims Submission for MIPS Quality

Sam Ross, QPP Advisor/Manager
March 7, 2018

Visit our website at http://qpp-il.org! We will help you navigate the complexities of the new CMS payment models so you can focus on what you do best – taking extraordinary care of your patients.

When you sign up for the QPP Resource Center, you get access to resources that help you establish your baseline, identify goals, learn about requirements, and monitor progress. Plus, QPP Advisors are available to answer questions as they come up. All assistance is offered free-of-charge thanks to a grant from CMS.

Agenda

- Brief MACRA/QPP Overview
- MIPS Quality
- Claims Submission Resources
- Claims Coding and Score Tracking
- Additional Considerations and References

Brief MACRA/QPP Overview

MACRA (2015)

- Repeals “Sustainable Growth Rate”
- Streamlines multiple quality programs
- Expands pathways for level of risk and reward
- Supports multi-payer initiatives

2018 QPP Eligibility

1) Billing > $90,000 and treating > 200 Medicare patients per year (MIPS)

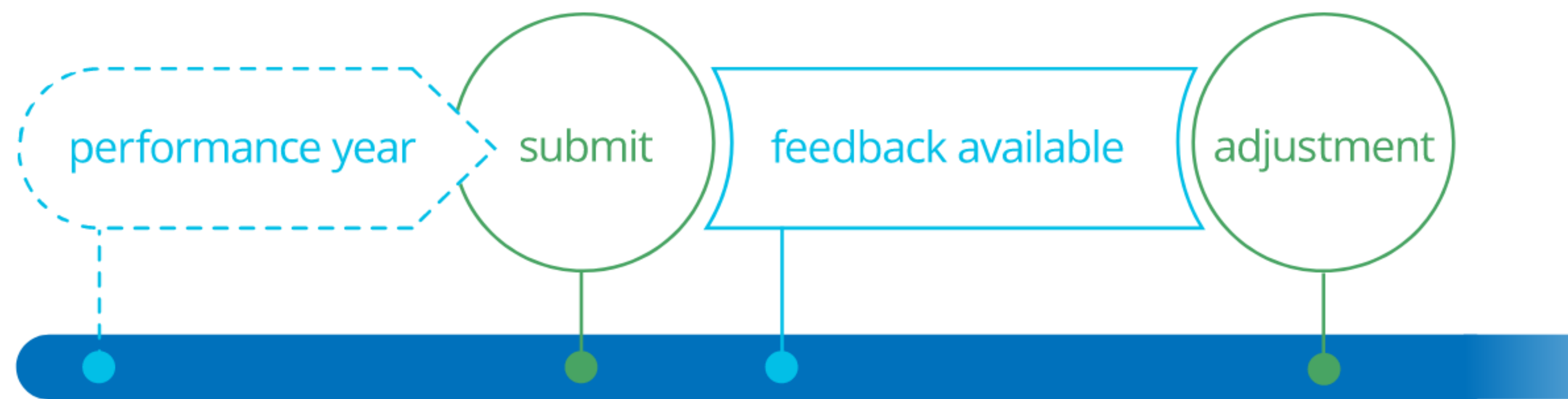
<u>or</u>

2) Treating 20% patients/receiving 25% of Medicare payments through an Advanced Alternative Payment Model (AAPM)

Merit-based Incentive Payment System (MIPS)

Advanced Alternative Payment Models (AAPM)

2018 QPP Timeline



Calendar Year 2018

Performance period begins 1/1/18 and ends on 12/31/18. During the year, record quality data, how you used CEHRT and implemented improvement activities.

March 31, 2019

Deadline to report QPP data to qualify for positive payment adjustment under MIPS or 5% bonus under AAPM.

2019

Medicare analyzes reported data and provides feedback on performance and MIPS payment adjustments or AAPM bonus.

2020

MIPS payment adjustments applied to Medicare Part B reimbursements beginning 1/1/20. AAPM bonuses awarded in 2020.

MIPS Quality

Quality Concepts

- Promotes measurement and improvement of care processes, outcomes, patient experience, patient safety, efficiency and care coordination
- Ends and replaces the Physician Quality Reporting System (PQRS) and the Quality component of the Value-Based Payment Modifier (VM)
- Requires full-year reporting
- Contributes 50% weight of MIPS score for 2018
- Variation in available measures, reporting requirements and scoring depending on submission method (claims, EHR, registry/QCDR, web interface)

Quality Measures

- 240 total to choose from (excludes web interface and custom QCDR measures)
- Specialty measure sets to help clinicians choose appropriate measures
- Participants report at least 6 measures, including one “outcome” or “high priority” measure (reporting all measures from a measure set with <6 is also acceptable)
- Must submit all measures through same method
  - CAHPS Survey measure is exception if selected as one of 6
  - All-cause hospital readmissions measure is automatically calculated/scored from claims for groups of 16+ with at least 200 cases

Quality Scoring

- Structure:
  - Earn maximum 60 points (70 if eligible for admissions measure)
  - Performance is [Points Earned]/[Maximum Points]
  - Score is performance * 50% category weight

- Method:
  - Report numerator/denominator/exception/exclusion
  - Performance scored against benchmarks from two years prior

- Bonus:
  - Maximum 10% for additional outcome/high-priority measures
  - Maximum 10% for reporting via CEHRT
  - Maximum 10% improvement bonus

Claims Submission Resources

Claims Measures

- 73 measures available (https://qpp.cms.gov/mips/quality-measures) for individual reporting only

- Download benchmark data at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Quality-Benchmarks.zip

- Filter by EHR submission (column C) and select minimum 6 by Measure ID

Table 2: MIPS Benchmark Results Using DY2016 and PY2018 Logic

Measure_Name	Measure_I	Submission_Metho	Measure_Typ	Benchmar	Standard_Deviatio	Averag	Decile_3
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	1	Claims	Outcome	Y	21.7	22	33.33 - 23.54
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	12	Claims	Process	Y	11.3	96.5	98.99 - 99.99
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	14	Claims	Process	Y	11.7	97	99.60 - 99.99
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	Claims	Process	Y	13.1	96.6	--

Claims Measure Specifications

- Specification sheets define the measure:
  - Measure type, description, instructions
  - Denominator, numerator, exclusion/exception
  - Measure flow

- Download specifications by measure ID at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html

- Quality
  - Quality Measure Specifications: 2/9/2018
    - Claims Registry Measures 001-050
    - Claims Registry Measures 051-100
    - Claims Registry Measures 101-150
    - Claims Registry Measures 151-200
    - Claims Registry Measures 201-250

Specification Sheet Example

Quality ID #47 (NQF 0326): Care Plan – National Quality Strategy Domain: Communication and Care Coordination

2018 OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS ONLY

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. There is no diagnosis associated with this measure. This measure may be submitted by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NOTE: *This measure is appropriate for use in all healthcare settings (e.g., inpatient, nursing home, ambulatory) except the emergency department. For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.*

Measure Submission:
The listed denominator criteria is used to identify the intended patient population. The numerator quality-data codes included in this specification are used to submit the quality actions allowed by the measure. All measure-specific coding should be submitted on the claim(s) representing the eligible encounter.

Claims Coding and Score Tracking

Claims Coding CMS 1500

- Denominator criteria typically entered as standard practice
- Add numerator/exclusion/exception Quality Data Codes (QDC) at $0.01

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H.	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07	05	17	07	05	17	11		99213		A	47	00	1		NPI	9876543210
2	07	05	17	07	05	17	11		G8598		A	0	01			NPI	9876543210
3																NPI	
4																NPI	
5																NPI	
6																NPI	

1. MIPS quality code

2. $0.01 charge

25. FEDERAL TAX I.D. NUMBER: 111222333444 | 26. PATIENT'S ACCOUNT NO.: 555666 | 27. ACCEPT ASSIGNMENT? [X] YES [ ] NO | 28. TOTAL CHARGE: $ 47 00 | 29. AMOUNT PAID: $ 00 00

33. BILLING PROVIDER INFO & PH #: Physician Practice Inc, 789 Healthcare Street, Doctor Town IL 60606

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — OMB APPROVAL PENDING

Tracking Scores

- Log into QPP submission site and click “Account Dashboard”
- Click “As individuals” under the REPORT header at right of practice

Samuel Ross

Account Dashboard

Manage User Access

Help and Support

Account Dashboard

The submission window is now open

You can update your data at any time the submission window is open (January 2 – March 31, 2018 for MIPS reporting or January 22 – March 16, 2018 for CMS Web Interface reporting). Once the submission window is closed, CMS will begin calculating payment adjustments.

PRACTICES (1)

TIN: # CHICAGO, IL 606401917

SPECIAL STATUS

Small Practice

Read more about special statuses

REPORT

As a group ›

As individuals ›

REPORT

As a group ›

As individuals ›

COLLAPSE

Quality Payment PROGRAM

Tracking Scores

- Individuals linked to the practice will appear under “Connected Clinicians”*
- Click “Quality Measures” under the REPORT header next to clinician for whom you are tracking scores

Account Dashboard

, MDSC

TIN# 36

Connected Clinicians

Group Reporting

Account Dashboard > Practices >

, MDSC

Connected Clinicians

Report data for clinicians as individuals

You can update your data at any time the submission window is open (January 2 – March 31, 2018 for MIPS reporting or January 22 – March 16, 2018 for CMS Web Interface reporting). Once the submission window is closed, CMS will begin calculating payment adjustments.

CONNECTED CLINICIANS (1)

at MDSC

NPI: #158 Doctor of Medicine

SPECIAL STATUS

Small Practice

Read more about special statuses

REPORT

- Quality Measures ›
- Advancing Care Information ›
- Improvement Activities ›

REPORT

- Quality Measures ›
- Advancing Care Information ›
- Improvement Activities ›

* If clinicians for whom you need to report are missing, they must be linked to the practice/TIN through PECOS at https://pecos.cms.hhs.gov/

Tracking Scores

- Scores by submission method will display
- Projected score will be listed under Claims heading

< Connected Clinicians

Elig Org 43
TIN# 000783226

LOUISE BELCHER
NPI# 0002357792

Individual Reporting
- Quality Measures
- Advancing Care Information
- Improvement Activities

Quality

The Quality score is based on the **highest score** among all submission method scores. ⓘ **Read full instructions**

Your Scores by Submission Methods

Your highest score is:

Claims

51.5
OUT OF 60

Tracking Scores

- Scroll down for submission summary and details
- Each measure submitted will appear with performance and points earned
- Click the > to review details for measure

Claims Submission Details

Measures that count toward Quality Performance Score (6)

Your Measure Score includes both performance points and bonus points.

Measure Name EXPAND ALL	Performance Rate	Measure Score	Download Specifications
> **Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care** Measure ID: 019	100%	10.0	⤓
> **Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin** Measure ID: 021	100%	11.0	⤓

Tracking Scores

- Benchmark deciles with your position indicated
- Explanation of how performance and bonus points were calculated

Care Plan
Measure ID: 047

90% 7.3

BENCHMARK DATA

Lowest Benchmark — Highest Benchmark

13.68% | 34.58% | 62.87% | 86.92% | 97.11% | 99.6% | -- -- | >= 100%

90% | Decile 6

PERFORMANCE POINTS

Points from Benchmark Decile	6.0
Partial Points	0.3

BONUS POINTS

High Priority Outcome or Patient Experience	--
Other High Priority	1.0
End-to-End Reporting	--

Measure Score	7.3

Additional Considerations and References

Additional Considerations

- How will codes be documented by clinical staff?
- How will codes be retrieved/entered by administrative staff?
- Must report 60% of eligible cases
- Absence QDC = not reporting eligible case
- Cannot re-submit claims just to add QDC
- Claims for 2018 must get to national data warehouse by 3/1/19

References

- https://qpp.cms.gov/mips/quality-measures
- https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html
- https://www.youtube.com/watch?v=ITtCRHOFKn0

THANK YOU!!

Quality Payment Program of Illinois

http://qpp-il.org

info@qpp-il.org

844-QPP-DESK (844-777-3375)