One Patient-One Claim-No Penalty

Submitting a single claim for any point in 2017 can avoid a penalty in 2019

Merit-based Incentive Payment System (MIPS)

The new MIPS program has been implemented and will apply to practices that have $30K or more Medicare payments a year. UltraMED wants all our users to make this transition as easy as possible and provide as much advice and support as we can. This document spells out the easiest way to avoid a penalty in 2019.

How does MIPS work?

MIPS replaces PQRS with a new set of things that practices need to do in order to avoid penalties or receive bonuses. Medicare has created a website to help in this transition. It is very helpful and fairly easy to use, however, much of the information provided is for larger practices and groups. We will focus first on the easiest way to avoid any penalty for 2017.

One Patient, One Measure, No Penalty

Go to www.qpp.cms.gov

This is an extremely helpful tool to assist in complying with MIPS and not getting the penalty.

Not participating will mean a 4% reduction in your Medicare payments for 2019.

Submitting a single claim for any point in 2017 can avoid a penalty in 2019.

Submitting 90 days of 2017 data to Medicare means no penalty and maybe a bonus. If you want to work for an increased bonus read the information provided at the qpp site. This AMA link also explains the single patient method of avoiding **www.ama-assn.org/qpp-reporting**

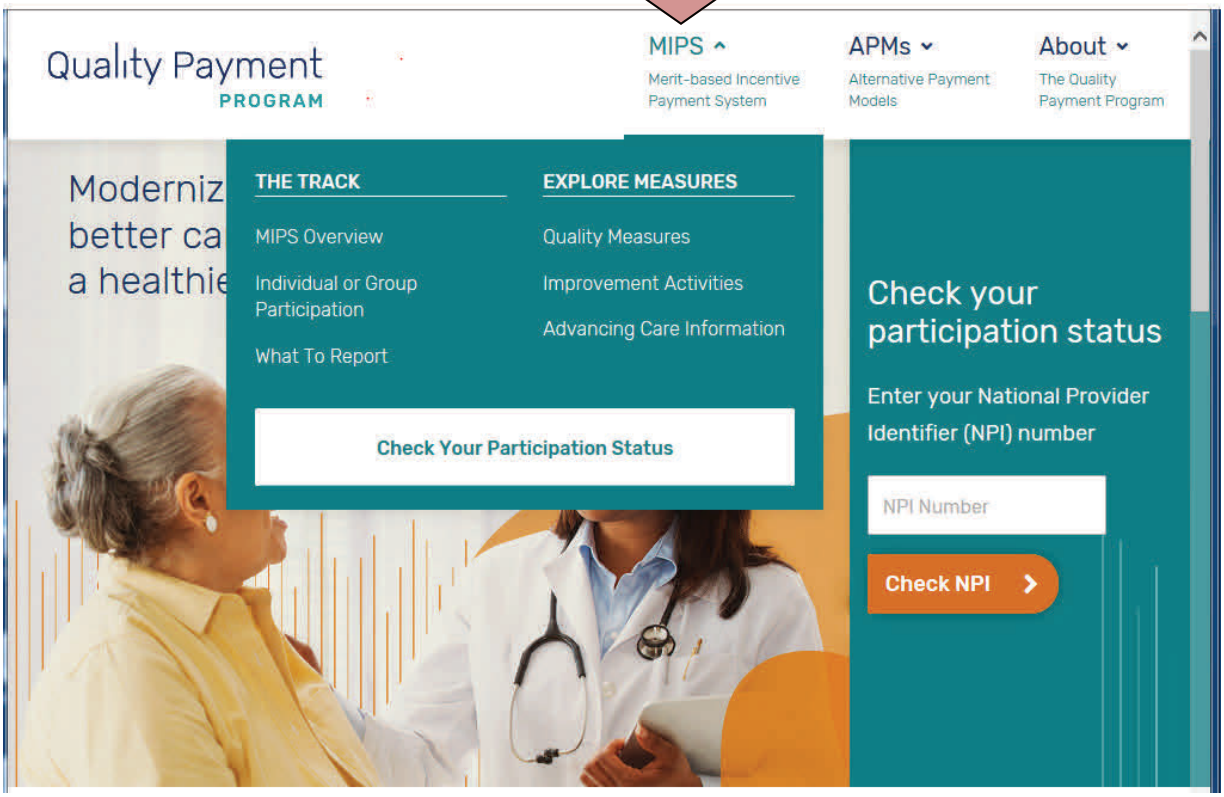
Check Your Participation Status

On the home page enter your NPI number in the "Check your participation status (Green BOX)" and follow instructions. You should see a response which will tell you if you need to participate in this program. If you are listed as required to participate you must to avoid the penalty

At the top of the page click on MIPS and a green dropdown box will open. Click on quality measures and you should be at the "Quality Measures". This is shown on the next page.

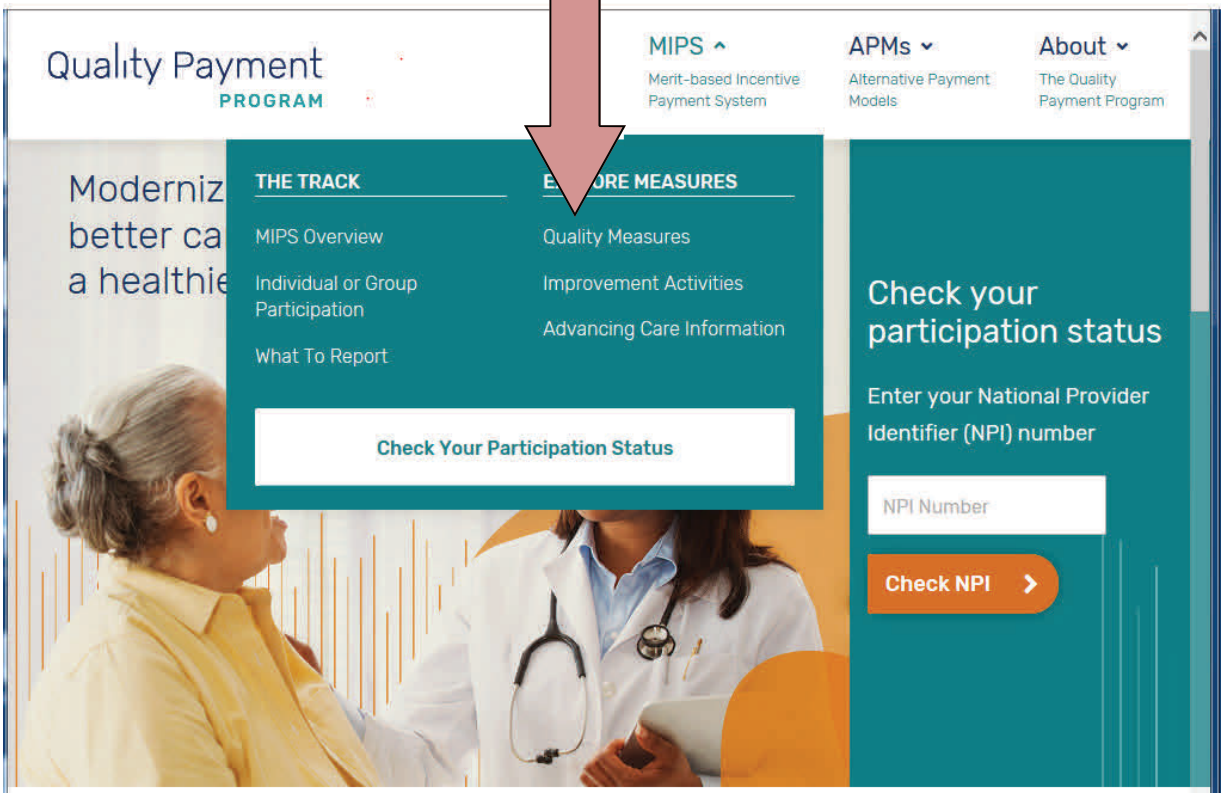
Click “MIPS”

1

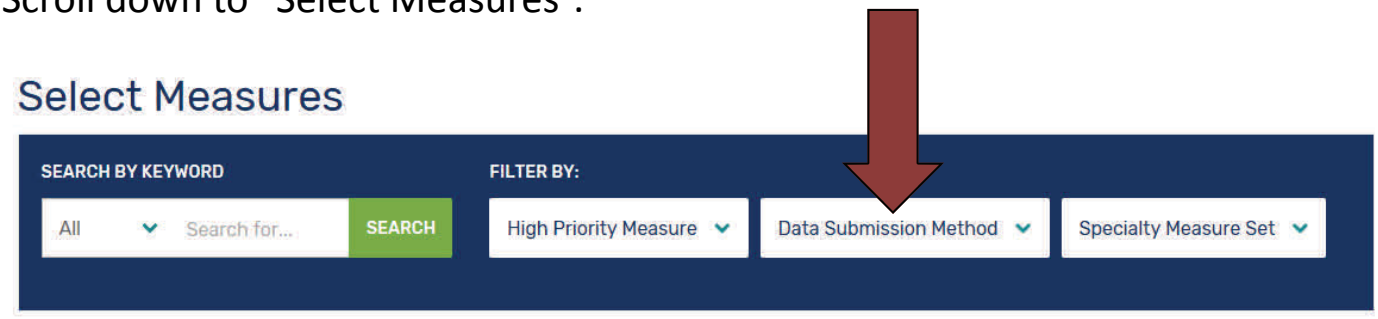


Click “Quality Measures”

2

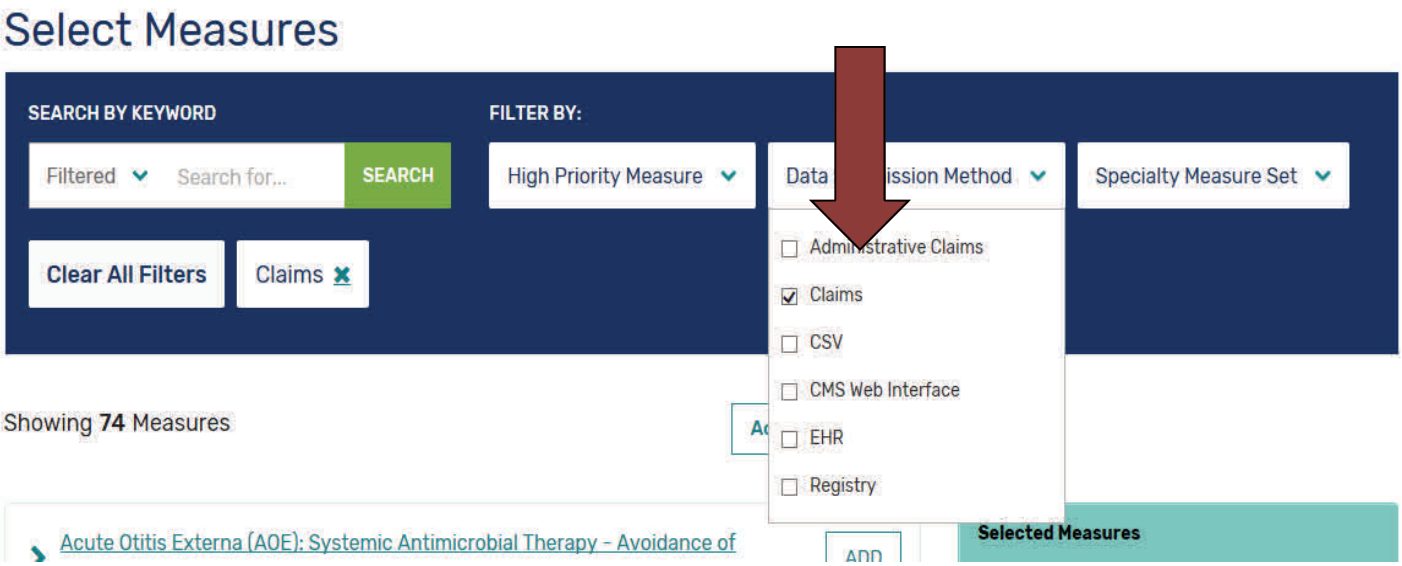


This tool is designed to assist you in picking your quality measures.
Scroll down to “Select Measures”.



Next click on “Data Submission Method” and then check the “Claims” box.

This will give you only those items that can be reported by claim .



This will result in a list of measures which can be reported by claim in order to satisfy MIPS basic simple requirements to avoid any penalty in 2019 for failure to report in 2017. I am going to choose “Documentation of Current Medications in the Medical Record”.

Scroll down the page and click on “Documentation of Current Medications in the Medical Record”. You will the see the information shown on the next page. This measure can be used by practically any type of practice. Most practices are already doing this as part of their day to day routine. Note that the “Quality ID is 130. This is the document you will need to use for this measure.

Documentation of Current Medications in the Medical Record

REMOVE

Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

MEASURE NUMBER

- eMeasure ID: CMS68v6
- eMeasure NQF: None
- NQF: 0419
- Quality ID: 130

NQS DOMAIN

PS

MEASURE TYPE

Process

HIGH PRIORITY MEASURE

Yes

DATA SUBMISSION METHOD

- Claims
- EHR
- Registry

SPECIALTY MEASURE SET

- Allergy/Immunology
- Internal Medicine
- Anesthesiology
- Cardiology
- Dermatology
- Emergency Medicine
- Gastroenterology
- General Surgery
- General Oncology
- Hospitalists
- Neurology
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Physical Medicine
- Preventive Medicine
- Rheumatology
- Thoracic Surgery
- Urology
- Vascular Surgery
- Mental/Behavioral Health
- Plastic Surgery
- General Practice/Family Medicine

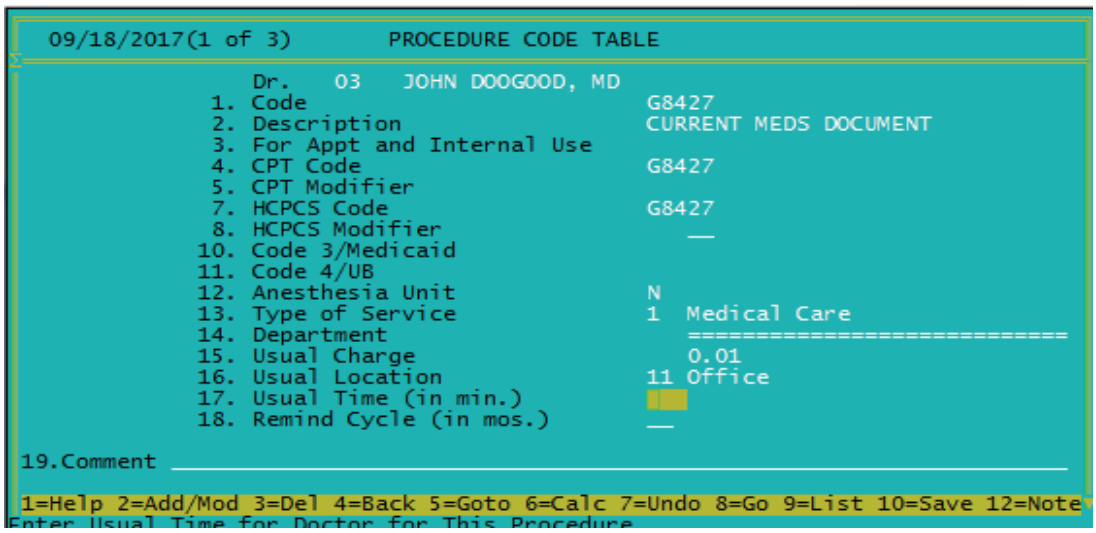
Using the Measure

Your next task is to retrieve the measure from the Quality Measure file. We have done that for you. The next three pages provide you with all the information you need to understand this measure. The critical information you need in in the items circled in red. The code which must be entered and transmitted on your claim to Medicare is G8427.

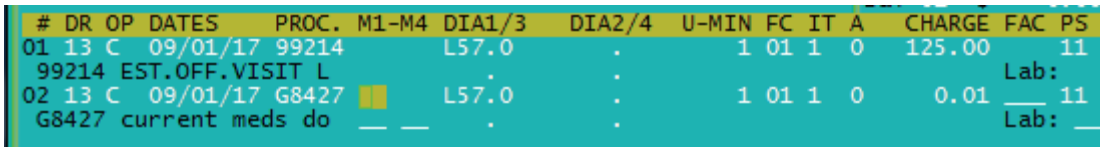
Setting Up UltraMED and Billing Your Claim

The code G8427 should be entered into UltraMED as a procedure. Below is an example. Note the charge is .01 cent. This tells Medicare to process this as part of the claim.

Enter Procedure



Enter Transaction



Choose a Medicare patient with an office visit ready to bill. Enter the transaction as illustrated in the picture above. We recommend that you use a patient that has a visit only to keep it simple. Create your claim (by itself with no other claims) and transmit it to Medicare using your normal billing procedures.

When you get the EOB back you will see a Remittance Advice Remark Code N620 or CO 246 if you have successfully met the requirement. KEEP THIS EOB IN A SAFE PLACE! It is proof that you have qualified for no penalty in 2019!

Billing this claim means no penalty in 2019!

Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record – National Quality Strategy Domain: Patient Safety

2017 OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS ONLY

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list ***must*** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency and route of administration

INSTRUCTIONS:
This measure is to be reported at each denominator eligible visit during the 12 month performance period. Eligible clinicians meet the intent of this measure by making their best effort to document a current, complete and accurate medication list during each encounter. There is no diagnosis associated with this measure. This measure may be reported by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting:
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 reported on the claim(s) representing the eligible encounter.

DENOMINATOR:
All visits for Patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the **performance period** (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 92002, 92004, 92012, 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, 99221, 99222, 99223, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

NUMERATOR:
Eligible clinician attests to documenting, updating or reviewing a patient's current medications using all immediate resources available on the date of encounter. This list ***must*** include ALL known prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosages, frequency and route of administration

Definitions:
Current Medications – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.
Route – Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical)

Not Eligible (Denominator Exception) – A patient is not eligible if the following reason is documented:

- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: The eligible clinician must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible clinicians reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible clinician documented that the patient is not currently taking any medications

Numerator Quality-Data Coding Options:

Current Medications Documented

Performance Met: G8427:	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications

OR

Current Medications not Documented, Patient not Eligible

Denominator Exception: G8430:	Eligible clinician attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible clinician

OR

Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason not Given

Performance Not Met: G8428:	Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given

RATIONALE:

Maintaining an accurate and complete medication list has proven to be a challenging documentation endeavor for various health care provider settings. While most of outpatient encounters (2/3) result in providers prescribing at least one medication, hospitals have been the focus of medication safety efforts (Stock et al., 2009). Nassaralla et al. (2007) caution that this is at odds with the current trend, where patients with chronic illnesses are increasingly being treated in the outpatient setting and require careful monitoring of multiple medications. Additionally Nassaralla et al. (2007) reveal that it is in fact in outpatient settings where more fatal adverse drug events (ADE) occur when these are compared to those occurring in hospitals (1 of 131 outpatient deaths compared to 1 in 854 inpatient deaths). In the outpatient setting, adverse drug events (ADEs) occur 25% of the time and over one-third of these are considered preventable (Tache et al., 2011). Particularly vulnerable are patients over 65 years, with evidence suggesting that the rate of ADEs per 10,000 person per year increases with age; 25-44 years old at 1.3; 45-64 at 2.2, and 65 + at 3.8 (Sarkar et al., 2011). Another vulnerable group are chronically ill individuals. These population groups are more likely to experience ADEs and subsequent hospitalization.

A multiplicity of providers and inadequate care coordination among them has been identified as barriers to collecting complete and reliable medication records. Documentation of current medications in the medical record facilitates the process of medication review and reconciliation by the provider, which are necessary for reducing ADEs and promoting medication safety. The need for provider to provider coordination regarding medication records, and the existing gap in implementation, is highlighted in the American Medical Association's (AMA) Physician's Role in Medication Reconciliation (2007), which states that "critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes" (p.7). This is because clinical decisions based on information that is incomplete and/or inaccurate are likely to lead to medication error and ADEs. Weeks et al. (2010) noted similar barriers and

identified the utilization of health information technology as an opportunity for facilitating the creation of universal medication lists.

CLINICAL RECOMMENDATION STATEMENTS:

The Joint Commission's 2015 Ambulatory Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section "Use Medicines Safely NPSG.03.06.01" states the following: "Maintain and communicate accurate patient medication information. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected to reconcile current and newly ordered medications and to safely prescribe medications in the future." (Joint Commission, 2015, retrieved at: http://www.jointcommission.org/assets/1/6/2015_NPSG_AHC1.PDF).

The National Quality Forum's 2010 update of the Safe Practices for Better Healthcare, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care (p. 40).