AMERICAN ACADEMY™
OF OPHTHALMOLOGY

American Academy of Ophthalmology

How to Use Claims to Manually Report 2018 Quality Data under MIPS

Background: In 2018, the reporting requirement for the Quality category of the MIPS program was increased to the full calendar year. The purpose of this guide is to educate ophthalmologists on how to meet the requirements of the Quality category of MIPS using Medicare claims reporting. Failure to successfully participate in MIPS in 2018 will lead to a 5% penalty on all Medicare Part B payments in 2020, so participation is in your best interest. Two things to consider before reading:

1. *Avoiding the Penalty or Earning a Bonus*?
   - This guide is focused on helping ophthalmologists in small practices (≤ 15 clinicians) meet the minimum criteria to avoid a penalty under the MIPS program. If you would like to do more (either to prepare yourself for next year or to earn a bonus), see Appendix B.
2. *Reporting as an Individual or as a Group?*
   - In the Quality category, **only providers reporting as individuals** may submit data via claims. Either you are in a solo practice, or in a group practice where every member of the group is reporting at the individual level.
3. *Is claims-based reporting the best option for you or your group?*
   - The Academy recommends the IRIS Registry® for quality reporting. It is a free member benefit and is tailored to ophthalmologists. In addition, the IRIS Registry Web Portal does not require reporting in real time as claims-based reporting does, and there is less uncertainty as you are able to track the patients and quality measures on which you report. Under claims-based reporting, CMS only confirms on remittance advice that the submission was received, but not that it was successful.

Contents:

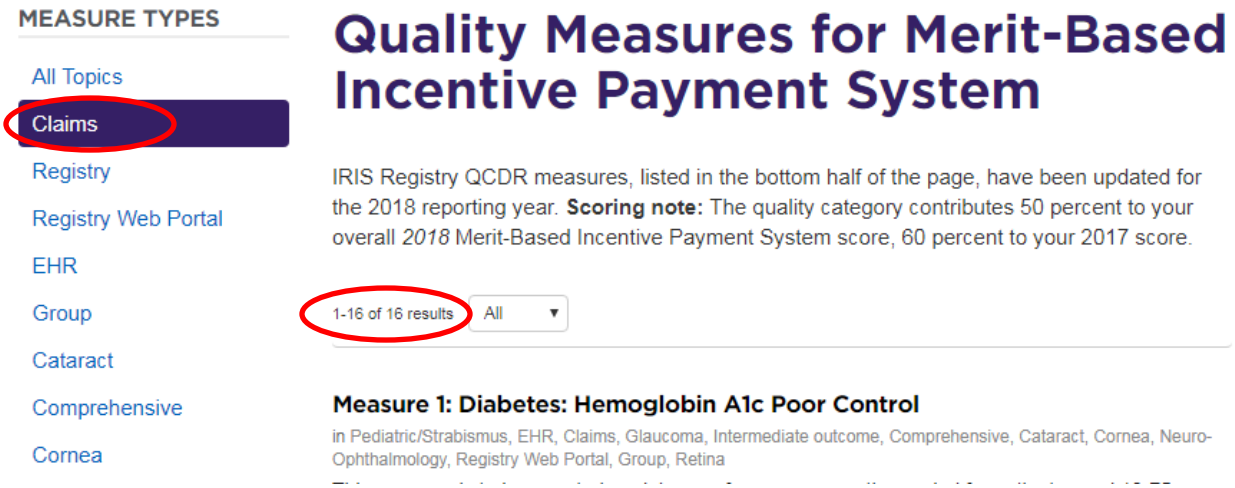
I. Minimum Reporting:

A. Finding the Right Measures

For the Quality category in the 2018 transition year (*the second year of the MIPS program)*, all clinicians in **small practices (≤ 15 clinicians)** can avoid the payment penalty by simply reporting on **6 measures (including 1 outcome measure), for 1 patient each**. The steps to fulfilling these minimum reporting requirements are listed below:

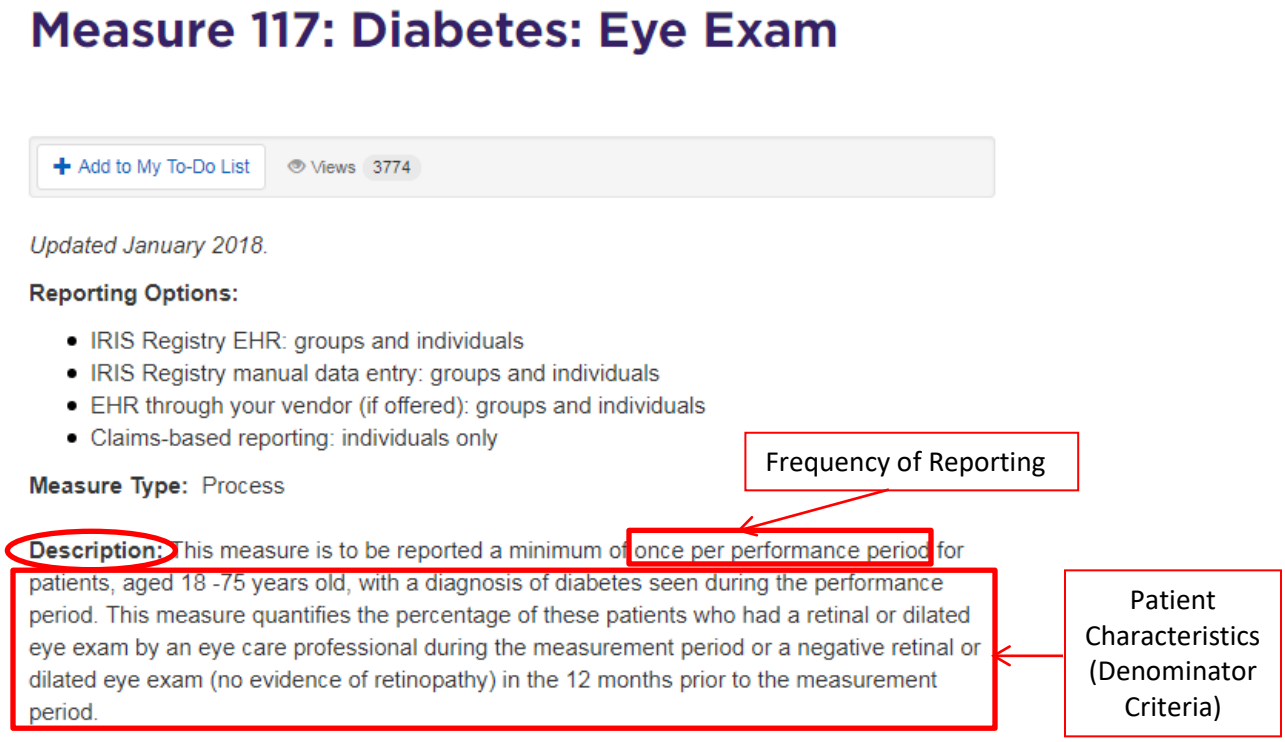
i) Visit the MIPS Quality Reporting page on the Academy website. Here, you will see the full list of 61 MIPS Quality measures that are either *specific* or relevant to ophthalmology.

ii) **Select the applicable measures**. Not all of these 61 measures can be reported via claims data. Some can only be reported via EHR or the IRIS Registry. To filter the list, select **Claims** under the side panel labeled "Measure Types."



This will narrow the list to 16 ophthalmology relevant measures that can be submitted via claims. Each measure is identified based on its **Quality ID #.** Make sure to select applicable measures (measures relevant to your services or care rendered) to report on. (*In this example, Measure 117 has been selected)*

iii) View the basic description of the measure. The **Description** section will describe how often the numerator/denominator codes for a measure have to be included in a claim for the patient.



iv) **Denominator:** There are 3 criteria for patient inclusion in the denominator (denominator eligibility).

1. Patient Characteristics: Description located in "Description" (see above)

2. Diagnosis Codes (ICD-10-CM): Codes located in "Diagnosis Codes"

3. Procedure Codes (CPT and HCPCS): Codes located in "CPT Codes"

The quality measure may also have exclusions for the denominator

Diagnosis Codes

CMS has stated that ICD-10 should be coded to the greatest specificity and unspecified codes may be denied. Therefore, the codes listed below with a strikethrough should not be included on your claim or submitted with this quality measure.

E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3219, E10.3291, E10.3292, E10.3293, ~~E10.3299~~, E10.3311, E10.3312, E10.3313, ~~E10.3319~~, E10.3391, E10.3392, E10.3393, ~~E10.3399~~, E10.3411, E10.3412, E10.3413, ~~E10.3419~~, E10.3491, E10.3492, E10.3493, ~~E10.3499~~, E10.3511, E10.3512, E10.3513, ~~E10.3519~~, E10.3521, E10.3522, E10.3523, ~~E10.3529~~, E10.3531, E10.3532, E10.3533, ~~E10.3539~~, E10.3541, E10.3542, E10.3543, ~~E10.3549~~, E10.3551, E10.3552, E10.3553, ~~E10.3559~~, E10.3591, E10.3592, E10.3593, ~~E10.3599~~, E10.36, E10.37X1, E10.37X2, E10.37X3, ~~E10.37X9~~, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.3211, E11.3212, E11.3213, ~~E11.3219~~, E11.3291, E11.3292, E11.3293, ~~E11.3299~~, E11.3311, E11.3312, E11.3313, ~~E11.3319~~, E11.3391, E11.3392, E11.3393, ~~E11.3399~~, E11.3411, E11.3412, E11.3413, ~~E11.3419~~, E11.3491, E11.3492, E11.3493, ~~E11.3499~~, E11.3511, E11.3512, E11.3513, ~~E11.3519~~, E11.3521, E11.3522, E11.3523, ~~E11.3529~~, E11.3531, E11.3532, E11.3533, ~~E11.3539~~, E11.3541, E11.3542, E11.3543, ~~E11.3549~~, E11.3551, E11.3552, E11.3553, ~~E11.3559~~, E11.3591, E11.3592, E11.3593, ~~E11.3599~~, E11.36, E11.37X1, E11.37X2, E11.37X3, ~~E11.37X9~~, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, 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~~, E13.36, E13.37X1, E13.37X2, E13.37X3, ~~E13.37X9~~, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, O24.011, O24.012, O24.013, ~~O24.019~~, O24.02, O24.03, O24.111, O24.112, O24.113, ~~O24.119~~, O24.12, O24.13, O24.311, O24.312, O24.313, ~~O24.319~~, O24.32, O24.33, O24.811, O24.812, O24.813, ~~O24.819~~, O24.82, O24.83

Diagnosis Codes

CPT Codes

CPT Codes

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

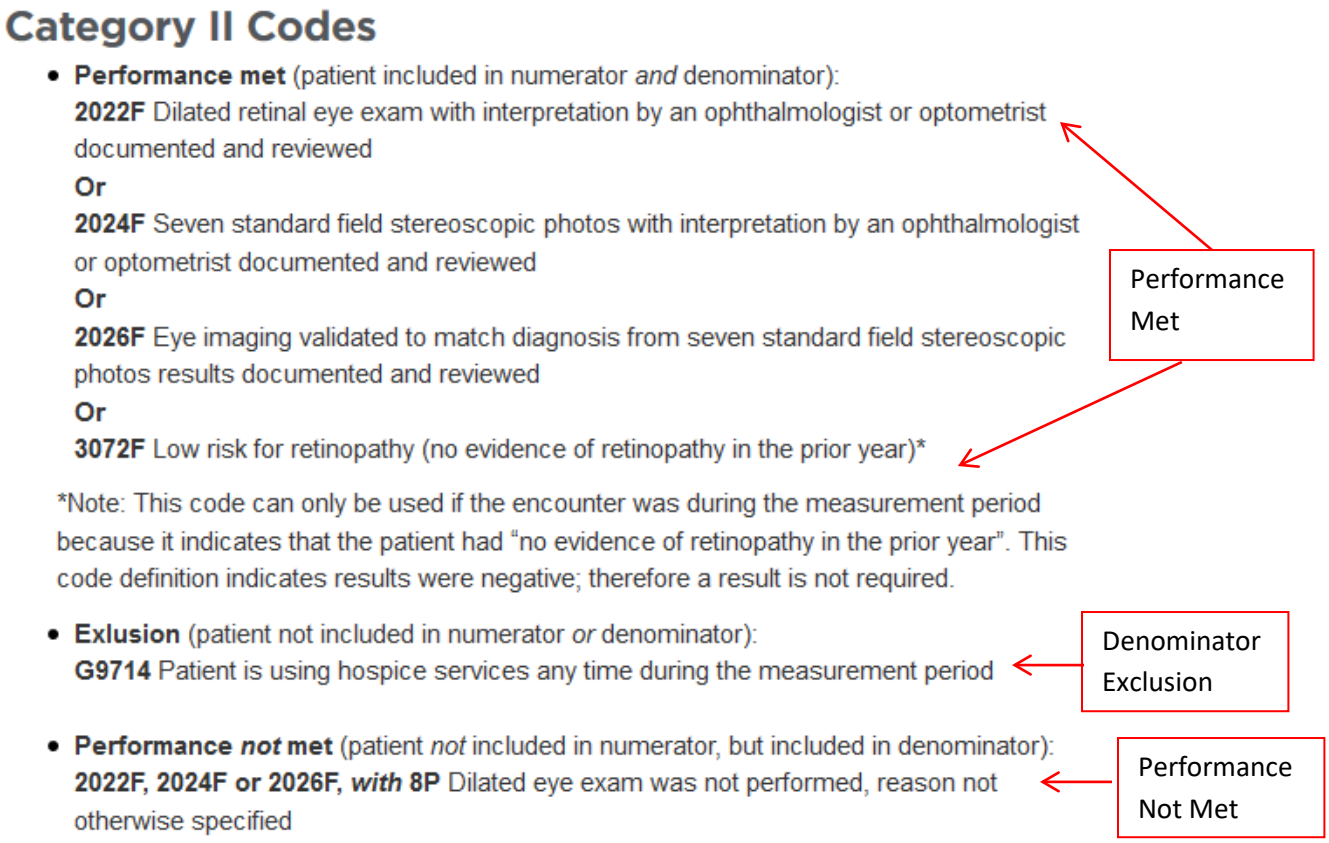
Denominator Exclusions (patient ineligible): Patient is using hospice services any time during the measurement period: G9714

Denominator Exclusion

Note: Some codes have an asterisk (*) next to them. These are for Registry submission only.

v) **Numerator:** The Numerator is based on CPTII codes, and these Quality Data Codes (QDCs) are organized into one of three categories.

1. **Performance Met (Patient is Included in Numerator, Patient is Included in Denominator)**
2. **Denominator Exclusion (Patient is Not Included in Numerator, Patient is Not Included in Denominator).**
3. **Performance Not Met (Patient is Not Included in Numerator, Patient is Included in Denominator) Denominator)**



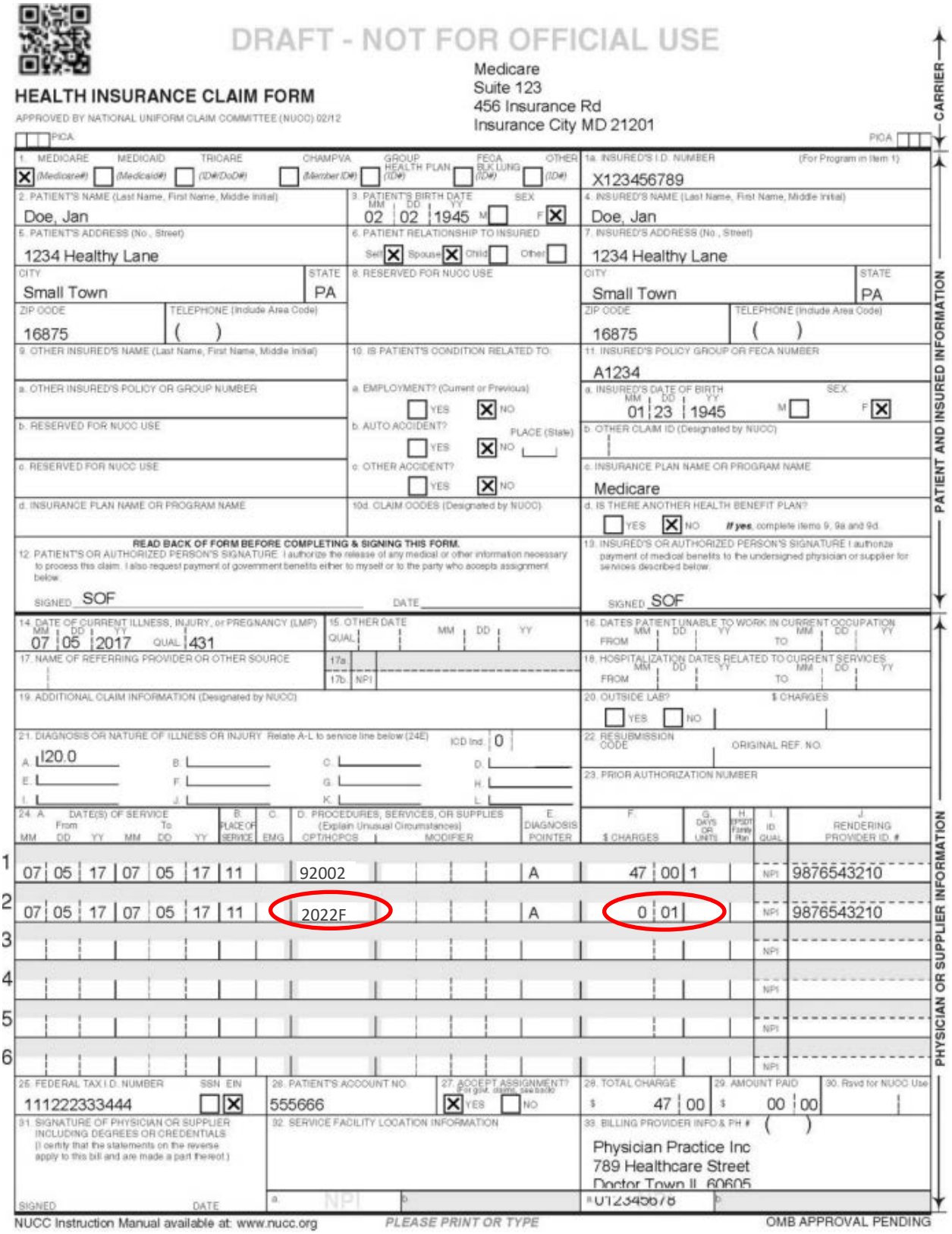
B. Reporting the Measures

i) Report on Quality Measures on a regular CMS 1500 Medicare Part B Claim. Identify a patient encounter that is relevant to your selected quality measure (or vice versa), and add the QDC to the "Procedures, Services, and Supplies" section of the Claim form.

ii) **Note:** *The Quality Code must be submitted as its own line item, and must include a value of $0.01 under the "$ Charge" section*.

iii) **Note:** When reporting, make Sure to Use MIPS QDCs, not old PQRS QDCs.

On the next page is an example of a CMS 1500 form with Quality Reporting. The patient was seen for an office visit, and the provider is reporting on Quality Measure ID# 117, using Quality Data Code 2022F.



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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Medicare
Suite 123
456 Insurance Rd
Insurance City MD 21201

CARRIER

PICA

1. MEDICARE [X] (Medicare#) | MEDICAID [ ] (Medicaid#) | TRICARE [ ] (ID#/DoD#) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (ID#) | FECA BLK LUNG [ ] (ID#) | OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): X123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jan

3. PATIENT'S BIRTH DATE: 02 | 02 | 1945 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Jan

5. PATIENT'S ADDRESS (No., Street): 1234 Healthy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 1234 Healthy Lane

CITY: Small Town | STATE: PA

8. RESERVED FOR NUCC USE

CITY: Small Town | STATE: PA

ZIP CODE: 16875 | TELEPHONE (Include Area Code): ( )

ZIP CODE: 16875 | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: A1234

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 01 | 23 | 1945 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicare

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SOF DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SOF

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 07 | 05 | 2017 QUAL: 431

15. OTHER DATE QUAL: MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM | DD | YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM | DD | YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. I20.0 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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 (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	07 05 17	07 05 17	11		92002		A	47 00	1		NPI	9876543210
2	07 05 17	07 05 17	11		2022F		A	0 01			NPI	9876543210
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 111222333444 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 555666

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 47 00

29. AMOUNT PAID: $ 00 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #: ( )

Physician Practice Inc
789 Healthcare Street
Doctor Town IL 60605

a. b. 1234567

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

II. Beyond Minimum Reporting (Partial/Full path)

Clinicians in small practices (≤ 15 clinicians) will receive 3 out of 10 points for each quality measure reported on at least 1 patient (up to 6 measures, maximum). To be eligible to receive the remaining 7 out of 10 points for each quality measure, additional criteria must be met.

Going beyond minimum reporting requirements are the partial and full paths. The only difference between these paths is how comprehensive your reporting is. The maximum number of points within the Quality category is 60, and a provider can report on up to 6 measures (6 measures x 10 points each = 60 points total). The Quality category is weighted at 50% of the MIPS Final Score, meaning that a perfect Quality score will contribute 50% of the MIPS Final Score. Other basic requirements include:

i) **Performance Period:** Quality reporting must be done for a full calendar year within the 2018 performance year.

ii) **Data Completeness:** For each measure, the clinician must report on at least 60% of all Medicare Part B denominator-eligible patients seen during the performance year (this number is the data completeness numerator for the measure). [1]

iii) Case Minimum: For any quality measure, at least 20 patients must be included in the denominator.

Scoring: Apart from the 3 base points for participation, the additional 7 out of 10 points are based on **performance rate**, which is calculated based on the following formula:

$$\frac{Performance\ Met}{Data\ Completeness\ Numerator - Denominator\ Exclusion - Denominator\ Exception}$$

This performance rate percentage is compared to a benchmark (*individual for each measure based on collective performance*). Your score, out of 10, depends on which decile along the benchmark your performance rate lies within. **Note:** Since clinicians in small practices receive a base score of 3 points, the first three deciles are pooled into Decile 3. See Appendix B for performance required for each measure in order to earn more than 3 points.

Decile Range	Points Awarded	Decile Range	Points Awarded
Decile 3	3-3.9	Decile 7	7-7.9
Decile 4	4-4.9	Decile 8	8-8.9
Decile 5	5-5.9	Decile 9	9-9.9
Decile 6	6-6.9	Decile 10	10

[1] For example, for the Diabetic Retinopathy measures, the denominator-eligible patients are all patients between the ages of 18 and 75 years with diabetes.

Appendix A: **Comparison of 2017 vs. 2018 MIPS Quality Data Codes**

Measure Title	Measure ID #	QDC Changes
Diabetes: Hemoglobin A1C poor Control	1	NONE
Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	12	NONE
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	14	Change: **Performance Met: G9974** (Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage and the level of macular degeneration severity) **Denominator Exclusion: G9975** (Documentation of medical reason(s) for not performing a dilated macular examination) **Denominator Exclusion: G9892** (Documentation of patient reason(s) for not performing a dilated macular examination) **Performance *Not* Met: G9893** (Dilated macular exam not performed)
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	NONE
Care Plan	47	NONE
Preventive Care and Screening: Influenza Immunization	110	NONE
Pneumonia Vaccination Status for Older Adults	111	NONE
Diabetes: Eye Exam	117	NONE
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	128	NONE
Documentation of Current Medications	130	NONE
Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	140	NONE

Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR	141	NONE
Preventive Care and Screening: Tobacco use: Screening and Cessation Intervention	226	**Major Changes: This is now a 3-Part Measure** Patient is Tobacco User: All parts required; Non-Users: Part I and III. **Part I -** Patients screened for tobacco use at least once within 24 months **Performance Met: G9902 or G9903** (Patient screened and identified as a tobacco user or non-user, respectively) **Denominator Exclusion: G9904** (Documentation of medical reason(s) for not screening for tobacco use*) **Performance *Not* Met: G9905** (Patient not screened for tobacco use, reason not given) **Part II -** Identified tobacco users receive tobacco cessation intervention **Performance Met: G9906** (Patient identified as a tobacco user received tobacco cessation intervention (counselling and/or pharmacotherapy) **Denominator Exclusion: G9907 AND G9902** (Documentation of medical reason(s) for not providing tobacco cessation intervention*) **Performance *Not* Met: G9908 AND G9902** (Patient identified as tobacco user did not receive tobacco cessation intervention, reason not given) **Part III -** Patients screened AND either non-tobacco user or received tobacco cessation intervention, if positive **Performance Met: CPTII 4004F or CPTII 1036F** (Patient screened and identified as a tobacco user AND received intervention; or non-user, respectively) **Denominator Exclusion 1: CPTII 4004F + 1P** (Tobacco screening not performed OR tobacco cessation intervention not provided, for medical reasons*) **Denominator Exclusion 2: G9909** (Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user*) **Performance *Not* Met: CPTII 4004F + 8P** (Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise specified) *e.g., limited life expectancy, other medical reason

Controlling High Blood Pressure	236	Addition: **Denominator Exclusion: G9910** Patients age 65 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 any time during the measurement period)
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	317	NONE
Melanoma Reporting	397	NONE

Appendix B: 2018 Claims Quality Measures Benchmarks

Measure Name	Measure ID	Submission Method	Measure Type	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	12	Claims	Process	98.99 - 99.99	--	--	--	--	--	--	100.00	Yes
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	14	Claims	Process	99.60 - 99.99	--	--	--	--	--	--	100.00	Yes
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	Claims	Process High Priority	--	--	--	--	--	--	--	100	Yes
Diabetes: Eye Exam	117	Claims	Process	88.98 - 98.44	98.45 - 99.99	--	--	--	--	--	100.00	Yes
Documentation of Current Medications in the Medical Record	130	Claims	Process High Priority	97.20 - 99.23	99.24 - 99.79	99.80 - 99.99	--	--	--	--	100.00	Yes
Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	140	Claims	Process	97.33 - 99.99	--	--	--	--	--	--	100.00	Yes
Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	141	Claims	Outcome	--	--	--	--	--	--	--	100	Yes

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Claims	Process	96.65 - 98.59	98.60 - 99.61	99.62 - 99.99	--	--	--	--	100.00	Yes
Melanoma Reporting	397	Claims	Outcome	68.33 - 78.42	78.43 - 95.11	95.12 - 99.99	--	--	--	--	100	Yes
Diabetes: Hemoglobin A1c Poor Control	1	Claims	Outcome	33.33 - 23.54	23.53 - 18.25	18.24 - 14.30	14.29 - 11.55	11.54 - 8.90	8.89 - 6.26	6.25 - 3.34	≤ 3.33	No
Care Plan	47	Claims	Process	18.63 - 36.26	36.27 - 68.14	68.15 - 93.72	93.73 - 98.73	98.74 - 99.99	--	--	100.00	No
Preventive Care and Screening: Influenza Immunization	110	Claims	Process	23.29 - 33.13	33.14 - 46.93	46.94 - 62.62	62.63 - 74.35	74.36 - 86.05	86.06 - 97.34	97.35 - 99.99	100.00	No
Pneumonia Vaccination Status for Older Adults	111	Claims	Process	44.78 - 55.87	55.88 - 65.57	65.58 - 73.27	73.28 - 80.67	80.68 - 87.34	87.35 - 93.84	93.85 - 99.68	≥99.69	No
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	128	Claims	Process	43.20 - 48.42	48.43 - 58.92	58.93 - 83.56	83.57 - 96.60	96.61 - 99.53	99.54 - 99.99	--	100.00	No
Controlling High Blood Pressure	236	Claims	Outcome	58.02 - 63.90	63.91 - 68.36	68.37 - 72.91	72.92 - 76.91	76.92 - 81.65	81.66 - 86.95	86.96 - 94.06	≥94.07	No
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	317	Claims	Process	49.53 - 57.74	57.75 - 66.45	66.46 - 78.56	78.57 - 90.52	90.53 - 98.16	98.17 - 99.99	--	100.00	No