American Academy of Ophthalmology

How to Read a 2020 MIPS Quality Measure

Background: Under the Quality Payment Program, the quality category takes the place of PQRS. The purpose of this guide is to educate ophthalmologists on how to read a quality measure on the AAO website. Quality constitutes 45 percent of your MIPS Final Score.

I. **Performance Period:** Quality performance period in 2020 is the full calendar year.

II. **Data Completeness:** In order to have your performance scored on any measure, the clinician must report on at least **70% of all of each measure's 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.

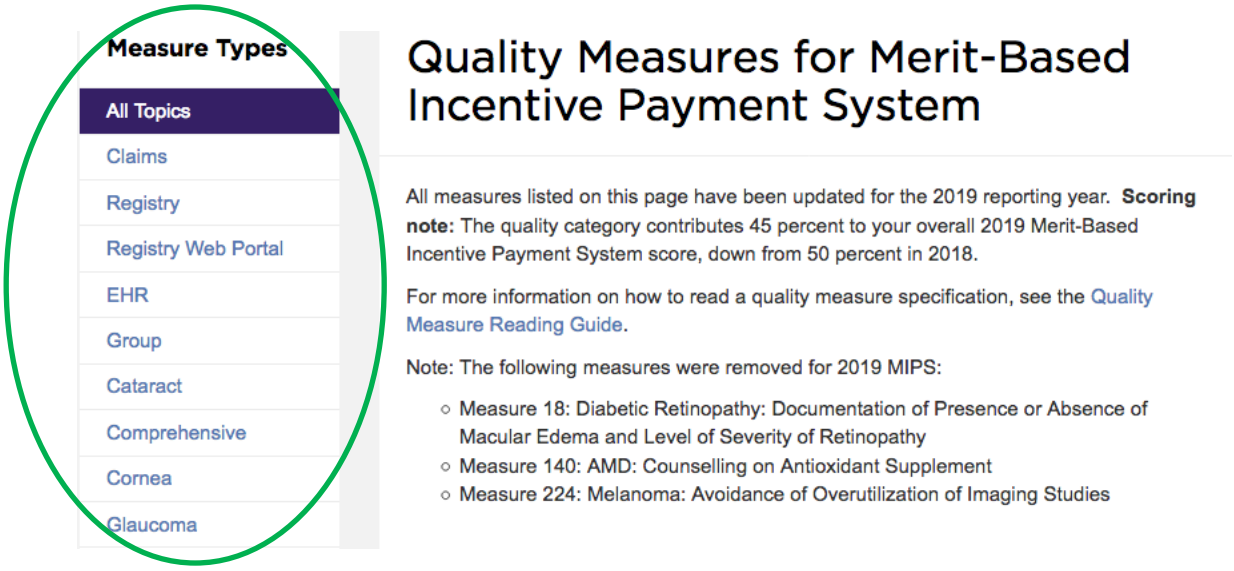
IV. **How to Find Quality Measures**

A. Visit the MIPS Quality Reporting page on the Academy website. Here, you will see the full list of 53 MIPS Quality measures that are either *specific* or relevant to ophthalmology.

B. These measures can be filtered by subspecialty and by applicable submission types.

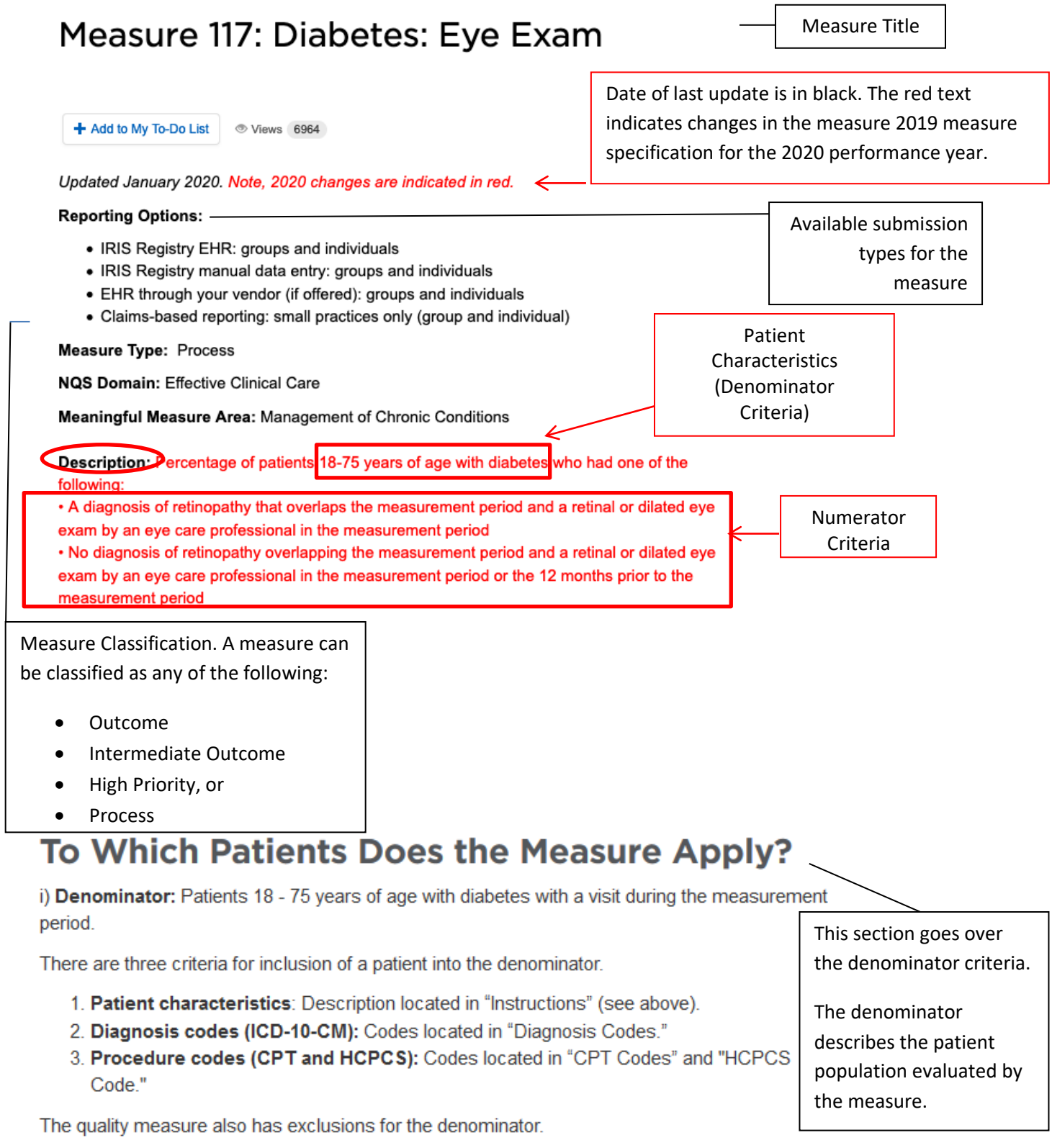
i. Not all filters are displayed in the snapshot below.

ii. Measures can only be submitted via claims by individuals in small practices or group reported by small practices.



[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.

V. How to Read a Measure Once You Find It



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 O24.113, ~~O24.119~~, O24.12, O24.13, O24.311, O24.312, O24.313, ~~O24~~ O24.811, O24.812, O24.813, ~~O24.819~~, O24.82, O24.83

The Diagnosis Codes Section lists the ICD-10 codes that help define the patients included in the measure denominator (See "To Which Patients Does This Measure Apply?" above).

Diagnosis 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, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, ~~G0402~~, G0438, G0439

Denominator Note: *Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.

The CPT Codes Section lists the CPT codes that help define the patients included in the measure denominator (See "To Which Patients Does This Measure Apply?" above).

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

Numerator: The Numerator is based on Quality Data Codes (QDCs) which are organized into one of three categories.

1. **Denominator Exclusion –** Patient is ineligible to be measured. (Patient is Not Included in Numerator, Patient is Not Included in Denominator).
2. **Performance Met** (Patient is Included in Numerator, Patient is Included in Denominator)
3. **Denominator Exception –** Patient is eligible to be measured, but there is a medical reason for not performing the numerator criteria. (Patient is Not Included in Numerator, Patient is Not Included in Denominator).
4. **Performance Not Met** (Patient is Not Included in Numerator, Patient is Included in Denominator).

This section explains how to satisfy and report the measure for each available submission mechanism.

How to Report the Measure

This section explains how to report your performance without an EHR through Claims and the IRIS Registry Web Portal.

Claims and IRIS Registry Manual Reporting

Numerator: Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal or diabetic with no diagnosis of retinopathy overlapping the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period or the year prior to the measurement period.

Numerator note: The eye exam must be performed or reviewed by an ophthalmologist or optometrist. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

Numerator: describes the outcome or clinical action counted as meeting the measure requirements.

Quality Data Codes

- **Denominator Exclusions (patient ineligible for measure):**
  G9714: Patient is using hospice services any time during the measurement period.
  Or
  G2105: Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 days during the measurement period.
  Or
  G2106: Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia (Donepezil, Rivastigimine, Galantamine, Memantine) during the measurement period or the year prior to the measurement period.
  Or
  G2107: Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period.

Denominator Exclusion

- **Performance met** (patient included in numerator *and* denominator):
  G2102 Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
  Or
  G2103 Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
  Or
  G2104 Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed
  Or
  3072F Low risk for retinopathy (no evidence of retinopathy in the prior year)*

Performance Met

*Note: This code can only be used if the encounter was during the measurement period because it indicates that the patient had "no evidence of retinopathy in the prior year". This code definition indicates results were negative; therefore a result is not required.

- **Performance *not* met** (patient *not* included in numerator, but included in denominator):
  G2102 with 8P or G2103 with 8P or G2104 with 8P** Dilated eye exam was not performed, reason not otherwise specified

Performance Not Met

**Note: For Performance Year 2020 reporting, the Centers for Medicare & Medicaid Services and the American Medical Association have approved the use of the 8P modifier with HCPCS codes to report the Performance Not Met numerator option for Quality ID #117.

IRIS Registry EHR Reporting

Instructions: Percentage of patients aged 18 – 75 years of age with diabetes (type 1 or type 2) with and without a diagnosis of retinopathy overlapping the measurement period, who has a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.

These are the required elements to be documented at least once a year to meet the measure performance requirements.

- Retinal or dilated eye exam, unless exam showing no retinopathy in previous year

This section explains how your performance is measured through IRIS Registry-EHR Integration.

These are the general documentation requirements for this measure for those submitting through IRIS-EHR integration.

How CMS Scores Your Performance

- If you successfully report a measure for *less than* 70 percent of your patients, you will earn points based on your practice size:
  - Small practices (≤ 15 clinicians) will receive 3 points,
  - Larger practices (> 15 clinicians) will receive 0 points.
- If you successfully report a measure for *at least* 70 percent of your patients, but do not report at least 20 cases, you will receive 3 points.
- If you report this measure for *at least* 70 percent of applicable patients and on *at least* 20 patients during a performance period, you will earn points based on the decile that corresponds to your performance rate. Not all measures offer points for every decile.
- For those reporting this measure using claims or IRIS Registry manual/web portal, there is a 7 point cap.

This section describes the process by which measures are evaluated and how degree of reporting impacts maximum available score.

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

Not included in the measure specifications is the performance calculation.

Benchmarks

Decile/Points	EHR (including EHR-IRIS integration)	IRIS Registry web portal (No EHR)	Claims
3	0.6 - 6.83	0.61 - 23.29	3.32 - 25.79
4	6.84 - 21.2	23.3 - 80.68	25.8 - 91.04
5	21.21 - 49.99	80.69 - 97.83	91.05 - 99.99
6	50 - 97.37	97.84 - 99.99	--
7	97.38 - 99.84	100 *Capped at 7 points*	100 *Capped at 7 points*
8	99.85 - 99.99	--	--
9	--	--	--
10	100	--	--

Measures that are topped out (average score of 95% or greater) for 2 years will have a cap of 7 points out of 10.

Each collection type is scored differently based on your performance. This table shows the number of points per performance range by collection type.