

MIPS QUALITY GUIDE 2023

➤ Step-by-Step to Success

Overview of MIPS Quality Category

Quality is at least 30% of your MIPS Final Score

To be “reliably scored against the performance benchmarks” CMS requires that your Quality Measures have:

Sufficient Case Volume

At least 20 cases/occurrences during the year. Measures will earn 0 points in the 2023 performance year if case minimum requirements are not met. Small practices will continue to earn 3 points.

70% Data Completeness

Definition: To meet data completeness criteria, you must report performance data (performance met, not met, or any denominator exceptions) for at least 70% of the eligible population (denominator).

Measures will earn 0 points for the 2023 performance years if data completeness is not met. Small practices will continue to earn 3 points.

Data completeness criteria and benchmarks are different for each Collection Type



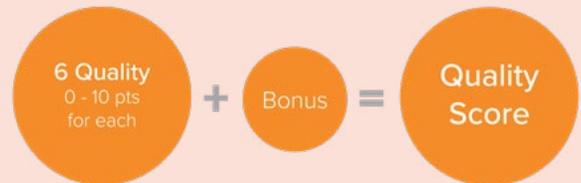
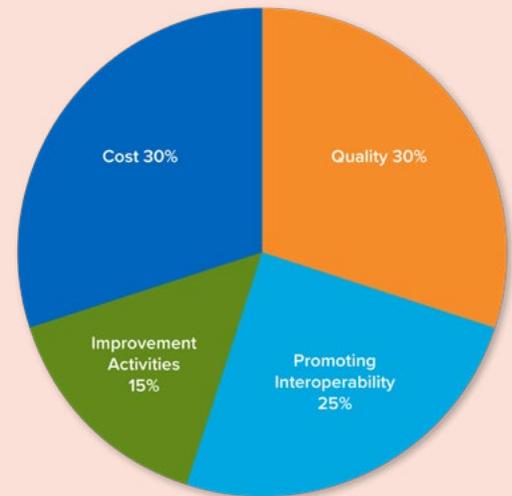
Claims Medicare Part B patients (small practices only)



eCQM/MIPS CQM/QCDR all patients across all payors

MIPS Performance

Categories for 2023



Bonuses Available for Quality Score

Small Practice = 6 points will be added to the numerator of the Quality category for small practices* that submit at least one Quality measure.

*15 or fewer Medicare eligible clinicians.

Choose & Report on Six Quality Measures

At least one measure needs to be an Outcome Measure. If an Outcome Measure is not applicable to your specialty and workflow, have at least one High Priority Measure instead. Collect measure data for the 12-month performance period (January 1 - December 31).

Note: CMS will take your highest score—so to ensure your best Quality score, we recommend that you choose more than six Quality measures.

Go to <https://qpp.cms.gov/mips/explore-measures> to see details for CMS’s Quality Measures.

Quality Collection Types

The 6 measures may be collected via different collection types. Definition: Collection Type – the way in which the data for the Quality Measure is collected.

eCQM

Data is collected in the EHR using eCQM templates, reports are run in the Clinical Quality Reporting Module (CQR). Upload the QRDA III report to CMS to attest.

Claims Based

Quality codes are included on your claims to Medicare throughout the year. This method is only allowed for Small Practices.

MIPS CQM

Zero dollar, non-billable Quality codes are captured using the billing module throughout the year. The Qualified Registry Report captures the required fields for certain measures and is available to share with a Qualified Registry.

eCQM (EHR) Measures

Once you have imported the eCQM subnotes for your chosen measures – get familiar with the details and documentation requirements.

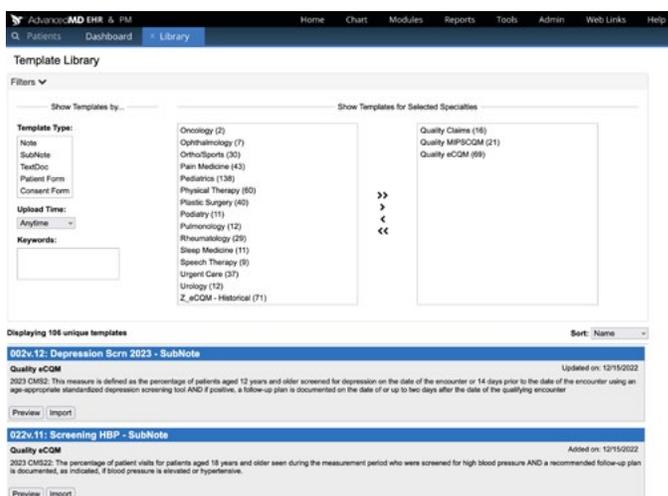
Most often practices will create one eCQM note template with all of the measures the provider/clinician is participating in, and link the signed note to the patient visit. Alternately, create an eCQM tab on the office's pre-existing visit note. Drop the subnote templates into the tab. Or finally, drop an eCQM subnote directly into the patient's visit note.

For more information about creating or modifying a note template see the

AdvancedMD Help Files or contact Professional Services for additional 1:1.

Use the AdvancedMD CQR module (PM > Modules > Clinical Quality Reporting) to run reports periodically to identify any needed workflow or documentation changes to improve your performance in each measure. Note: QRDA III performance reports only support eCQM measures.

For more information about using CQR see the AdvancedMD Help Files and Video Training Library.



Note: Altering templates fields can affect your eCQM report data. eCQM template fields have been created, configured, and coded to work with the AdvancedMD CQR module.

Any edits you make to a template field includes the possibility that you will break the coding relationships resulting in data not being captured. Edits could include moving templates within a note template. You can make adjustments to non-field related areas such as Word Merge, Auto-Fill, and the additional information such as descriptions on templates.

Claims Based Measures—Remember only Medicare carriers* need codes on claims

Medicare Part B claims can be submitted if your practice has 15 or fewer clinicians. Go to QPP Resource Library <https://qpp.cms.gov/about/resource-library>

Download the “Medicare Part B Claims Measure Specifications and Supporting Documents”. This contains the specifications for the Claims Quality Measures.

Each specification document has details about the measure, the target patient population, documentation required, and suggested workflows. Most importantly it contains the list of the codes that you need to submit on your claims for this measure and what each code means.

Please keep in mind it's not enough to put the code on your claim—you need to be sure you have the documentation in your records to validate the code you choose for your claim.

Import these codes into your PM (Master Files > Transaction Codes > Procedure Code Import).

Suggested workflow: configure your note templates with fields that capture your codes. Include checkbox fields that have been tied to the claim codes for the measure. When

documenting a visit—select the checkboxes with the appropriate codes for your measures and save the visit. Add/Link a Pre-filled Chargeslip to the note and those codes will be added to your claims. Note: Add codes to the Charge Slip Template in order to use link Pre-Filled Charge Slip.

See the Quality Claims folder for the list of available claim subnotes.

Note: Some clients will use AdvancedMD's Analysis of Services report to help identify which Quality claim codes they have submitted to Medicare. Setting up Charge Code Categories for each Quality Measure to assign to the codes for your measures can help facilitate running that report for your Quality Measures.

For more information, see AdvancedMD Help File eCQM Medicare Part B Claim Templates.

Note: Some Medicare intermediaries require that these claim codes be submitted with \$.01 on them, other Medicare intermediaries prefer them to be \$0 line items. Check with your Medicare intermediaries to know which they will accept for Quality claim codes and set up your codes appropriately.

For those that prefer \$0 line items—make sure that your Medicare carriers* have the “Bill \$0.00 Claims/Line Item” box checked.

For those that prefer \$.01 charges—set those up in the PM Fee Schedules, adding \$.01 charge for each of the claim codes.

*Medicare, RR Medicare, Medicare as Secondary

MIPS CQM Measures (Registry)

Use the Qualified Registry report to submit specialty specific quality measure data to the CMS QPP. You can collect MIPS CQM data (Registry Measures) using either the PM or EHR.

The generated report file includes required CQM measure data you can upload to a qualified third-party registry vendor. Once registry data is uploaded to the vendor, you can view your measure performance rates before your data is submitted to CMS.

Although AdvancedMD is not a qualified registry vendor, you can set up the AdvancedMD software to collect CQM measures data for the report:

1. Review CQM measure specifications.
2. Import measure specification *HCPCS codes to the software application using the Procedure Code Import tool in PM. Save the HCPS codes as non-billable.

3. Create customized Charge Slip templates that include HCPCS codes.
4. Create custom EHR templates to document measure performance. (optional)
5. Document measure performance by selecting HCPCS codes when completing visit charge slips.

Once you have set up your software system and entered charges for patient visits, run and export the Qualified Registry report in CSV file format and upload the report file to a qualified registry vendor.

*HCPCS is a collection of standardized codes that represent medical procedures, supplies, products and services. The codes are used to facilitate the processing of health insurance claims by Medicare and other insurers.

See the Qualified Registry Report Help File for more information.

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