HOW TO AVOID THE 4% MIPS PENALTY IN 2019 WITHOUT AN EHR OR A REGISTRY!

A couple of disclaimers.
First, what I'm about to lay out in this document (and slides that follow) SHOULD work, and you SHOULD avoid the 4% MIPS penalty in 2019-- even without an EHR, OR a Registry!
No one will know until sometime in 2018, or perhaps not until you get your first EOB in 2019.
I can't take any responsibility that this will actually work, but I have run it by AAD Staff, and they agree that what I have done should THEORETICALLY exempt me (and anyone else doing it) from the MIPS penalty in 2019.
This should work in 2017 (for 2019), but not in future years - unless the rules get relaxed again by CMS.

So, without further ado...
1. Goto: *https://qpp.cms.gov/mips/quality-measures*
2. Filter by "Data Submission" and check off "Claims"
3. You should then have a list of the 74 quality measures that you can submit through claims (ie no EHR or Registry necessary).
4. You can choose any one you like, but I find the easiest one to be: "Documentation of Current Medications in the Medical Record”
5. If you click on the link, it identifies this measure as "Quality ID: 130."
6. On another part of the website, you can download a large zipfile with all of the measures (if you use my example, don't bother doing this), and how to submit them: *https://qpp.cms.gov/about/resource-library.* Scroll down and click on Quality Measure Specifications, and then download 2017_Measure_130_Claims.pdf from the list. (this file is attached to this email)
7. This will show you that to report Measure 130 by claim, you need to use a G code. In this case **G8427.**
8. So now you have to satisfy the measure- which reads:

*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***

9. So once you have done that, you can now report the code on your claim. The CPT code is G8427, and you should link it to any ICD-10 code in your claim (you can list this with an E/M and/or a procedure code).

10. Some clearinghouses won't accept $0 charges, so I recommend you place a $0.01 charge to it (and write it off later).

11. Upon receiving your EOB, you should notice 2 remark codes relating to the G8427 line (I have attached a highlighted EOB to this email as well)- CO-246 and N620.

Both of these codes indicate that CMS acknowledges your quality submission.

As stated earlier, for 2017 (for the 2019 Penalty year) you ONLY need to do this 1 time, for 1 patient-- and you should be exempt from the 4% penalty, BUT as I also said earlier, I would recommend doing it around a dozen times, just to be sure.

I hope this helps!

Good luck!!

Mark D. Kaufmann, MD

- *https://qpp.cms.gov/mips/quality-measures*

Select Measures

SEARCH ALL BY KEYWORD

All | Search for... | SEARCH

FILTER BY:

High Priority Measure | Data Submission Method | Specialty Measure Set

Showing **271** Measures

Add All Measures

- Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use — ADD
- Acute Otitis Externa (AOE): Topical Therapy — ADD
- ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication — ADD

Selected Measures

1 Measures Added

Download (CSV) | Clear All

Documentation of Current Medications in the Medical Record ✖

Select Measures

SEARCH ALL BY KEYWORD

Filtered | Search for... | SEARCH

FILTER BY:

High Priority Measure | Data Submission Method | Specialty Measure Set

- [ ] Administrative Claims
- [x] Claims
- [ ] CSV
- [ ] CMS Web Interface
- [ ] EHR
- [ ] Registry

Clear All Filters | Claims ✖

Showing **74** Measures

Ac

Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use — ADD

Acute Otitis Externa (AOE): Topical Therapy — ADD

Age-Related Macular Degeneration (AMD): Counseling on Antioxidant — ADD

Selected Measures

1 Measures Added

Download (CSV) | Clear All

Documentation of Current

Documentation of Current Medications in the Medical Record

ADD

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: N/A
- NQF: 0419
- Quality ID: 130

NQS Domain

Patient Safety

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

- *https://qpp.cms.gov/about/resource-library*

MIPS Measures for Primary Care Clinicians (571KB)	PDF	June 15th, 2017
MIPS Participation Fact Sheet (133KB)	PDF	May 4th, 2017
Predictive QP Methodology Fact Sheet (1.1MB)	PDF	June 2nd, 2017
QCDR Self-Nomination Fact Sheet (161KB)	PDF	December 29th, 2016
Qualified Registry Self-Nomination Fact Sheet (143KB)	PDF	December 29th, 2016
Quality Measure Encounter Codes (131KB)	ZIP	December 29th, 2016
Quality Measure Specifications (249.3MB)	ZIP	December 29th, 2016
Quality Measure Specifications Supporting Documents (8.3MB)	ZIP	February 13th, 2017
Quality Payment Program Fact Sheet (3.6MB)	PDF	October 14th, 2016
Quality Payment Program: Key Objectives (101KB)	PDF	December 29th, 2016
Small Practice Fact Sheet (288KB)	PDF	October 14th, 2016
Support for Small Practices (161KB)	PDF	March 17th, 2017
Technical Assistance Resource Guide (359KB)	PDF	May 10th, 2017

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)

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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

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Quality Measure Cl... ×

04/06/2017 - 04/06/2017	0	HC:G8427	$0.01	$0.00	- CO-246: $0.01
		REM: N620			

Adjustment Group Codes
CO : Contractual Obligations
PR : Patient Responsibility

Adjustment Reason Codes
2 : Coinsurance Amount
45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)
237 : Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
246 : This non-payable code is for required reporting only.
253 : Sequestration - reduction in federal payment

Remark Codes
MA01 : Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA18 : Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
N620 : Alert: This procedure code is for quality reporting/informational purposes only.
N699 : Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program