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Fine-Tuning the Nuts and Bolts of 2018 MIPS for Diagnostic Radiology

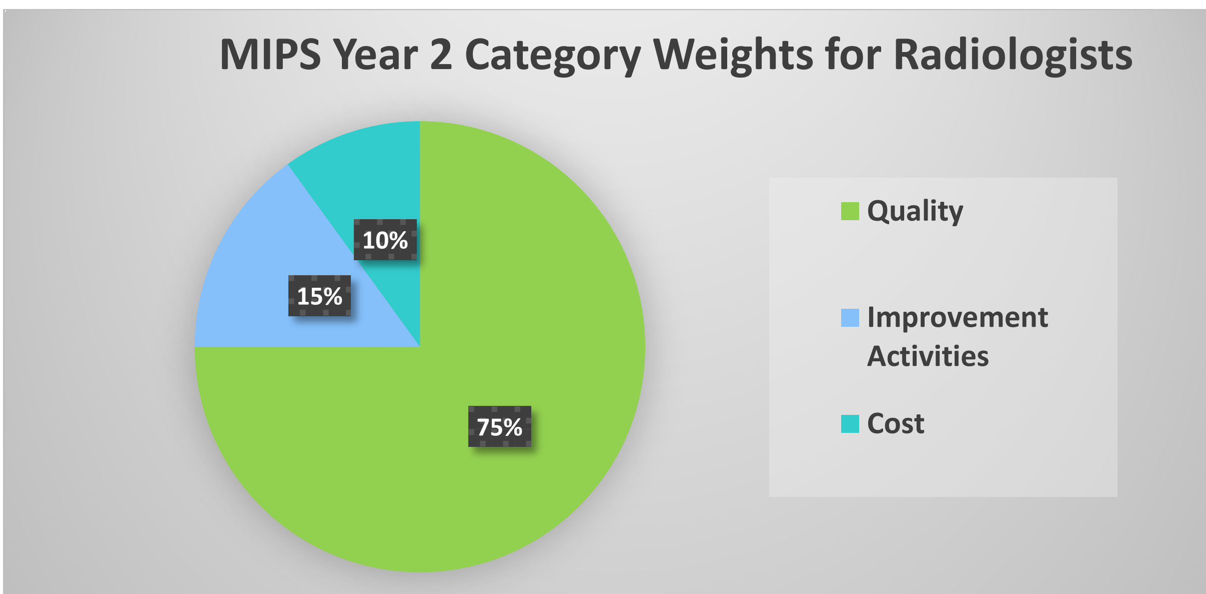
By now most of you have received the results of your 2017 MIPS reporting and understand that your designated payment adjustment will be applied to your traditional Medicare payments in 2019 for services provided in 2019. Remember, the Payment Year will always follow the Performance Year by two years.

Where the first year of MIPS proved a bit challenging to understand for most of us, APS has seen this second year flow more smoothly due to the streamlined processes we've developed to facilitate meeting the requirements of the program. Equally important, we continue to monitor and incorporate program changes into those processes and our communication with our clients.

Let's look at the requirements for Diagnostic Radiologists in this second year of MIPS.

The four MIPS categories – Quality, Practice Improvement Activities, Promoting Interoperability (previously called Advancing Care Information), and Cost – see a shift in how they're weighted for final scoring purposes to reflect the introduction of the Cost category into the calculation this year.

Also, again this year Radiologists are automatically exempt from Promoting Interoperability (the EHR-based category), so its weight is reallocated to the Quality category.



Information provided by APS Medical Billing, July 2018

QUALITY CATEGORY

The radiology-related measures are the same as last year. **Again this year, clinicians will report 6 measures, one of which must be designated an Outcome or High Priority measure.**

Measure ID	Measure Description	Outcome/High Priority Measure
145	Exposure Dose or Time Reported for Procedures Using Fluoroscopy	Yes
146	Inappropriate Use of "Probably Benign" Assessment Category	Yes
147	Correlation with Existing Imaging Studies for all Patients Undergoing Bone Scintigraphy	Yes
195	Stenosis Measurements in Carotid Imaging Reports	No
225	Reminder System for Screening mammograms	No
359	Utilization of Standard Nomenclature for CT Imaging Description	Yes
360	Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies	Yes
361	Reporting to a Radiation Dose Index Registry (DIR)	Yes
362	Computed Tomography (CT) Images Available for Patient Follow-up and Comparison Purposes	Yes
363	Search for Prior Computed Tomography (CT) Studies Through a Secure, Authorized, Media-Free, Shared Archive	Yes
364	Inappropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines	Yes
405	Abdominal Lesions: Appropriate Follow-up Imaging for Incidental Findings	No
406	Thyroid Nodules: Appropriate Follow-up Imaging for Incidental Findings in Patients with No Known Thyroid Disease	Yes
436	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	No

During our coding and billing processes, APS has been applying PQRS codes to eligible cases all along and continues to amass the quality data that will ultimately be submitted to CMS on behalf of our clients in March, 2019.

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Clinical Practice Improvement Activities Category

Practice Improvement Activities are those that improve clinical practice and/or the delivery of care to promote improved outcomes. Clinicians choose from a list of 100 activities to select those matching the quality initiatives that their practice has actively engaged in for at least 90 consecutive days in 2018. This category is reported via attestation, there is no additional data submitted to the program. CMS expects each practice to retain documentation supporting the activities to which they've attested.

The full list of activities can be downloaded at the link below and we encourage you to review the available activities and their respective content.

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html

Each Improvement Activity is weighted as either Medium or High. **Obtaining the maximum 40 points for this category is directed by the group's size or other special status designations as shown below:**

Groups with 15 or Fewer Clinicians (aka Small Practice), Non-Patient Facing Clinicians and/or Clinicians Located in a Rural Area or HPSA	**Group with More than 15 Clinicians that aren't in a Rural Area or HPSA**
*1 high-weighted activity OR *2 medium-weighted activities	*2 high-weighted activities OR *1 high-weighted activity and 2 medium-weighted activities OR *4 medium-weighted activities

In the 2017 Performance Year, the most frequently-reported Practice Improvement Activities by our Radiology clients were:

Activity ID	Activity Name	Activity Weight
IA_EPA_1	Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record	High
IA_CC_1	Implementation of use of specialist reports back to referring clinician or group to close referral loop	Medium
IC_PSPA_2	Participation in MOC Part IV	Medium
IA_PSPA_14	Participation in quality initiatives such as Bridge to Excellence or other similar Program	Medium

Again this year, APS will take care of completing the attestations for this category on behalf of our clients.

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Cost Category

This category will be included in the MIPS scoring for the first time this year. According to CMS, "a cost measure represents the Medicare payments for services furnished to a beneficiary during an episode of care. The episode of care is the basis for identifying services through claims that are furnished to address a condition within a specified time frame."

Because these events can be captured and calculated using adjudicated claims analysis, no additional data submission is required for this category.

Miscellaneous

Again this year, clinicians can participate in MIPS as individuals or as part of a group

- Individuals and Groups with ≤ $90,000 in Part B allowed charges or ≤ 200 Part B beneficiaries are excluded from participation

The performance threshold has been increased from 3 points in 2017 to 15 this year.

Small Practices (those with 15 or fewer clinicians) receive the following special considerations this year:

- 5 bonus points will be added to their final score
- 3 points will be awarded for reported Quality Measures that don't meet data completeness requirements
    - At least 60% of all cases eligible for a measure must be reported
    - There must be at least 20 cases comprising each reported measure

Starting this year, there is an opportunity to earn additional percentage points based on the rate of improvement in the Quality Category from last year as long as certain criteria are met.

Clinicians/Groups that are participating in an Advanced Payment Model (APM) are encouraged to seek direction from their APM entities regarding requirements and participation.

Resources

To view your MIPS eligibility for the 2018 performance year (both as an individual or as part of a group), to see special status designations such as Small Practice, Non-Patient Facing, etc., and to see if CMS identifies you as being part of an APM, enter your NPI at the following link:

https://qpp.cms.gov/participation-lookup

CMS has tons of information and resources to help guide you through the current performance year at:

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html

Questions for APS can be directed to your Practice Manager or MIPSInfo@apsmedbill.com.