MD interactive

2023 MIPS for Large* Practices

(*more than 15 in the TIN)

Express Step-by-Step Guide

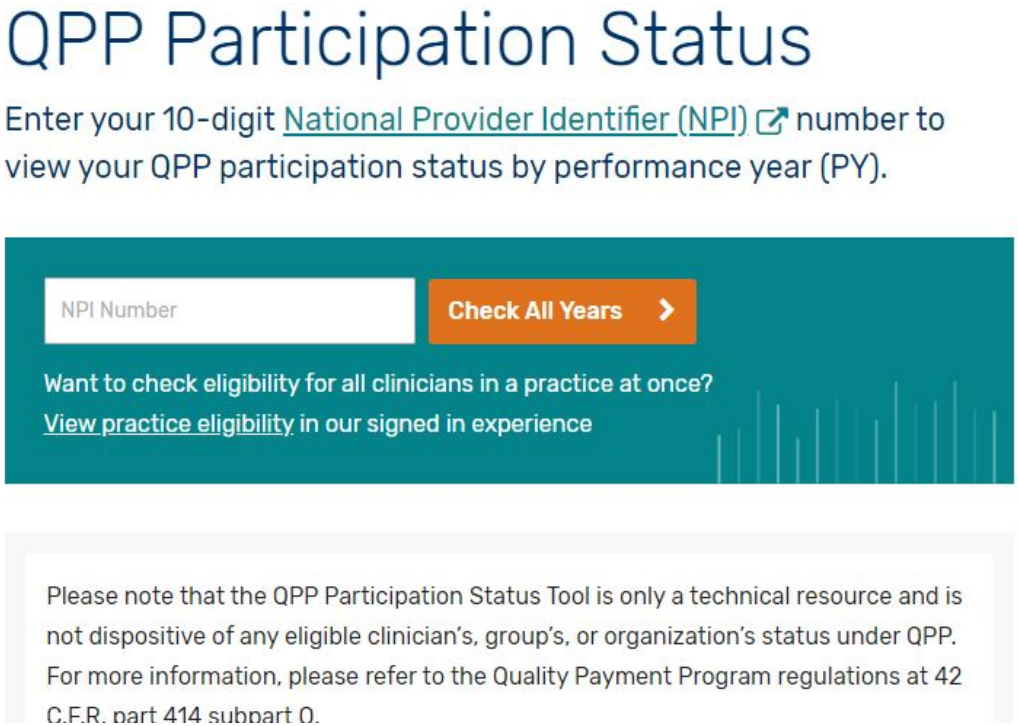
Here's What You Will Learn:

- ✓ Why do you need to report MIPS?
- ✓ Are you MIPS eligible?
- ✓ What do you report?
- ✓ How do you report?
- ✓ How much is it going to cost?
- ✓ What should you do now?

Why Report MIPS?

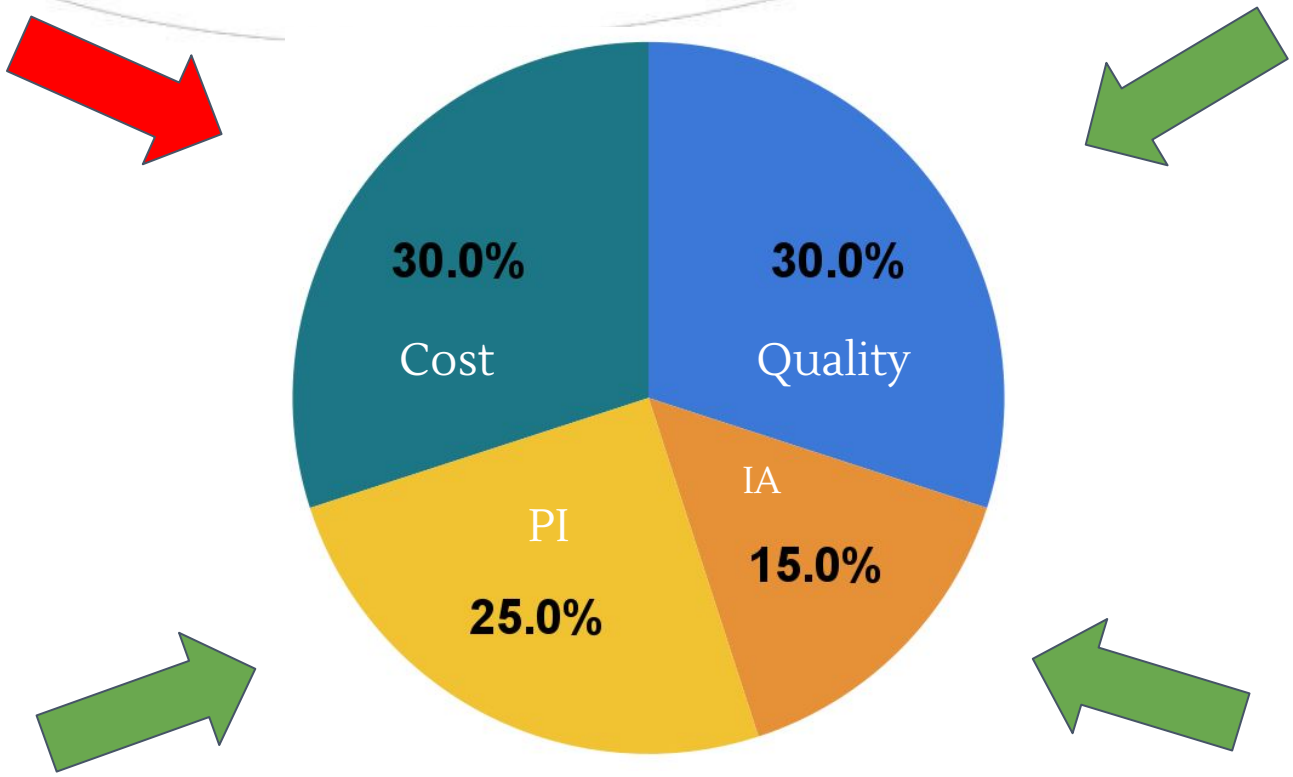
9% penalty on Medicare payments for not reporting

Check MIPS Eligibility



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

What Do You Report? for MIPS



Maximum Score Potential = 100

Points to Avoid Penalty = 75 (!)

What Do You Report? Quality

- 6 Quality measures
- At least 70% ALL denominator eligible encounters
- January 1 -December 31, 2023 encounter dates

What Do I Report?
Quality

MIPS by Specialty

Allergy/Immunology	Anesthesiology/Nurse Anesthetist/CRNA	Audiology	Cardiology
Chiropractor	Colon/Rectal Surgery	Dentistry	Dermatology
Electrophysiology Cardiac Specialist	Emergency Medicine	Endocrinology	Family Medicine
Gastroenterology	General Surgery	Geriatrics	Hand Surgery
Hospice/Palliative Care	Hospitalists	Infectious Disease	Internal Medicine

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What Do I Report for Quality?
Read the CMS Measure Description

Quality ID #130: Documentation of Current Medications in the Medical Record

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

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.

INSTRUCTIONS:
This measure is to be submitted at **each denominator eligible visit** during the 12-month performance period. Merit-based Incentive Payment System (MIPS) 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 submitted by MIPS eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NOTE: *Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.*

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All visits occurring during the 12-month measurement period for patients aged 18 years and older

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.*

Defines patient eligibility.

Describes measure compliance.

How Can I Report? Quality

Upload MDinteractive excel templates or QRDA files

Or

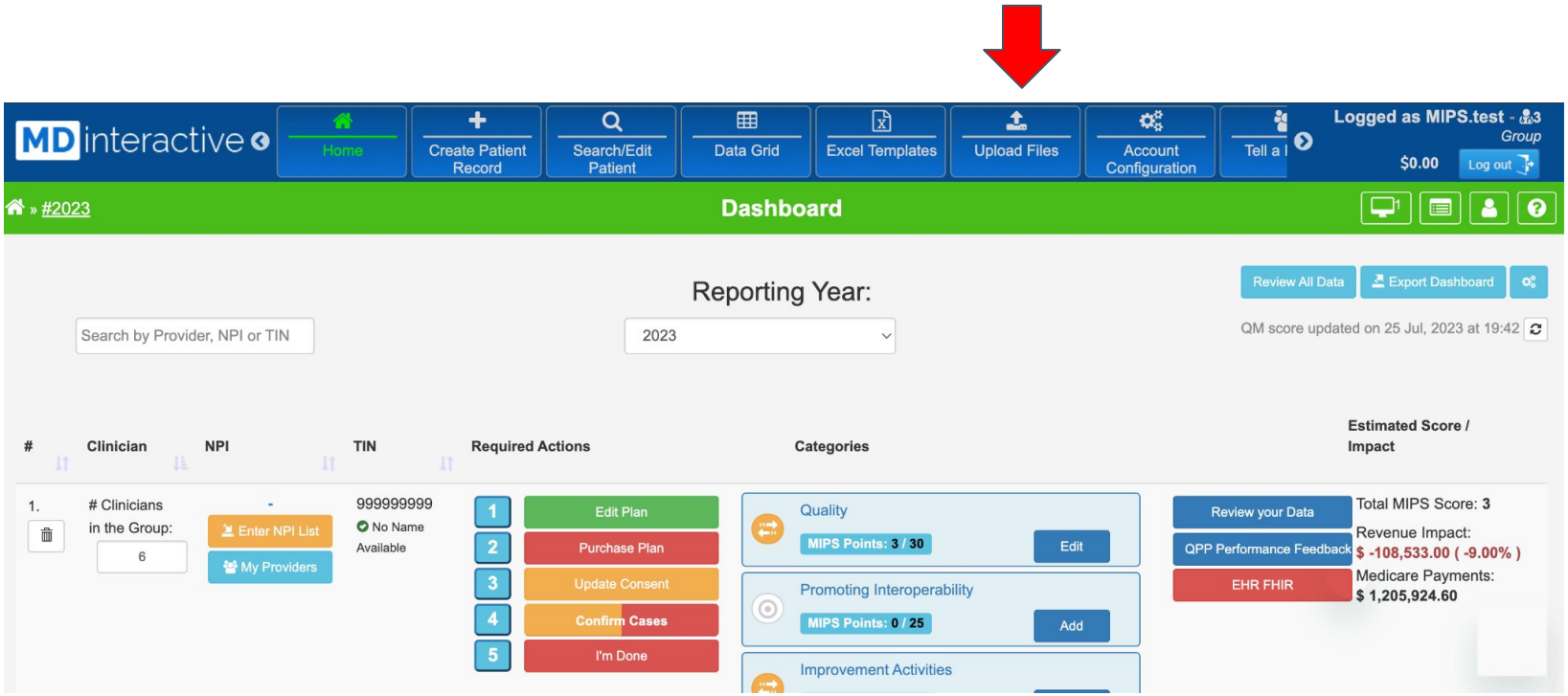
EHR data extraction through FHIR (Fast Healthcare Interoperability Resources)

Or

Use Create Patient Record or Data Grid options to manually enter patient data

How Do I Report? Quality

Upload MDinteractive excel templates or QRDA files:



How Do I Report? Quality: FHIR

- EHR data extraction through FHIR (Fast Healthcare Interoperability Resources):
  - MDinteractive periodically queries quality data through FHIR API
  - Display results on MDinteractive dashboard

How Do I Report? Quality

Use Create Patient Record or Data Grid to manually enter patient data

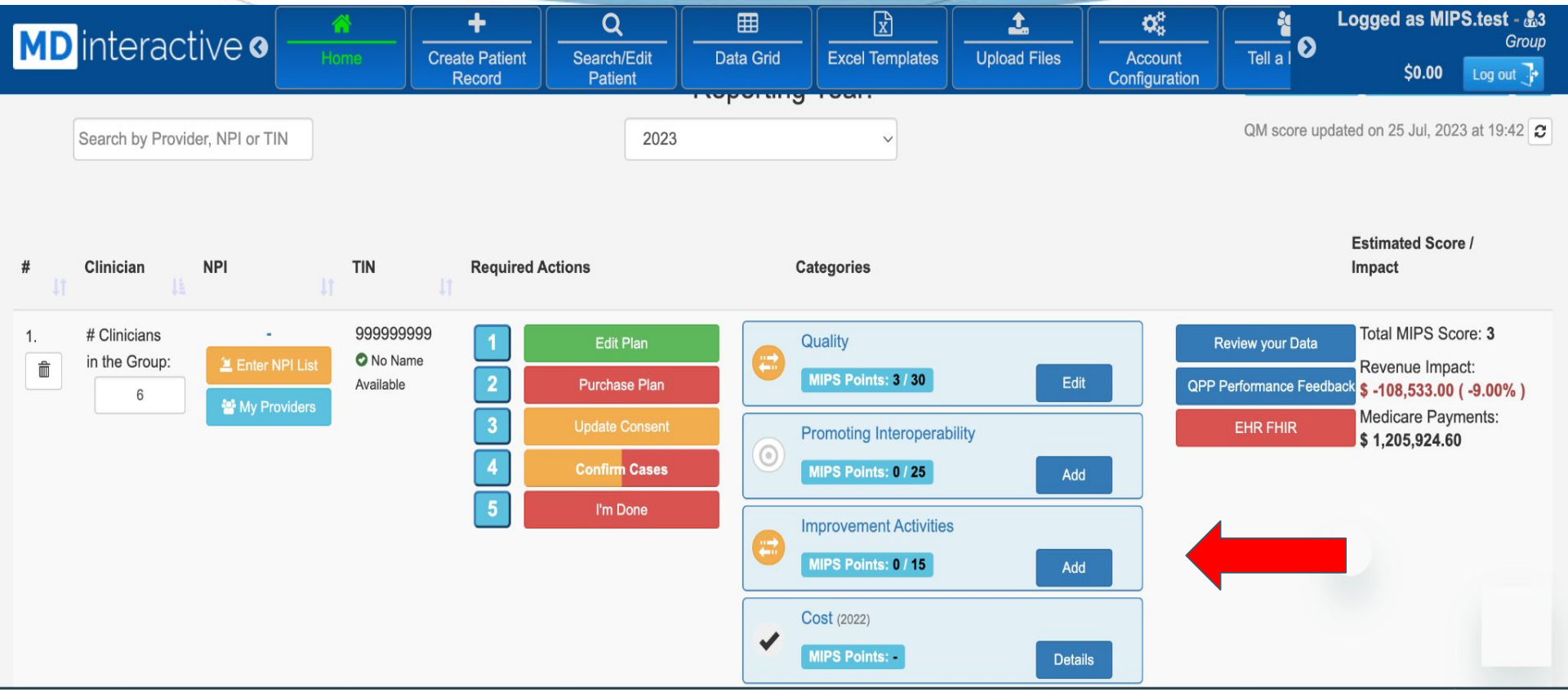
What Do I Report?
Improvement Activities

- two high-weighted
- or four medium-weighted Improvement Activities
- completed for at least 90 days in 2023 by at least 50% of providers in the TIN

Choose activities, implement, retain documentation

How Do I Report?

Improvement Activities



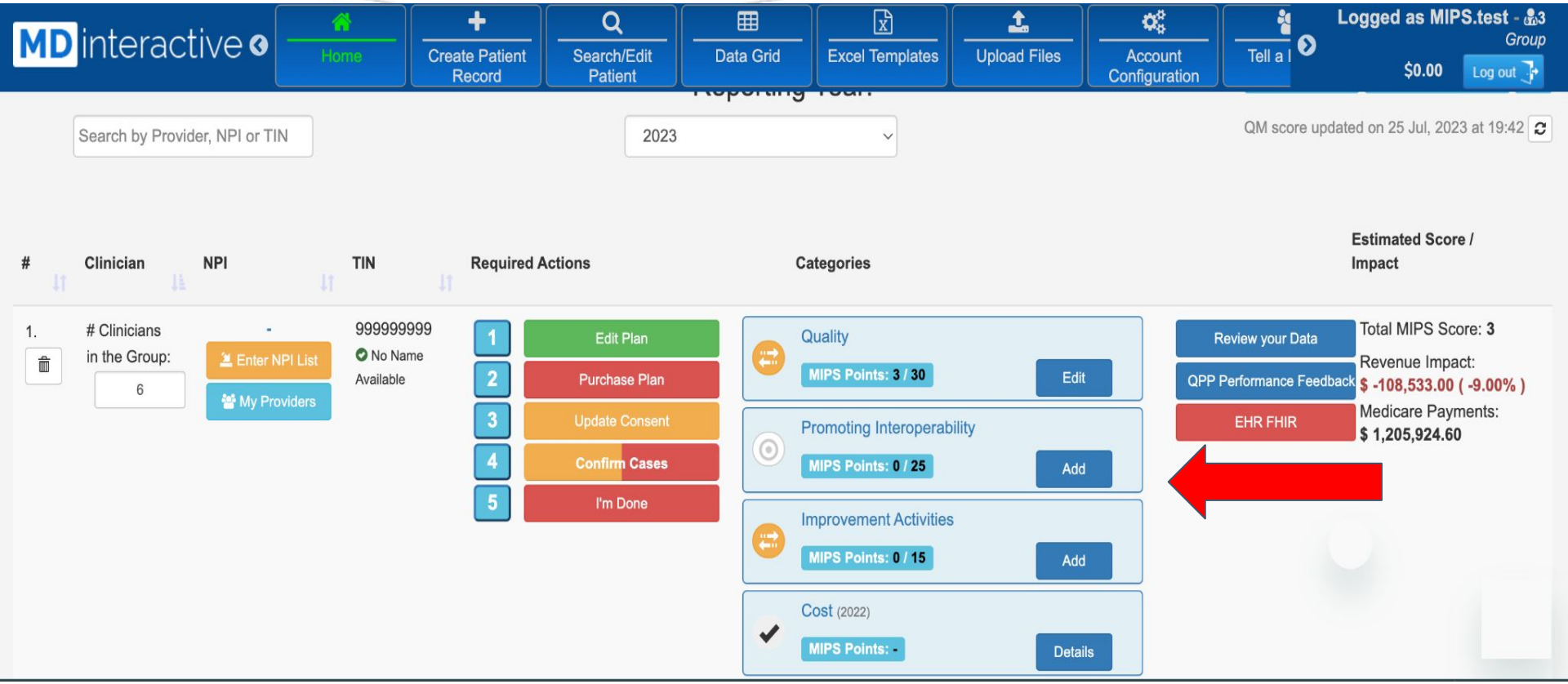
What Do I Report?
Promoting Interoperability

12 measures across 4 objectives:

1. E-prescribing
2. Provider to Patient Exchange ***(required*)***
3. Health Information Exchange
4. Public Health and Clinical Data Exchange

Run a PI report from your certified EHR to ensure your EHR is correctly tracking all PI objectives. **With the exception of Provider to Patient Exchange, measures can be claimed as an exclusion if applicable.*

How Do I Report?
Promoting Interoperability



How Much Is It Going to Cost?

Reporting at the TIN/group level:

- Reporting 1 MIPS category: $199 per clinician
- Reporting 2 MIPS categories: $299 per clinician
- Reporting 3 MIPS categories: $349 per clinician

Reporting at the NPI/Individual level:

- Reporting 1 MIPS category: $389 per clinician
- Reporting 2 MIPS categories: $439 per clinician
- Reporting 3 MIPS categories: $499 per clinician

What Should I Do Now?

1. Create an account: www.mdinteractive.com
2. Check your **MIPS Eligibility**
3. Pick your **Quality Measures** and your reporting approach
4. Pick your **Improvement Activities** and implement
5. Run an EHR **Promoting Interoperability** report and add the data to your MDinteractive account

MD interactive

Your One Stop.
for All Things MIPS.

Questions?

Phone: 1-800-634-4731

Chat: www.mdinteractive.com

Email: support@mdinteractive.com