Quality Payment PROGRAM

Merit-Based Incentive Payment System (MIPS) Promoting Interoperability Performance Category Measure 2018 Performance Period

Objective:	**Health Information Exchange**
Measure:	**Clinical Information Reconciliation** For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician performs clinical information reconciliation. The MIPS eligible clinician must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies. (3) Current Problem list. Review of the patient's current and active diagnoses.
Measure ID:	**PI_HIE_3**

Definition of Terms

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the MIPS eligible clinician.

Referral – Cases where one provider refers a patient to another, but the referring provider maintains his or her care of the patient as well**.**

Current problem lists – At a minimum a list of current and active diagnoses.

Active/current medication list – A list of medications to which a given patient has known allergies.

Allergy – An exaggerated immune response or reaction to substances that are generally not harmful.

Reporting Requirements

NUMERATOR/DENOMINATOR

- **NUMERATOR:** The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.

- **DENOMINATOR:** The number of transitions of care or referrals during the performance period for which the MIPS eligible clinician was the recipient of the transition or referral or has never before encountered the patient.

Scoring Information

BASE SCORE/PERFORMANCE SCORE/BONUS SCORE

- Required for Base Score: **No**
- Percentage of Performance Score: **Up to 10%**
- Eligible for Bonus Score: **One-time bonus of 10% for MIPS eligible clinicians and groups who report using 2015 Edition CEHRT exclusively for the 2018 performance period and submit only Promoting Interoperability measures**

Note: MIPS eligible clinicians must fulfill the requirements of base score measures to earn a base score in order to earn any score in the Promoting Interoperability performance category. In addition to the base score, MIPS eligible clinicians have the opportunity to earn additional credit through the submission of performance measures and a bonus measure and/or activity.

Additional Information

- MIPS eligible clinicians can report the Promoting Interoperability objectives and measures if they have technology certified to the 2015 Edition, or a combination of technologies from the 2014 and 2015 Editions that support these measures.
- In CY 2018, a one-time bonus will be earned by MIPS eligible clinicians and groups who report using 2015 Edition certified electronic health record technology (CEHRT) exclusively and only submit Promoting Interoperability measures.
- Actions included in the numerator must occur within the performance period.

- This measure is worth up to 10 percentage points towards the Promoting Interoperability performance category score. More information about Promoting Interoperability scoring is available on the QPP website.
- For the measure, only patients whose records are maintained using CEHRT must be included in the denominator for transitions of care.
- Apart from the three fields noted as required for the summary of care record (i.e., current problem list, current medication list, and current medication allergy list), in circumstances where there is no information available to populate one or more of the fields listed (because the MIPS eligible clinician does not record such information or because there is no information to record), the MIPS eligible clinician may leave the field(s) blank and still meet the measure.
- For the measure, the process may include both automated and manual reconciliation to allow the receiving MIPS eligible clinician to work with both the electronic data provided with any necessary review and to work directly with the patient to reconcile their health information.
- For the measure, if no update is necessary, the process of reconciliation may consist of simply verifying that fact or reviewing a record received on referral and determining that such information is merely duplicative of existing information in the patient record.
- Non-medical staff may conduct reconciliation under the direction of the MIPS eligible clinician so long as the clinician or other credentialed medical staff is responsible and accountable for review of the information and for the assessment of and action on any relevant CDS.
- When MIPS eligible clinicians choose to report as a group, data should be aggregated for all MIPS eligible clinicians under one Taxpayer Identification Number (TIN). This includes those MIPS eligible clinicians who may qualify for reweighting such as a significant hardship exception, hospital or ASC-based status, or in a specialty which is not required to report data to the Promoting Interoperability performance category. If these MIPS eligible clinicians choose to report as a part of a group practice, they will be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians.

Regulatory References

- For further discussion, please see the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) final rule: 81 FR 77229.
- In order to meet this objective and measure, MIPS eligible clinicians must use the capabilities and standards of CEHRT at 45 CFR 170.315 (b)(2) through (b)(3) and (a)(6) through (a)(8).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this measure.

Certification Criteria*	
§ 170.315(b)(2) Care Coordination	(2) Clinical information reconciliation and incorporation—(i) General requirements. Paragraphs (b)(2)(ii) and (iii) of this section must be completed based on the receipt of a transition of care/referral summary formatted in accordance with the standards adopted in §170.205(a)(3) and §170.205(a)(4) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates. (ii) Correct patient. Upon receipt of a transition of care/referral summary formatted according to the standards adopted §170.205(a)(3) and §170.205(a)(4), technology must be able to demonstrate that the transition of care/referral summary received can be properly matched to the correct patient. (iii) Reconciliation. Enable a user to reconcile the data that represent a patient's active medication list, medication allergy list, and problem list as follows. For each list type: (A) Simultaneously display (i.e., in a single view) the data from at least two sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date. (B) Enable a user to create a single reconciled list of each of the following: Medications; medication allergies; and problems. (C) Enable a user to review and validate the accuracy of a final set of data. (D) Upon a user's confirmation, automatically update the list, and incorporate the following data expressed according to the specified standard(s): (1) Medications. At a minimum, the version of the standard specified in §170.207(d)(3);

	(2) Medication allergies. At a minimum, the version of the standard specified in §170.207(d)(3); and
§ 170.315(b)(3) Care Coordination	(3) Problems. At a minimum, the version of the standard specified in §170.207(a)(4). (iv) System verification. Based on the data reconciled and incorporated, the technology must be able to create a file formatted according to the standard specified in §170.205(a)(4) using the Continuity of Care Document template.
§ 170.315(a)(6) Problem list	Enable a user to record, change, and access a patient's active problem list: (i) Ambulatory setting only. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in §170.207(a)(4). (ii) Inpatient setting only. For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in §170.207(a)(4)
§ 170.315(a)(7) Medication list	Enable a user to record, change, and access a patient's active medication list as well as medication history: (i) Ambulatory setting only. Over multiple encounters. (ii) Inpatient setting only. For the duration of an entire hospitalization.
§ 170.315(a)(8) Medication Allergy List	Enable a user to record, change, and access a patient's active medication allergy list as well as medication allergy history: (i) Ambulatory setting only. Over multiple encounters. (ii) Inpatient setting only. For the duration of an entire hospitalization.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria	
§ 170.202(a) Transport standards	ONC Applicability Statement for Secure Health Transport, Version 1.0 (incorporated by reference in §170.299).
§ 170.202 (2)(b) Transport standards	ONC Applicability Statement for Secure Health Transport, Version 1.2 (incorporated by reference in §170.299). (b) Standard. ONC XDR and XDM for Direct Messaging Specification (incorporated by reference in §170.299).
§ 170.202 (2)(c) Transport standards	ONC Transport and Security Specification (incorporated by reference in §170.299).
§ 170.205(a)(1) Patient Summary Record	Health Level Seven Clinical Document Architecture (CDA) Release 2, Continuity of Care Document (CCD) (incorporated by reference in §170.299). Implementation specifications. The Healthcare Information Technology Standards Panel (HITSP) Summary Documents Using HL7 CCD Component HITSP/C32 (incorporated by reference in §170.299).

Additional certification and standards criteria may apply. Review the ONC 2015 Edition Final Rule for more information.