

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

<u>Objective:</u>	Health Information Exchange
<u>Measure:</u>	Request/Accept Summary of Care 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 receives or retrieves and incorporates into the patient's record an electronic summary of care document.
<u>Measure ID:</u>	PI_HIE_2
<u>Exclusion:</u>	Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.
<u>Measure Exclusion ID:</u>	PI_LVITC_1

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.

Reporting Requirements

NUMERATOR/DENOMINATOR

- **NUMERATOR:** The number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the clinician into the certified electronic health record technology (CEHRT).
- **DENOMINATOR:** The number of patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.

Scoring Information

BASE SCORE/PERFORMANCE SCORE/BONUS SCORE

- Required for Base Score: **Yes**
- 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.
- Actions included in the numerator must occur within the performance period.
- This measure contributes to the 50% base score for the Promoting Interoperability performance category. MIPS eligible clinicians must submit a “yes” for the security risk analysis measure, and at least a 1 in the numerator for the numerator/denominator of the remaining measures or claim exclusions. The measure is also worth up to 10 percentage points towards the performance category score.
- More information about Promoting Interoperability scoring is available on the [QPP website](#).

- For the purposes of defining the cases in the denominator for the measure, we stated that what constitutes “unavailable” and, therefore, may be excluded from the denominator, will be that a MIPS eligible clinician—
 - Requested an electronic summary of care record to be sent and did not receive an electronic summary of care document; and
 - The MIPS eligible clinician either:
 - Queried at least one external source via health information exchange (HIE) functionality and did not locate a summary of care for the patient, or the clinician does not have access to HIE functionality to support such a query, or
 - Confirmed that HIE functionality supporting query for summary of care documents was not operational in the provider’s geographic region and not available within the MIPS eligible clinician’s EHR network as of the start of the performance period.
- For the measure, a record cannot be considered to be incorporated if it is discarded without the reconciliation of clinical information or if it is stored in a manner that is not accessible for MIPS eligible clinician use within the EHR. The Request/Accept Summary of Care measure remains a required measure for the base score in the Promoting Interoperability performance category. For required measures in the base score, CMS requires a one in the numerator or a “yes” response to yes/no measures or the claiming of exclusions. Measures included in the base score are required in order for a MIPS eligible clinician to earn any score in the Promoting Interoperability performance category.
- MIPS eligible clinician may claim the exclusions if they are reporting as a group. However, the group must meet the requirements of the exclusion as a group.
- 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 77228](#).
- 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)(1).

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)(1) Care Coordination	<p>(1) Transitions of care—(i) Send and receive via edge protocol—(A) Send transition of care/referral summaries through a method that conforms to the standard specified in §170.202(d) and that leads to such summaries being processed by a service that has implemented the standard specified in §170.202(a)(2); and</p> <p>(B) Receive transition of care/referral summaries through a method that conforms to the standard specified in §170.202(d) from a service that has implemented the standard specified in §170.202(a)(2).</p> <p>(C) XDM processing. Receive and make available the contents of a XDM package formatted in accordance with the standard adopted in §170.205(p)(1) when the technology is also being certified using an SMTP-based edge protocol.</p> <p>(ii) Validate and display—(A) Validate C-CDA conformance—system performance. Demonstrate the ability to detect valid and invalid transition of care/referral summaries received and formatted in accordance with the standards specified in §170.205(a)(3) and §170.205(a)(4) for the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates. This includes the ability to:</p> <ol style="list-style-type: none">1) Parse each of the document types.(2) Detect errors in corresponding “document-templates,” “section-templates,” and “entry-templates,” including invalid vocabulary standards and codes not specified in the standards adopted in §170.205(a)(3) and §170.205(a)(4).(3) Identify valid document-templates and process the data elements required in the corresponding section-templates and entry-templates from the standards adopted in §170.205(a)(3) and §170.205(a)(4).

(4) Correctly interpret empty sections and null combinations.

(5) Record errors encountered and allow a user through at least one of the following ways to:

(i) Be notified of the errors produced.

(ii) Review the errors produced.

(B) Display. Display in human readable format the data included in transition of care/referral summaries received and formatted according to the standards specified in §170.205(a)(3) and §170.205(a)(4).

(C) Display section views. Allow for the individual display of each section (and the accompanying document header information) that is included in a transition of care/referral summary received and formatted in accordance with the standards adopted in §170.205(a)(3) and §170.205(a)(4) in a manner that enables the user to:

(1) Directly display only the data within a particular section;

(2) Set a preference for the display order of specific sections; and

(3) Set the initial quantity of sections to be displayed.

(iii) Create. Enable a user to create a transition of care/referral summary formatted in accordance with the standard specified in §170.205(a)(4) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates that includes, at a minimum:

(A) The Common Clinical Data Set.

(B) Encounter diagnoses. Formatted according to at least one of the following standards:

(1) The standard specified in §170.207(i).

(2) At a minimum, the version of the standard specified in §170.207(a)(4).

(C) Cognitive status.

(D) Functional status.

(E) Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information.

(F) Inpatient setting only. Discharge instructions.

(G) Patient matching data. First name, last name, previous name, middle name (including middle initial), suffix, date of birth, address, phone number, and sex. The following constraints apply:

(1) Date of birth constraint—(i) The year, month and day of birth must be present for a date of birth. The technology must include a null value when the date of birth is unknown.

(ii) Optional. When the hour, minute, and second are associated with a date of birth the technology must demonstrate that the correct time zone offset is included.

(2) Phone number constraint. Represent phone number (home, business, cell) in accordance with the standards adopted in §170.207(q)(1). All phone numbers must be included when multiple phone numbers are present.

(A)(3) Sex constraint. Represent sex in accordance with the standard adopted in §170.207(n)(1).

* 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.