New Jersey Innovation Institute
An NJIT Corporation

2018 MIPS Reporting

Ophthalmology

Quality Reporting Requirements:

- Report on 6 quality measures or a specialty measure set
- Include at least ONE outcome or high-priority measure
- Report on patients of All-Payers (Medicare and Non-Medicare patients)

Specialty Measure Set (18):

- **12**: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
- **14**: Age-Related Macular Degeneration (AMD): Dilated Macular Examination
- **18**: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- **19**: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care- **High Priority**
- **117**: Diabetes: Eye Exam
- **130**: Documentation of Current Medications in the Medical Record- **High Priority**
- **140**: Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
- **141**: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care- **Outcome, High Priority**
- **191**: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery- **Outcome, High Priority**
- **192**: Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures- **Outcome, High Priority**
- **226**: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention **Outcome, High Priority**
- **303**: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery-
- **374**: Closing the Referral Loop: Receipt of Specialist Report- **High Priority**
- **384**: Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery- **Outcome, High Priority**
- **385**: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery- **Outcome, High Priority**
- **388**: Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy)- **Outcome, High Priority**
- **389**: Cataract Surgery: Difference Between Planned and Final Refraction- **Outcome, High Priority**

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- **402**: Tobacco Use and Help with Quitting Among Adolescents

Additional Measures:

- **001:** Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)- **Outcome, High Priority**
- **047:** Care Plan- **High Priority**
- **110:** Preventive Care and Screening: Influenza Immunization
- **111:** Pneumococcal Vaccination Status for Older Adults
- **112:** Breast Cancer Screening
- **113:** Colorectal Cancer Screening
- **119:** Diabetes: Medical Attention for Nephropathy
- **128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- **131:** Pain Assessment and Follow-Up- **High Priority**
- **204:** Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- **236:** Controlling High Blood Pressure- **Outcome, High Priority**
- **238:** Use of High-Risk Medications in the Elderly- **High Priority**
- **304:** Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery- **Outcome, High Priority**
- **317:** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Promoting Interoperability (PI) Reporting Requirements:

- Report on ALL required base measure to earn any credit for PI
- To satisfy base score requirements, clinicians must submit a numerator of at least 1 or answer Yes
- Report on additional performance measures or bonus measure to increase your PI Score

PI Base Score Measures:

PI Objectives and Measure Set (2015 CEHRT)	2018 PI Transition Objectives and Measure Set (2014 or 2015 CEHRT)
○ Security Risk Analysis ○ e-Prescribing* ○ Provide Patient Access ○ Send a Summary of Care* ○ Request/Accept Summary of Care*	○ Security Risk Analysis ○ e-Prescribing* ○ Provide Patient Access ○ Health Information Exchange*

*Exclusion available for measure if denominator is less than 100 patients or occurrences

2018 MIPS for Ophthalmology

Improvement Activities (IA) Reporting Requirements:

- Attest to up to 4 activities for a minimum of 90 days
- Choose one of the following combinations:
    - 2 High Weighted Activities
    - 1 High Weighted Activity and 2 Medium Weighted Activates
    - 4 Medium Weighted Activities

Medium Weighted:

- Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop- **EHR Bonus**
- TCPI Participation
- Implementation of documentation improvements for practice/process improvements
- Collection and use of patient experience and satisfaction data on access
- Implementation of medication management practice improvements- **EHR Bonus**
- Annual registration in the Prescription Drug Monitoring Program
- Engagement of patients through implementation of improvements in patient portal- **EHR Bonus**
- Chronic Care and Preventative Care Management for Empaneled Patients- **EHR Bonus**

High Weighted:

- Engagement of New Medicaid Patients and Follow-up
- Engage Patients and Families to Guide Improvement in the System of Care- **EHR Bonus**
- Participation in the CMS Transforming Clinical Practice Initiative
- Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
- Consultation of the Prescription Drug Monitoring Program

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Cost Reporting:

- CMS calculate Cost measures using administrative claims data if a clinician or group meets the cases minimum for attributed patients
- Individuals and Groups are not required to SUBMIT any additional information for the cost category

Cost Measures:

Medicare Spending Per Beneficiary (MSPB):

- The Medicare Spending Per Beneficiary (MSPB) clinician measure assesses the cost to Medicare of services performed by an individual clinician during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's hospital stay.

Total Per Capita Costs for All Attributed Beneficiaries (TPCC):

- The Total Per Capita Costs for All Attributed Beneficiaries (TPCC) measure is a payment-standardized, annualized, risk-adjusted, and specialty-adjusted measure that evaluates the overall cost of care provided to beneficiaries attributed to clinicians, as identified by a unique Taxpayer Identification Number/National Provider Identifier (TIN-NPI).