MIPS FACT SHEET

Chronic Pain

Executive Summary

Congress enacted the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) in April 2015, which established a new value-based payment system for Medicare fee-for-service (FFS) physician reimbursement called the Merit-Based Incentive Payment System (MIPS). Under MIPS, beginning January 1, 2017, Medicare commenced assessment of physician performance in 4 categories: (1) quality, (2) cost, (3) clinical practice improvement activities, and (4) advancing care information (previously known as "Meaningful Use"). Based on actual performance in 2017, Medicare will adjust an individual clinician's FFS Part B payments in 2019 in a positive, neutral, or negative manner by up to 4 percent.

The second performance year of MIPS will begin January 1, 2018. In 2018, Medicare will continue many—but not all—of the "transition" policies implemented in the first year of MIPS to make movement to the new payment system as seamless as possible for physicians. For the second year of MIPS, performance in 2018 will impact a physician's Medicare Part B reimbursement payment in 2020 in a positive, neutral, or negative manner by up to 5 percent.

For the 2018 MIPS performance year, clinicians who earn at least 15 out of a possible 100 points will avoid a negative payment adjustment in 2020. Clinicians who earn more than 15 total MIPS points will be eligible to receive a positive payment adjustment and those earning less than 15 points will receive a negative payment adjustment. Physicians who earn 70 points or more will be eligible for "exceptional" bonus payments. In addition to earning points for performance in each of the MIPS performance categories, physicians also may earn bonus points that count toward their MIPS total performance score through the:

- Small practice bonus: Physicians in practices consisting of 15 or fewer clinicians and solo practitioners are eligible to receive a small practice bonus score of 5 points. To receive the bonus score, clinicians must participate in MIPS by reporting data on at least one performance category.
- Complex patient bonus: Physicians may earn a complex patient bonus score of up to 5 points for treating patients who are particularly medically complex and relatively low income. Clinicians do not have to report data for the complex patient bonus. Instead, Medicare will calculate a complex patient bonus for each clinician using claims and other data.

Table 1 shows the minimum data reporting period requirements for each MIPS performance category and how much each MIPS performance category contributes to a clinician's MIPS total performance score. Note that unlike the first year of MIPS, clinicians must submit a full year of quality data to meet MIPS reporting requirements in 2018.

Table 1: 2018 MIPS Performance Categories Data Reporting Period and Composition of MIPS Total Performance Score

Performance Category	Performance Period	Contribution to MIPS Total Score
Quality	Full calendar year	50%
Cost	Full calendar year	10%
Improvement Activities	Minimum of continuous 90-day period	15%
Advancing Care Information	Minimum of continuous 90-day period	25%

All physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and groups that include these professionals must participate in MIPS in order to receive Medicare reimbursement, with certain limited exceptions. Below provides a guide of selected 2018 MIPS quality measures, clinical practice improvement activities, and advancing care information measures, inclusive of the data submission method necessary for each measure or activity. Note these measures and activities are suggestions only, and providers may find metrics that are more appropriate and applicable for their practices based on the broader list of MIPS measures and activities.

For more information on MIPS and MACRA generally, please visit Medicare's Quality Payment Program website. Medicare intends to report MIPS performance data on individual clinicians on its Physician Compare website.

Quality

MIPS-eligible clinicians and groups must report at least 6 quality measures, with each measure worth up to 10 points for a total of 60 points depending on actual performance. One of the 6 measures must be an "outcome" measure. If an "outcome" measure is not available, the clinician must still report a total of 6 measures, but include one other "high priority" measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures) in lieu of the "outcome" measure. Physicians in small practices (with 15 or fewer clinicians) will earn a minimum of 3 points for each quality measure submitted. Physicians can receive bonus points for submitting additional quality measures on outcomes and patient experience, as well as submitting measures through "end-to-end" electronic reporting using certified electronic health record technology (CEHRT). In "end-to-end" electronic reporting, a physician uses CEHRT to record information and data necessary for the measure and then transmits that data electronically to a third party (for example, a qualified registry), which in turn submits the data electronically to Medicare.

Clinicians may report on any quality metrics from the full list of MIPS quality measures for 2018. Alternatively, anesthesiologist clinicians may want to report on measures in the anesthesiology-specific specialty measure set. If an anesthesiologist clinician elects to use the anesthesiology-specific measure set, the same quality reporting requirements apply (i.e., 6 measures including 1 "outcome measure or other "high priority" measure) for purposes of MIPS reporting.

Medicare requires that clinicians submit quality data on at least 60 percent of patients regardless of payer when using qualified clinical data registries (QCDRs), qualified registries, or certified electronic health record technology (CEHRT, or EHR technology certified by Medicare to meet Advancing Care Information standards described below) and on 60 percent of Medicare beneficiaries when submitting quality measures via traditional claims submission. Medicare will award 1 point for each quality measure submitted not meeting the 60 percent threshold except for clinicians in small practices who will receive 3 points for each quality measure submitted even if they do not meet the 60 percent data submission threshold.

Table 2: Quality Measures for Chronic Pain

Quality ID	Measure Name	Measure Type	Data Submission Method
021 (!)	Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin	Process	Claims, Registry
039	Screening for Osteoporosis for Women Aged 65-85 Years of Age	Process	Claims, Registry
047 (!)	Care Plan	Process	Claims, Registry
109 (!)	Osteoarthritis (OA): Function and Pain Assessment	Process	Claims, Registry
128*	Care & Screening: Body Mass Index (BMI) Screening & Follow-Up Plan	Process	Claims, EHR, CMS Web Interface, Registry
130 (!)	Documentation of Current Medications in the Medical Record	Process	Claims, EHR, Registry
131 (!)	Pain Assessment and Follow-Up	Process	Claims, Registry
134	Preventive Care & Screening: Screening for Clinical Depression & Follow-Up Plan	Process	Claims, EHR, CMS Web Interface, Registry
145 (!)	Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy	Process	Claims, Registry
154 (!)	Falls: Risk Assessment	Process	Claims, Registry
155 (!)	Falls: Plan of Care	Process	Claims, Registry
182 (!)	Functional Outcome Assessment	Process	Claims, Registry
220 (!)	Functional Status Change for Patients with Lumbar Impairments	Outcome	Registry
226*	Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention	Process	Claims, EHR, CMS Web Interface, Registry
238* (!)	Use of High-Risk Medications in the Elderly	Process	EHR, Registry
276	Sleep Apnea: Assessment of Sleep Symptoms	Process	Registry
318 (!)	Falls: Screening for Future Fall Risk	Process	EHR, CMS Web Interface
342 (!)	Pain Brought Under Control within 48 Hours	Outcome	Registry
357 (!)	Surgical Site Infection (SSI)	Outcome	Registry
374* (!)	Closing the Referral Loop: Receipt of Specialist Report	Process	Registry, EHR
408	Opioid Therapy Follow-up Evaluation	Process	Registry
412	Documentation of Signed Opioid Treatment Agreement	Process	Registry
414	Evaluation or Interview for Risk of Opioid Misuse	Process	Registry
435 (!)	Quality of Life Assessment for Patients With Primary Headache Disorders	Outcome	Claims, Registry

(!) "High Priority" measure

**Measure has substantive modifications in 2018. Clinicians reporting this measure should check measure specifications.*

Clinical Practice Improvement Activities

To achieve a full performance score in this category, physicians must earn 40 points by attesting to integrating specific clinical practice improvement activities into patient care. Medicare will assign 20 points for "high" weighted activities and 10 points for "medium" weighted activities. Hence, a physician may earn a full score by attesting to 2 "high" weighted activities or 4 "medium" weighted activities, or some combination of both. Certain physicians, including "non-patient facing" clinicians, clinicians in rural areas, and those in small practices (15 or fewer clinicians) have to earn 20 points (rather than 40 points) to achieve a full performance score. Clinicians may earn bonus points for attesting to improvement activities using CEHRT. The full list of MIPS clinical practice improvement activities for 2018 can be found at https://qpp.cms.gov/mips/improvement-activities

Table 3: Clinical Practice Improvement Activities

Activity ID	Activity Name	Subcategory Name
	High	
IA_PSPA_6	Consultation of the Prescription Drug Monitoring Program	Patient Safety & Practice Assessment
IA_BE_6	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement	Beneficiary Engagement
IA_PSPA_22	CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain	Patient Safety & Practice Assessment
	Medium	
IA_BMH_4	Depression screening	Behavioral and Mental Health
IA_CC_8	Implementation of documentation improvements for practice/process improvements	Care Coordination
IA_PM_15	Implementation of episodic care management practice improvements	Population Management
IA_BMH_2	Tobacco use	Behavioral and Mental Health
IA_PSPA_21	Implementation of fall screening and assessment programs	Patient Safety & Practice Assessment
IA_PSPA_5	Annual registration in the Prescription Drug Monitoring Program	Patient Safety & Practice Assessment
IA_PSPA_10	Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments	Patient Safety & Practice Assessment
IA_PSPA_27	Invasive procedure or surgery anticoagulation medication management (Patient Safety & Assessment)	
IA_BE_14	Engage patients and families to guide improvement in the system of care	Beneficiary Engagement
IA_BE_16	Evidenced-based techniques to promote self-management into usual care	Beneficiary Engagement
IA_BE_20	Implementation of condition-specific chronic disease self-management support programs	Beneficiary Engagement
IA_CC_2	Implementation of improvements that contribute to more timely communication of test results	Care Coordination
IA_BE_21*	Improved practices that disseminate appropriate self-management materials	Beneficiary Engagement
IA_PSPA_18*	Measurement and improvement at the practice and panel level	Patient Safety & Practice Assessment
IA_BE_13	Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms	Beneficiary Engagement
IA_BE_1	Use of certified EHR to capture patient reported outcomes	Beneficiary Engagement
IA_EPA_3	Collection and use of patient experience and satisfaction data on access	Expanded Practice Access

Activity ID	Activity Name	Subcategory Name
	Medium *(continued)*	
IA_PM_16	Implementation of medication management practice improvements	Population Management
IA_PSPA_3*	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or other similar activity	Patient Safety & Practice Assessment
IA_PSPA_2*	Participation in MOC Part IV	Patient Safety & Practice Assessment
IA_EPA_2	Use of telehealth services that expand practice access	Expanded Practice Access
IA_PSPA_27	Invasive procedure or surgery anticoagulation medication management	Patient Safety & Practice Assessment

**Improvement activity has substantive modifications in 2018. Clinicians attesting to this improvement activity should check activity specifications.*

Advancing Care Information (previously "Meaningful Use")

Physicians must report 5 measures to receive a minimum base score representing 50 percent of the total score for the advancing care information category. Clinicians may submit up to 10 more measures for additional performance credit. For 2018, clinicians may use CEHRT certified to the 2014 Edition or 2015 Edition or a combination of the two. Clinicians may earn a bonus of 10 percentage points in this performance category by using only the 2015 Edition of CEHRT. Medicare will exempt certain clinicians from reporting data in the advancing care information performance category, including hospital-based clinicians, hospital-based clinicians in off-campus outpatient hospitals, ambulatory surgical center-based clinicians, clinicians using decertified CEHRT, and clinicians in small practices. Clinicians must apply to Medicare to receive the exemption by December 31, 2018, for the 2018 performance year. The full list of MIPS advancing care information measures for 2018 can be found at https://qpp.cms.gov/mips/advancing-care-information

Table 4: Advancing Care Information Measures

Measure ID	Measure Name	Required for Base Score	Performance Score Weight
ACI_PHCDRR_5	Clinical Data Registry Reporting	No	0
ACI_PEA_2	Patient-Specific Education	No	Up to 10%
ACI_CCTPE_2	Secure Messaging	No	Up to 10%
ACI_HIE_3	Clinical Information Reconciliation	No	Up to 10%
ACI_CCTPE_3	Patient-Generated Health Data	No	Up to 10%
ACI_EP_1	e-Prescribing	Yes	0
ACI_PEA_1	Provide Patient Access	Yes	Up to 10%
ACI_PPHI_1	Security Risk Analysis	Yes	0
ACI_HIE_1	Send a Summary of Care Record	Yes	Up to 10%

Cost (no reporting required)

Unlike the first year of MIPS, Medicare will assess clinicians on cost performance beginning in 2018. Physicians do not report any cost data to Medicare. Instead, Medicare will calculate a clinician's cost performance on 2 cost efficiency measures using claims data. Only certain clinicians will receive a MIPS cost performance score, depending on the type of care they provide to patients. For example, most "non-patient facing" clinicians will not be assessed on cost performance in 2018. Physicians will not be penalized in MIPS if Medicare does not assign them a cost performance score. Medicare plans to provide informal feedback to clinicians during 2018 on their cost performance. Cost represents 10 percent of a clinician's MIPS total performance score in 2018 but by law may represent between 10 percent and 30 percent of a clinician's MIPS total performance score in 2019.

Glossary of Terms

Claims Submission: Under this method of MIPS data submission, clinicians submit MIPS data through the administrative claims they currently use to bill Medicare for services rendered. Claims data submission will include only claims submitted for the treatment of Medicare patients and will not include claims for the treatment of non-Medicare patients.

Efficiency Measure: These types of quality measures evaluate a provider's relative efficiency in the delivery of health care items and services when treating patients, specifically related to: (1) potentially unnecessary utilization, (2) appropriate use, and (3) cost.

EHR Submission: This MIPS data submission method allows clinicians and group practices to submit MIPS data through their electronic health record (EHR) system. For 2017, clinicians may use certified electronic health record technology (CERHT) certified to the 2014 Edition or 2015 Edition. Medicare expects that MIPS data submitted via EHR will include both Medicare and non-Medicare patients.

High Priority Measure: Clinicians must report a high priority quality measure if an outcome measure is not available or applicable. Clinicians may receive bonus points up to a cap for reporting additional high priority measures. Medicare has deemed certain measures as "high priority" because it believes these measures are critical to assessing health care quality. High priority measures fall into one of five categories: (1) appropriate use, (2) patient safety, (3) efficiency, (4) patient experience, and (5) care coordination.

Intermediate Outcome Measure: These types of quality measures evaluate intermediate results that lead to longer-term, end-result health outcomes in individual patients or broader patient populations due to healthcare interventions. For example, an intermediate outcome measure could assess a physiologic value like blood pressure with the goal of achieving longer-term improved cardiac outcomes.

Non-Patient Facing Clinician: An individual "non-patient-facing" clinician is a MIPS-eligible clinician who bills 100 or fewer patient-facing encounters (including Medicare telehealth services) during the non-patient facing determination period. A group of non-patient-facing clinicians is one in which more than 75 percent of the National Provider Identifiers (NPIs) billing under the group's Tax Identification Number (TIN) meet the definition of a non-patient-facing, individual, MIPS-eligible clinician during the non-patient facing determination period.

Outcome Measure: These types of quality measures assess the health changes that occur in individual patients or broader patient populations as a result of health care interventions. Outcome measures can evaluate: (1) end results such as mortality or function, (2) intermediate results such as physiologic values like blood pressure that lead to longer-term end result outcomes, or (3) proxies used to indicate outcomes such as hospital readmission rates indicating a negative change in health status post discharge. Medicare expects to increase MIPS reporting requirements for outcome measures in future years as it develops and adopts more of these type of measures.

Process Measure: These types of quality measures evaluate steps taken in a clinical process, which typically follow evidence-based best practices, designed to achieve a specific health outcome. Process measures may assess specific interactions between the clinician and patient or an action or series of actions aiming to result in a specific outcome, such as conducting an analysis of sleep apnea symptoms.

Registry Submission: Under this MIPS data submission method, an entity, such as a medical specialty society, collects data from individual clinicians or group practices and submits that data to Medicare on behalf of its participants. Medicare expects that MIPS data submitted via qualified registries will include both Medicare and non-Medicare patients.