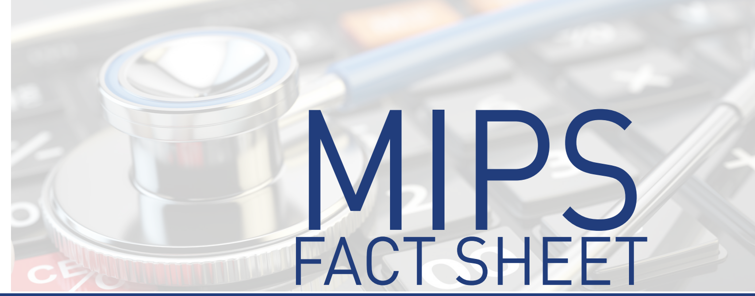


# Regional Anesthesia and Acute Pain

## 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 Regional Anesthesia and Acute Pain | | | |
|---|---|---|---|
| **Quality ID** | **Measure Name** | **Measure Type** | **Data Submission Method** |
| 408 | Opioid Therapy Follow-up | Process | Registry |
| 131 (!) | Pain Assessment and Follow-Up | Process | Claims, Registry |
| 342 (!) | Pain Brought Under Control Within 48 Hours | Outcome | Registry |
| 404 (!) | Anesthesiology Smoking Abstinence | Intermediate Outcome | Registry |
| 322 (!) | Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients | Efficiency | Registry |
| 324 (!) | Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients | Efficiency | Registry |
| 376* | Functional Status Assessment for Total Hip Replacement | Process | EHR |
| 375* | Functional Status Assessment for Total Knee Replacement | Process | EHR |
| 109 (!) | Osteoarthritis (OA): Function and Pain Assessment | Process | Claims, Registry |
| 424 (!) | Perioperative Temperature Management | Outcome | Registry |
| 426 (!) | Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit (PACU) | Process | Registry |
| 430 (!) | Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy | Process | Registry |
| 276 | Sleep Apnea: Assessment of Sleep Symptoms | Process | Registry |
| 357 (!) | Surgical Site Infection (SSI) | Outcome | Registry |
| 352 (!) | Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet | Process | Registry |
| 351 (!) | Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation | Process | Registry |
| 023 (!) | Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) | Process | Claims, Registry |
| 130 | Documentation of Current Medications in the Medical Record | Process | Claims, EHR, Registry |
| 076 (!) | Prevention of Central Venous Catheter-Related Bloodstream Infections | Process | Claims, Registry |
| 427 (!) | Post-Anesthetic Transfer of Care: Use of Checklist Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit | Process | Registry |
| 431 | Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling | Process | Registry |
| 444 (!) | Medication Management for People with Asthma | Process | Registry |
| 317 | Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented | Process | Claims, EHR, 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) must 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](https://qpp.cms.gov/mips/improvement-activities)

**Table 3: Clinical Practice Improvement Activities**

| Activity ID | Activity Name | Subcategory Name |
|---|---|---|
| | **High** | |
| IA_EPA_1 | Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record | Expanded Practice Access |
| IA_BE_6 | Collection and follow-up on patient experience and satisfaction data on beneficiary engagement | Beneficiary Engagement |
| IA_PSPA_23 | Completion of CDC Training on Antibiotic Stewardship | Patient Safety & Practice Assessment |
| | **Medium** | |
| IA_CC_8 | Implementation of documentation improvements for practice/ process improvements | Care Coordination |
| IA_PSPA_19* | Implementation of formal quality improvement methods, practice changes or other practice improvement processes | Patient Safety & Practice Assessment |
| IA_PSPA_20 | Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes | Patient Safety & Practice Assessment |
| IA_AHE_2 | Leveraging a QCDR to standardize processes for screening | Achieving Health Equity |
| IA_AHE_4* | Leveraging a QCDR for use of standard questionnaires | Achieving Health Equity |
| IA_PSPA_18* | Measurement and improvement at the practice and panel level | Patient Safety & Practice Assessment |
| IA_PSPA_2* | Participation in MOC Part IV | Patient Safety & Practice Assessment |
| IA_PSPA_12 | Participation in private payer CPIA | 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_PSPA_8* | Use of patient safety tools | Patient Safety & Practice Assessment |
| IA_BE_21* | Improved practices that disseminate appropriate self-management materials | Beneficiary Engagement |
| IA_PM_11* | Regular review practices in place on targeted patient population needs | Population Management |
| IA_BE_12 | Use evidence-based decision aids to support shared decision-making | Beneficiary Engagement |
| IA_PSPA_7 | Use of QCDR data for ongoing practice assessment and improvements | Patient Safety & Practice Assessment |
| IA_BE_2 | Use of QCDR to support clinical decision making | Beneficiary Engagement |
| IA_CC_15 | Perioperative Surgical Home (PSH) Care Coordination | Care Coordination |
| IA_PM_21 | Advance Care Planning | Population Management |
| IA_PSPA_24 | Initiate CDC Training on Antibiotic Stewardship | 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 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_HIE_2 | Summary of Care Measure | Yes | Up to 10% |
| ACI_PEA_1 | Provide Patient Access | Yes | Up to 10% |
| ACI_EP_1 | e-Prescribing | Yes | 0 |
| ACI_HIE_1 | Send a Summary of Care Record | Yes | Up to 10% |
| ACI_HIE_3 | Clinical Information Reconciliation | No | Up to 10% |
| ACI_PEA_2 | Patient-Specific Education | No | 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. Medicare will not penalize physicians if they do not receive 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.

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