Merit Based Incentive Program (MIPS)

This year, CMS is launching their MIPS initiative to replace other programs, such as, PQRS and MU. MIPS (Merit Based Payment Incentive Payment system) and APM’s (Advanced Alternative Payment models) are two tracks clinicians can take as part of the Medicare MACRA initiative. The track chosen by most clinicians is MIPS and this is the one we will address. It is coming up fast! By now, each of you should have received a letter from CMS discussing this new program and defining your status for reporting. You can have each eligible physician (EP), i.e., your radiologists, report as an individual, or you may want to have them report as a group, you will find the guidelines at https://qpp.acr.org/.

Do you need to report via MIPS?
The first step is to determine if your radiologists need to report, per MIPS. You can check if you are exempt from MIPS participation by going to this web site and entering your NPI. https://qpp.cms.gov/participation-lookup. If a physician bills Medicare $30,000 in Part B billing and/or sees at least 100 Medicare patients, you must enroll and report through MIPS. Radiologists are also exempt if they are enrolled in the Advance Payment Model (APPM).

MIPS is a phased in roll out and could result in up to +9% additional Medicare payments. Here is the payment schedule over time. You can also earn an additional 4% bonus payments for your 2019 payment adjustment if you report in 2017.

![Payment Schedule](image)

Although there are four categories of reporting, three for 2017, radiologists are considered as non-patient facing and, as such, have to report against two categories.

1. Quality – 85% of their target
2. Improvement Activities – 15% of their target.

Points are assigned to each of the items selected. For example, improvement activities could have a rating of 10% or 20%. In order to meet the target, the total percentage of items selected should be equal to the target percentage. See https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf

2017 is a transition year and there are several levels of participation.

1. The quick method is the test level and it is to report on one quality measure OR one improvement activity. Doing this would mean there would be no penalty in your 2019 payment adjustment, but no upside either.
2. The second is to report on 90 days on multiple quality measures and/or improvement activities and you may earn neutral or positive payment adjustment. If that option is chosen then the quality measures and improvement activities you select would be tracked and submitted for a 90-day period, October-December 2017. This could provide some upside on the reimbursement.

3. The third option would be to report for the full 2017 year, which could give even greater upside on payments.

**Reporting needs to be done thru a Qualified Clinical Data Registry (QCDR).** The one we recommend is the NRDR’s (National Radiology Data registry) QCDR. There is a cost for reporting performance measures and activities to CMS for MIPS; however, the cost is minimal for ACR members.

**What is medQ doing for this?**

dedQ, Inc. has created a special MIPS reporting module to produce certain data to submit to these registries. The Omnicare program can also produce the data that can be reported thru these registries, for breast and lung categories. More info about the ACR registry can be found at [https://www.acr.org/Quality-Safety/National-Radiology-Data-Registry/Qualified-Clinical-Data-Registry](https://www.acr.org/Quality-Safety/National-Radiology-Data-Registry/Qualified-Clinical-Data-Registry)

**Data must be submitted to this registry by January 31st 2018.** This gives the ACR enough time to submit that data to CMS on your behalf to avoid a negative payment adjustment.

We have identified a number of “Quality Performance measures” and “Improvement Activities” we feel are appropriate for our customers. All measures require the “Q/ris MIPS reporting module” however add on modules are required for specific measures s indicated below:

**Quality Performance measures:**

For an overview of Quality Performance measures see [https://qpp.cms.gov/mips/quality-measures](https://qpp.cms.gov/mips/quality-measures). For 2017 quality measures reporting both MIPS and non-MIPS measures are allowed. There are 52 2017 MIPS and Non-MIPS measures to choose from and the ACR has provided a list here [https://www.acr.org/Quality-Safety/Resources/MACRA-Resources](https://www.acr.org/Quality-Safety/Resources/MACRA-Resources). Here are the ones we recommend:

- Measure ACRad 15: Report Turnaround Time: Radiography (modified) – This is the mean radiography report turnaround time (RTAT). (Does not include mammography.)
- Measure ACRad 16: Report Turnaround Time: Ultrasound (Excluding Breast US) – This is the mean time from exam completion to final signature on report, in hours.
- Measure ACRad 17: Report Turnaround Time: MRI – This is the mean MRI report turnaround time (RTAT).
- Measure ACRad 18: Report Turnaround Time: CT – This is the mean CT report turnaround time (RTAT)
- Measure ACRad 19: Report Turnaround Time: PET- This is the mean PET report turnaround time (RTAT)
- Measure ACRad 20: Report Turnaround Time: Mammography – Mean mammography report turnaround time (RTAT)
With the addition of the “Q/ris Dose Capture Module” you can report on these additional quality measures:

- **Measure ACRad 31**: Percent of CT Abdomen-pelvis exams with contrast (single phase scan) for which Dose Length Product is at or below the size-specific diagnostic reference level. Note: This is calculated at facility/TIN level and assigned to all NPIs who read CT under that TIN.
- **Measure ACRad 32**: Percent of CT Chest exams without contrast (single phase scan) for which Dose Length Product is at or below the size-specific diagnostic reference level. Note: Calculated at facility/TIN level and assigned to all NPIs who read CT under that TIN.
- **Measure ACRad 33**: Percent of CT Head/Brain exams without contrast (single phase scan) for which Dose Length Product is at or below the size-specific diagnostic reference level. Note: Calculated at facility/TIN level and assigned to all NPIs who read CT under that TIN.

There are other measures which require more work at the site. These are:

- **Measure 436**: Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques – For this we need the site to modify their macros by procedure (for specific CPT codes) and the Radiologist while dictating can insert the appropriate statement required for this measure in the body of their report. For this measure to work the Radiologist would have to do this on each report associated with a specific set of procedure CPT codes. It is essentially the percentage of final reports for patients aged 18 years and older undergoing CT with documentation that one or more of the following dose reduction techniques were used:
  - Automated exposure control
  - Adjustment of the mA and/or kV according to patient size
  - Use of iterative reconstruction technique
- **Measure 364**: Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines – This is Percentage of final reports for computed tomography (CT) imaging studies of the thorax for patients aged 18 years and older with documented follow-up recommendations for incidentally detected pulmonary nodules (e.g., follow-up CT imaging studies needed or that no follow-up is needed) based at a minimum on nodule size AND patient risk factors. If you decide to report on this measure we will work with you on doing this.
- **Measure 365**: Appropriate Follow-up Imaging for Incidental Abdominal Lesions – This is much like the earlier one in that they require us to calculate the percentage of final reports for abdominal imaging studies for asymptomatic patients aged 18 years and older with one or more of the following noted incidentally with follow-up imaging recommended:
  - Liver lesion = 0.5 cm
  - Cystic kidney lesion < 1.0 cm
  - Adrenal lesion = 1.0 cm
Measure 359: Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging Description - Percentage of computed tomography (CT) imaging reports for all patients, regardless of age, with the imaging study named according to a standardized nomenclature and the standardized nomenclature is used in institution’s computer systems. For this we would need to work with the site in renaming CT exams using standard nomenclature.

With the addition of the “Q/ris Mammography module” you can also report on the following quality measures:

- Measure 225: Radiology Reminder system for screening mammograms - This is the percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram
- Measure 146: Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Screening Mammograms - Percentage of final reports for screening mammograms that are classified as “probably benign”
- Measure 112: Breast Cancer Screening - Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer.

Given this list it is up to the site to pick and choose the measures that make sense for them. Also based on the ones you choose you can go to the MIPS calculator which can be found at [https://qpp.acr.org/Calculator2](https://qpp.acr.org/Calculator2) to find out what bonus points you can get by reporting these.

Improvement activities:
“Improvement Activities” for the most part are reported thru the same QCDR used for reporting “Quality Performance measures” however the submission process is like attestation. It can also be reported thru the CMS website much like those of you who did Meaningful Use attestation. You say yes or no to the measures you report however in case of an audit there must backup the attestation. For an overview of “Improvement Activities” see [https://qpp.cms.gov/mips/improvement-activities](https://qpp.cms.gov/mips/improvement-activities)

The full list of ACR suggested Improvement activities can be found in the link in the Tools section at [https://www.acr.org/Quality-Safety/Resources/MACRA-Resources](https://www.acr.org/Quality-Safety/Resources/MACRA-Resources)

We can work with each site to help pick and choose the appropriate “Improvement activities” which are right for the site.

Additional measures will be available with the Q/ris CDS module (appropriate use criteria) coming in 2018

If you decide to move forward with this please contact medQ. Keep in mind the following dates:
- Oct 1st to December 31st 2017: 90-day reporting period for 2017 MIPS measures
- October 31st 2017: The deadline to sign up for the ACR’s QCDR. Please see this link
- January 31st 2018: Deadline to submit all measures the ACR QCDR.

If you are interested in adding this to your program, give us a call. 214-221-6330 ext 225 or email me at John@medQ.com