Learning Forum Friday

Making Your EHR Work for You

Questions and Answers

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Question 1:	**Where is there a current list of certified EHR software? Ours was certified, then lost it and did not notify us until I could not submit the data.** You can find a list of certified and decertified EHR software vendors, the Certified Health IT Product List (CHPL) and a Public User Guide on the website of the Office of the National Coordinator (ONC) located here: https://www.healthit.gov/.
Question 2:	**What are the steps to ensure we qualify for the 28 team MIPS bonuses?** There are several ways to qualify for the 2018 MIPS bonus: • Each eligible clinician in a small practice of less than 15 clinicians will receive five points added to their final score providing data completeness is met in one performance category. • Report additional outcome as high-priority or patient experience measure for bonus points in the quality category. • Practices can earn up to five points for treating complex patients/measures, by the hierarchal conditions category, the HCC risk. • You can earn an additional point per measure when you use EHR for reporting. Use of the 2015 EHR addition will receive 10% bonus points. This is for the promoting interoperability section. • Reporting on the available performance measures can earn up to 90% bonus. • Implement improvement activities using your EHR will give you a bonus. • Earn a 5% bonus by participating in a public health or clinical data registry.
Question 3:	**Please review the numerator and denominator ratio and how the patients are pulled into the denominator when you are reporting via an EHR versus when you're reporting via claims.** When reporting via an EHR, it is important that you use the latest update. The certified EHR has a built-in certification measure functionality to capture the patients in the numerator/denominator. The numerator will rely more on user input, so that is why it is important that everybody knows how to document correctly the structured field. The patients included in the EHR reporting method include all payers and the EHR does the work for you to identify them in the denominator portion. When reporting via claims, the claims measure specification sheet is used to identify which patients to include in the denominator and numerator. The quality data code found in the numerator section of each measure is included on the claim when it is submitted and identifies if the patient has had that test/activity. Patients included in the denominator of claims reporting include only Medicare fee-for-service (FFS) payor. With claims reporting, staff can submit quality data

codes on the claims of as little as 60% of the Medicare FFS patients who fell under that measure for the entire year.

For the registry reporting, you would include all payers, 60% data completeness, and use a measure specification sheet for the registry reporting of that measure.

Question 4:

Since quality was decreased to 50%, of the total score, how will each measure be weighted?

The quality measures will continue to be compared to a benchmark, just as they were in 2017, showing the performance needed to score the maximum points for a given measure. Each quality measure will score between three and 10 points. There is an exception though. Six measures have topped-out, and the score will be tapped at seven points each. Those six measures are:

- Perioperative care, ID number 21.
- Melanoma, ID number 224.
- Perioperative care, ID number 23.
- Image confirmation of breast lesion, ID number 262.
- Optimizing patient exposure to ionizing radiation, ID number 359.
- COPD bronchodilator therapy, ID number 52.

Quality measures that don't have a benchmark or don't have at least 20 patients will receive only three points. Quality measures that don't meet the data completeness criteria (60%) will receive only one point instead of three points. Small practices will have an advantage. Small practices with less than 15 eligible clinicians will receive three points instead of the one if they don't meet the data completeness. Data completeness means that if there were 100 patients included in the measure for the year, at least 60 will need to be reported on.

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