The Hand Surgeon’s Guide to Compliance

A step-by-step guide to complying with the Quality Payment Program (QPP) from the American Society for Surgery of the Hand.
Created by the ASSH Quality Metrics Committee, this document is intended to guide hand surgeons in complying with the Quality Payment Program (QPP), a program that stems from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). QPP replaced what was known as the Sustainable Growth Rate formula.

If you are planning to participate in the Advanced Alternative Payment Model track, this guide is not for you. Rather, this guide will lead physicians step-by-step through the Merit-Based Incentive Payment System (MIPS) track.

Our goal is to make QPP participation less of a burden for you and your practice. If you have questions about any of the steps listed in this guide, please contact us at info@assh.org.

*This guide was last updated on 9/27/17. While this guide was created using CMS resources, details of the QPP program may change frequently. The CMS QPP website is the official source of up-to-date, accurate information regarding this program.*
# STEP 1 - Pick Your Path

As a hand surgeon, you are required to participate in the QPP through one of the paths here:

<table>
<thead>
<tr>
<th>EXEMPTION</th>
<th>MIPS</th>
<th>APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are exempt from participating in QPP if one of the following is true:</td>
<td>A fee-for-service model that allows you to participate initially at your own pace. This guide will focus on this path.</td>
<td>An advanced alternative payment model that reduces costs of care and/or supports high-value services not typically covered under the Medicare fee schedule. This guide will not cover the APM track.</td>
</tr>
<tr>
<td>• This is your first year of Medicare Part B participation</td>
<td></td>
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<tr>
<td>• Your Medicare allowed charges are &lt; or equal to $30K or &lt; or equal to 100 patients</td>
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<tr>
<td>• You are non-patient facing with &lt; or equal to 100 patients</td>
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<tr>
<td>• You are participating in an Advanced Alternative Payment Model (APM)</td>
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**TIP:** To find out if you are exempt, enter your National Provider Identifier (NPI) [on this webpage](#).
You can choose to report as an **individual** or as a **group**. As an individual, your payment adjustment is based solely on your performance. To report as a group, you must have 2 or more eligible clinicians, and your adjustment is based on the group’s performance.

### INDIVIDUAL REPORTING

Here are your options for submitting your data:

1. Electronic Health Record (EHR)
2. Qualified Registry
3. Your routine Medicare claims process
4. Placing quality HCPCS codes on your claims

### GROUP REPORTING

Here are your options for submitting your data:

1. CMS Web Interface (for groups with 25 or more eligible clinicians) - must register by June 30, 2017
2. Qualified Clinical Data Registry (QCDR)
3. Qualified Registry
4. Electronic Health Record (EHR)
5. Administrative Claims
6. CAHPS for MIPS Survey (for groups with 2 or more eligible clinicians)
7. Attestation
8. Placing quality HCPCS codes on your claims

**TIP:** Reporting via an EHR is your best and easiest option. If you have an EHR and have questions about how to do so, contact your EHR vendor.
Your 2019 payment adjustment will depend on your level of reporting effort in 2017. You do not have to report this pace to anyone, but you should determine your level of effort before beginning to report data for your own benefit:

<table>
<thead>
<tr>
<th>NONE</th>
<th>TESTING</th>
<th>PARTIAL</th>
<th>FULL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting no data in 2017 and subsequent years.</td>
<td>Reporting on 1 quality measure OR 1 improvement activity OR 4 required ACI measures at any point in 2017. At this pace, you do not have to report for any specific number of days.</td>
<td>Reporting on 1 quality measure OR 1 improvement activity OR 4 required ACI measures for at least 90 consecutive days in 2017.</td>
<td>Meet all reporting requirements for at least 90 consecutive days in 2017.</td>
</tr>
<tr>
<td><strong>Payment adjustment:</strong></td>
<td><strong>Payment adjustment:</strong></td>
<td><strong>Payment adjustment:</strong></td>
<td><strong>Payment adjustment:</strong></td>
</tr>
<tr>
<td>-4% in 2019</td>
<td>Neutral (neither a negative nor positive adjustment)</td>
<td>Neutal (neither a negative nor positive adjustment)</td>
<td>≤4% positive adjustment</td>
</tr>
<tr>
<td>-5% in 2020</td>
<td>OR</td>
<td>OR</td>
<td>≤10% positive adjustment for exceptional performers</td>
</tr>
<tr>
<td>-7% in 2021</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-9% in 2022 and later</td>
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</table>
There are four components of MIPS reporting and scoring. Each component makes up a certain percentage of your overall MIPS score. Full MIPS reporting means you are meeting the requirements for each component, which will be explained in this document.
For full MIPS reporting, you must report on 6 measures, one of which must be an outcome measure. If no outcome measures apply, one must be a high-priority measure.

**Step 1: Choose Your Measures**

Here are some measures that either apply to hand surgery or are broad enough to be of use. Learn more about these measures and view the full list of available measures on this QPP webpage.

- ^Documentation of Current Medications in the Medical Record
- Documentation of Signed Opioid Treatment Agreement
- Evaluation or Interview for Risk of Opioid Misuse
- ^Functional Outcome Assessment
- ^*Functional Status Change for Patients with Elbow, Wrist or Hand Impairments
- ^Osteoarthritis (OA): Function and Pain Assessment
- ^*Pain Brought Under Control Within 48 Hours
- ^Pain Assessment and Follow-Up
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

^High-Priority Measures       ^Outcome Measures

**TIP:** This component was formerly known as PQRS. If you were participating in PQRS, you can continue reporting your measures as you were previously.
Step 2: Double Check Your List

- Does your list include 1 outcome measure or 1 high-priority measure?
- Are your measures compatible with your chosen data submission method (i.e. EHR, claims process, registry)?

Note: Check this page on the QPP website to ensure your measures comply with your submission method. Many of the methods have a limited number of applicable measures.

Step 3: Report Your Data

You will report your data for this component and all other components in this guide based on your chosen reporting mechanism (page 4). For this Quality Component, you can find the applicable measure numbers on the QPP website linked above.
**COMPONENT 2: Advancing Care**

**MIPS Path**

**Note:** This component requires the use of an EHR or participation in a registry.

For full MIPS reporting, you must report on ALL 5 of the required ACI measures. For partial or testing reporting, you must choose 4 of the required measures. This component was formerly known as meaningful use.

**Step 1: Choose Your Measure Set**

There are two different sets of measures to choose from, based on your EHR edition.

1. **Advancing Care Information Objectives and Measures**
   - Technology certified to the 2015 Edition OR
   - Combination of technologies from 2014 and 2015 Editions

2. **2017 Advancing Care Information Transition Objectives and Measures**
   - Technology certified to the 2015 Edition OR
   - Technology certified to the 2014 Edition OR
   - Combination of technologies from 2014 and 2015 Editions

**TIP:** Unsure about your EHR edition? [Search for it here](#).
Step 2: Report On the Required Measures

There are certain measures that are required for full reporting, making up 50% of your total ACI score. This is also known as your base score. These measures are:

For the Advancing Care Information Objectives and Measures Set:

1. Security Risk Analysis (yes/no statement)
2. E-Prescribing (numerator/denominator)
3. Provide Patient Access (numerator/denominator)
4. Send Summary of Care (numerator/denominator)
5. Request/Accept Summary of Care (numerator/denominator)

For the 2017 Advancing Care Information Transition Objectives and Measures Set:

1. E-Prescribing (numerator/denominator)
2. Health Information Exchange (numerator/denominator)
3. Provide Patient Access (numerator/denominator)
4. Security Risk Analysis (yes/no statement)

If you are taking part in partial reporting, your 4 measures should come from the applicable list above.

You can earn bonus points by reporting on additional measures (up to 9 total). View all the measures here.
COMPONENT 3: Improvement

MIPS Path

Improvement Activities are intended to improve clinical practice or care delivery. This is a brand new component. There are 92 different activities to choose from when reporting.

**Step 1: Determine Your Number of Activities**

For partial reporting, choose 1 activity. For full reporting, follow these guidelines:

- Groups with fewer than 15 participants: **2 activities**
- Participants in a rural or health professional shortage area: **2 activities**
- Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: **0 activities - automatic full credit**
- APM participants: **Varies** - see QPP site for details
- All other participants: **4 activities**

**Step 2: Choose Your Activities**

Each activity listed on the QPP Improvement page will be weighted as either medium (10 points each) or high (20 points each). To achieve the highest score of 100%, you need 40 points. You can choose two high-weight activities, four medium-weighted activities, or a combination of both.

Select activities your practice is either currently working on or can most readily implement.
COMPONENT 3: Improvement

Here are some activities that are applicable to hand surgery:

- Administration of the AHRQ Survey of Patient Safety Culture
- Annual registration in the Prescription Drug Monitoring Program
- Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
- Collection and use of patient experience and satisfaction data on access
- Depression screening
- Engagement of patients, family and caregivers in developing a plan of care
- Implementation of formal quality improvement methods, practice changes or other practice improvement processes
- Implementation of improvements that contribute to more timely communication of test results
- Integration of patient coaching practices between visits
- Measurement and improvement at the practice and panel level
- Provide 24/7 access to eligible clinicians or groups who have real-time access to patient’s medical record
- Tobacco use
- Use evidence-based decision aids to support shared decision-making
- Use of certified EHR to capture patient reported outcomes

^ High-weighted activity (20 points)
COMPONENT 4: Cost

No data submission is required for this component.

The Cost component is calculated based on your claims data. This component will not affect your MIPS score in 2017 (2019 payment adjustment), but will count for 10% of your score in 2018 and 30% of your score in 2019 and beyond.

Since you have less control over this component, we recommend that you do the following in order to help your Cost score:

- Ensure that your diagnosis coding is accurate
- Ensure that your claims are accurate
- Document your patient information accurately in their records
- Work with hospital committees that promote efficient patient care
This timeline applies to the 2017 data collection period.

<table>
<thead>
<tr>
<th>Data Collection</th>
<th>Submission Deadline</th>
<th>Feedback</th>
<th>Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1 - December 31, 2017</td>
<td>March 31, 2018</td>
<td>After your data submission, Medicare will provide feedback on your performance.</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>For 90-day reporting, the last day you can begin data collection is October 2, 2017.</td>
<td>You must submit your 2017 data by this date in order to qualify for a neutral or positive payment adjustment.</td>
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PAYMENT ADJUSTMENTS

Based on your performance, your 2019 medical payments will be either positively or negatively adjusted (i.e. MIPS payment adjustment) if you submit and/or attest your 2017 data by March 31, 2018. See page 5 of this guide to see how your reporting pace will affect your adjustment.

Source: CMS
CMS has created a program that provides direct technical assistance to help clinicians and small practices participate in the Quality Payment Program. The initiative is comprised of local, experienced organizations that will help clinicians in small and rural practices:

- Select and report on appropriate measures and activities to satisfy the requirements of each performance category under MIPS
- Engage in continuous quality improvement
- Optimize their health information technology (HIT)
- Evaluate their options for joining an Advanced Alternative Payment Model (APM)

To view the full list of contacts through this program, [click here](downloadable PDF).
QUESTIONS AND FEEDBACK

Was this guide helpful for you? Let us know!

RATE THE GUIDE

Still have questions?
Contact ASSH staff member Olivia Moran at:

omoran@assh.org
312-880-1918

References: