MIPS Measures & Scoring Summary
Nick Austin, Director of Product Management
• Making the assumption that everyone today has already viewed the previous webinar. If you have not, make sure to view it through the TheraOffice training center.

• FAQ
  • When reporting through registry, Quality Measures will be counted on 100% of your patients, regardless of insurance.
  • Submitting as Individuals vs Group is your choice and is based on whether or not you want certain providers to participate vs your entire company.
Registry Pricing

- If Submitting Individually
  - $299 Per Provider Per Year
- If Submitting as a Group
  - Custom Pricing
What You Get For Your Registry Fees

• TheraOffice Registry will collect, analyze, and report MIPS data to the Quality Payment Program (QPP).

• TheraOffice will provide quarterly updates to you on your MIPS progress.

• Data will be submitted all at once in Q1 2020. Before the data is submitted, a final consultation will be had with each registry customer to confirm who they want the data submitted for.

• Throughout the year, if we notice anyone falling behind, we will be reaching out to assist in understanding of the MIPS requirements.
Warning

• This webinar is based on information released in the final rule.
• We are still waiting on information to come out in the form of Measure Specifications.
• These specification documents can impact what measures are available to providers, how these measures are reported, and at what frequency they are required.

• Should anything change, we will be notifying you.
Quality

**Four Process Measures**
- BMI
- Current Medications
- Pain Assessment
- Outcome Assessment

**Seven Outcome Measures**
- FOTO measures based on body part
• Preventative Care and Screening: BMI Screening and Follow-Up Plan
• Measure #128
• Evals ONLY
• “Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.”
BMI - Definitions

**Height and Weight** – An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within twelve months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.

**Follow-Up Plan** – If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI, outside of normal parameters.
• New BMI section has been added.
• Enter the values and BMI will automatically be calculated for you.
• Follow-up plan options are available through a checkbox list
Current Medications

- Documentation of Current Medications in the Medical Record
- Measure #130
- Evals and Re-Evals
  - Re-Evals defined as submitting a 97164 code, not the use of a progress note.
- “Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration.”
The eligible clinician must document in the **medical record** they obtained, updated, or reviewed a medication list on the date of the encounter.”

We have often heard the debate of what is the medical record. Is it the data? Is it the report?

The answer is the medical record is everything. The patient profile, case information, notes, reports, flex notes, and yes, **image notes**.
• Existing Medication History grid is being updated for MIPS compliance with the correct columns.
• Option for indicating No Current Medications or attesting to the Current Medications being documented in Image Note
• MIPS Assessment automatically determined for you
• Pain Assessment and Follow-Up
• Measure #131
• Evals and Re-Evals
• “Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each (denominator eligible) visit AND documentation of a follow-up plan when pain is present.”
Pain Assessment – Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration.

Standardized Tool – An assessment tool that has been appropriately normed and validated for the population in which it is used. Example of tools for pain assessment, include, but are not limited to: Brief Pain Inventory, Faces Pain Scale, McGill Pain Questionnaire, Multidimensional Pain Inventory, Neuropathic Pain Scale, Numeric Rating Scale, Oswestry Disability Index, Roland Morris Disability Questionnaire, Verbal Descriptor Scale, Verbal Numeric Rating Scale, and Visual Analog Scale.
Outcome Assessment

- Functional Outcome Assessment
- Measure #182
- Eval and Re-Evals
- “Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.”
**Standardized Tool** – A tool that has been normed and validated. Examples of tools for functional outcome assessment include, but are not limited to: Oswestry Disability Index, Roland Morris Disability / Activity Questionnaire, Neck Disability Index, Patient-Reported Outcomes Measurement Information System, Disabilities of the Arm, Shoulder and Hand (DASH), and Knee outcome Survey Activities of Daily Living Scale.

**Note**: A functional outcome assessment is multidimensional and quantifies pain and musculoskeletal/neuromusculoskeletal capacity; therefore the use of a standardized tool assessing pain alone, such as the Visual Analog Scale (VAS), does NOT meet the criteria of a functional outcome assessment standardized tool.
• Existing Functional Testing section has been updated to include Pain Assessment and Functional Assessment drop downs.

• These drop downs are automatically populated based on the functional tests that are indicated above.
# Functional Outcome Tests

<table>
<thead>
<tr>
<th>Functional Test</th>
<th>Pain Assessment</th>
<th>Functional Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berg Balance</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>DASH</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Dizziness Handicap Index</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Foot Function Index</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Functional Reach Test</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Lower Extremity Functional Test</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Neck Disability Index</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>OPTIMAL – Confidence</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>OPTIMAL – Difficulty</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Oswestry</strong></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Roland Morris</strong></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>SPADI</strong></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Tinetti Assessment Tool</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>TUG</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Upper Extremity Functional Scale</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Visual Pain Analog Scale – 24 Hours</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Visual Pain Analog Scale – 2 Days</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Pain and Outcome Assessment - Override

- Override buttons are included for certain rare circumstances.
Why Override Pain Assessment?

- We’re assuming you are treating the patient because they have some degree of pain requiring a follow-up plan. If not, because they are being treated for required maintenance, an override is required.
- We are also assuming that a follow-up plan is inherent to the PT Documentation process.
- Patients not eligible is defined as patients with “severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others” OR “patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.”

<table>
<thead>
<tr>
<th>Measure Numerator Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Assessment Documented as Positive AND Follow-Up Plan Documented</td>
</tr>
<tr>
<td>Pain Assessment Documented as <strong>Negative</strong>, No Follow-Up Plan Required</td>
</tr>
<tr>
<td>Pain Assessment not Documented <strong>Patient not Eligible</strong></td>
</tr>
<tr>
<td>Pain Assessment Documented as Positive, Follow-Up Plan Not Documented, <strong>Patient Not Eligible</strong></td>
</tr>
<tr>
<td>Pain Assessment not Documented, Reason not Given</td>
</tr>
<tr>
<td>Pain Assessment Documented as Positive, <strong>Follow-Up Plan not Documented</strong>, Reason not Given</td>
</tr>
</tbody>
</table>
Why Override Outcome Assessment?

- Same assumptions as pain assessment with regards to treating a patient because of a functional deficiency and documenting the follow-up. If the patient was evaluated within 30 days for the same problem, there is also an option for that.
- Patient not eligible for outcome assessment is defined as “Patient refuses to participate” OR “Patient unable to complete questionnaire” OR “Patient is an urgent or emergent medical situation…”

Measure Numerator Options

- Functional Outcome Assessment Documented as Positive And Care Plan Documented
- Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan Not Required
- Functional Outcome Assessment Documented & Care Plan Documented, If Indicated, Within Previous 30 Days
- Functional Outcome Assessment Not Documented, Patient Not Eligible
- Functional Outcome Assessment Documented, Care Plan Not Documented, Patient Not Eligible
- Functional Outcome Assessment Not Documented, Reason Not Given
- Functional Outcome Assessment Documented as Positive, Care Plan Not Documented, Reason Not Given
**Outcome Measures (FOTO)**

**Functional Status Change for Patients With...**

- Knee Impairments (Measure #217)
- Hip Impairments (Measure #218)
- Foot or Ankle Impairments (Measure #219)
- Lumbar Impairments (Measure #220)
- Shoulder Impairments (Measure #221)
- Elbow, Wrist or Hand Impairments (Measure #222)
- Other General Orthopaedic Impairments (Measure #223)

Measured at Discharge by taking the risk adjusted difference between the expected score and the actual score.
Outcome Measures - TBD

- Currently finalizing with FOTO on the details of how these measures will be handled through TheraOffice.
- Should have all of the details available in the next webinar, so make sure to attend!
Locking a Note

- You will receive the following popup, validating your MIPS results when a corresponding Eval/Re-Eval Code is used.
- During the MIPS Setup Wizard on Update, you will be able to set whether or not Performance Met is required for every measure.

MIPS Validation Results

<table>
<thead>
<tr>
<th>Measure #128 - BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI Documented as Above Normal Parameters, AND Follow-Up Documented</td>
</tr>
<tr>
<td>✔ Met</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure #130 - Current Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Medications Documented</td>
</tr>
<tr>
<td>✔ Met</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure #131 - Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Assessment Documented as Positive AND Follow-Up Plan Documented</td>
</tr>
<tr>
<td>✔ Met</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure #131 - Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Outcome Assessment Documented As Positive And Care Plan Documented</td>
</tr>
<tr>
<td>✔ Met</td>
</tr>
</tbody>
</table>
Improvement Activities

A brand new category that was introduced specifically for MIPS inclusion. It consists of various activities that can be performed by clinics with hopes of making improvements to their processes through ways such as ongoing care, patient and clinician shared decision-making, safety practices and expanding access.

Depending upon a clinic’s location as well as the number of patients being treated, it is expected that two to four of the available activities are completed with the only requirement for submission of this category being an attestation that the activities themselves were performed.
Your Improvement Activity Requirements can be influenced if your clinic is granted a special designation.

<table>
<thead>
<tr>
<th>Special Designation Practices</th>
<th>Non-Patient Facing Designation</th>
<th>Health Professional Shortage Area</th>
<th>Rural Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Practice (15 or less providers)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Must be checked through [https://qpp.cms.gov/participation-lookup](https://qpp.cms.gov/participation-lookup)
**Improvement Activity Requirements**

**Special Designation Practice**
- 1 High-Weighted Activity OR
- 2 Medium-Weighted Activities

**Everyone Else**
- 2 High-Weighted Activities OR
- 1 High-Weighted Activities & 2 Medium-Weighted Activities OR
- 4 Medium-Weighted Activities
## APTA Recommended Improvement Activities

<table>
<thead>
<tr>
<th>Activity Name</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote use of patient-reported outcome tools</td>
<td>High</td>
</tr>
<tr>
<td>Use of QCDR for feedback reports that incorporate population health</td>
<td>High</td>
</tr>
<tr>
<td><strong>Collection and follow-up on patient experience and satisfaction data on beneficiary engagement</strong></td>
<td>High</td>
</tr>
<tr>
<td>Improved practices that disseminate appropriate self-management materials</td>
<td>Medium</td>
</tr>
<tr>
<td>Regular training in care coordination</td>
<td>Medium</td>
</tr>
<tr>
<td>Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.</td>
<td>Medium</td>
</tr>
<tr>
<td>Use group visits for common chronic conditions (eg. Diabetes)</td>
<td>Medium</td>
</tr>
<tr>
<td>Implementation of fall screening and assessment programs</td>
<td>Medium</td>
</tr>
<tr>
<td>Implementation of practices/processes for developing regular individual care plans</td>
<td>Medium</td>
</tr>
<tr>
<td>Use of tools to assist patient self-management</td>
<td>Medium</td>
</tr>
</tbody>
</table>
Improvement Activity Example

• Collection and follow-up on patient experience and satisfaction data on beneficiary engagement.
  • Description: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.

• ... that’s it? Where is the rest of the requirements?
  • There are none.
  • You simply attest to doing this. No specific documentation requirements. You simply follow the description and attest to doing it.
  • Attestations are done through your registry or if you are reporting via claims, through the QPP website: https://qpp.cms.gov
Other Improvement Activities

- 113 in total to choose from
- If you are struggling to easily complete the recommended ones, I would review the full list to see if there is any other overlap.
  - See a lot of Medicaid patients? Might want to consider the Engagement of new Medicaid Patients and Follow-Up improvement activity.
MIPS Scoring

- MIPS Scoring is based on a 100 point scale.
- The higher the score the better.
- Improvement Activities are scored based on whether or not you did them and their specific weighting.
- Quality measures are scored based on how often you met the performance thresholds versus previously established benchmarks.
  - PQRS was about reporting, MIPS is about performing!
Scoring on a (Steep) Curve

Quality Measures are scored on a curve based on benchmarked data.

To illustrate this, let’s take a look at the Functional Outcome Assessment measure. This measure awards 3-10 points towards your Quality Score (roughly 14% of your final MIPS Score). Let’s assume you are reporting this measure on 50 patients:

- 50/50 Patients = 10 Points
- 49/50 Patients = 5.3 Points
- 48/50 Patients = 3.5 Points
- <47/50 Patients = 3 Points

The necessity to be at 100% performance extends to those with a large sample size as well:

- 4999/5000 Patients = 5.9 Points

“That’s not a curve, that’s a cliff...” – Bro Ballantine, CFO @ Hands on Tech
Scoring Tips

**Require performance met through the TheraOffice MIPS Wizard**

**Quality measures require a minimum of 20 cases to count**

**+5 Point Bonus is available to any small practice that participates (15 or less providers)**

**Bonuses for complex patient population are available (they will determine this on their side through claims data)**

**Quality represents 85% of your final MIPS score, Improvement Activities is 15%**

**Require compliance with MIPS measures as part of your standard procedure for ALL patients, even if reporting claims.**
For the Ambitious


• Best guide on the detailed scoring methodology of the MIPS program. This is for 2018, though the principles will remain the same.
Questions

Thank you for attending today’s webinar! We will be leaving the webinar up for you to submit any questions you have, then we will be answering them in a follow-up FAQ. For any additional questions that come up later, please contact our support department.

TheraOffice Support
866.562.8413 x2
support@theraoffice.com

• 2019 Preview & TheraOffice .11 Release
  • November 29th @ 1:00 PM – 2:00 PM CST

Keep up with TheraOffice on Twitter, Facebook, & LinkedIn for more updates!