

## Just so YOU Know...

*Feb. 2018, Issue 2*

Friends and colleagues,

In this issue, I would like to focus on Rochester RHIO's value to the community of providers. By using the Provider Portal, an office's workflow can greatly improve. It takes 30-45 minutes on average to retrieve patient records through a phone call or fax. With Rochester RHIO's Explore clinical query portal, it takes seconds.

**Common Clinical Data Set:** The New York State Department of Health (NYSDOH) established a minimum data standard for providers to meet in tracking health factors that fulfill the current federal M.U requirements called C-CDA (Consolidated Clinical Document Architecture). There are 21 elements, which most providers already assess and record. Once contributed to Rochester RHIO, our platform will be able to send information back to a provider's EHR, which can be used for CMS quality measure reporting, improving Medicare Part B payments. So, I urge you to sign up for Contribute. To help, the state has an \$11,000 Data Exchange Incentive Program (DEIP) available. For more information, visit <http://www.nyehealth.org/services/hie-adoption/>.

### 21 Data Points in C-CDA

- |                               |                               |
|-------------------------------|-------------------------------|
| 1. Name                       | 12. Lab Results               |
| 2. Date of Birth              | 13. Vital Signs (ex: BP, BMI) |
| 3. Sex                        | 14. Care Plans                |
| 4. Race                       | 15. Procedures                |
| 5. Ethnicity                  | 16. Care Team                 |
| 6. Preferred language         | 17. Immunization              |
| 7. Smoking status             | 18. Unique Devices            |
| 8. Problem List (ex: HTN, DM) | 19. Assessment and Plan       |
| 9. Medication List            | 20. Goals                     |
| 10. Allergies                 | 21. Health Concerns           |
| 11. Lab Tests                 |                               |

**MIPS Summary:** The Merit-based Incentive Payment System for Medicare has become a conundrum of confusion. 2017 was the first no penalty, no extra payment year. The program was to be extended until 2020 and beyond for incentive payments coming in from 2018 and 2019 reporting's of the quality measures. There are over 246 measures, but you pick six based on your specialty as long as one measure is an improvement or high quality measure. Below I have prepared a summary of how to handle this mess and clear the confusion.

**MIPS Eligibility:** 200 Medicare patients and over \$90,000 in Medicare claims per MD or group of MDs; group practice including midlevel can combine patients and claims as long as a group is practicing under one TIN (Tax Identification Number).

**EIDM account** (Enterprise Identity Management account) needs to be open for login and password to report quality measures and improvement activity. Account is under QPP portal of IPRO.

<https://qpp.cms.gov/>. Reports can also be submitted through EHR vendor's QCDR (Qualified Clinical Data Registry), Institutional QCDR, or through Medicare claims to CMS, if no EHR (paper-based).

If submitting through Medicare claims, go to the CMS library under general MIPS. Open Excel spreadsheet. Column A and G are for measures and improvement activity submission. Attest it and then maintain proof of it for 10 years.

Meaningful Use accounts will not work for MIPS. A user must have an EIDM Account.

**Table:** [Summary Comparison MIPS Overview 2017-2020](#)

I hope all these is helpful to you and your practice administrator. Feel free to call me or write me any time. More next month. Stay tuned.