MIPS 2017: Do one and be done!

If you do not wish to participate in any of the bonuses available in 2017 for MIPS, you need to make sure you do the very minimum such that you AVOID a PENALTY in 2019. **We recommend that you use Measure 47 for this**. Before you start, read the claims version of the measure detail sheet which accompanies this instruction sheet. You must PASS (report at least one performance met code) this measure to avoid a penalty. Pay special attention to the 2017 Claims Individual Measure Flow on page 5 under Denominator. *(Figure 1 on the right).*

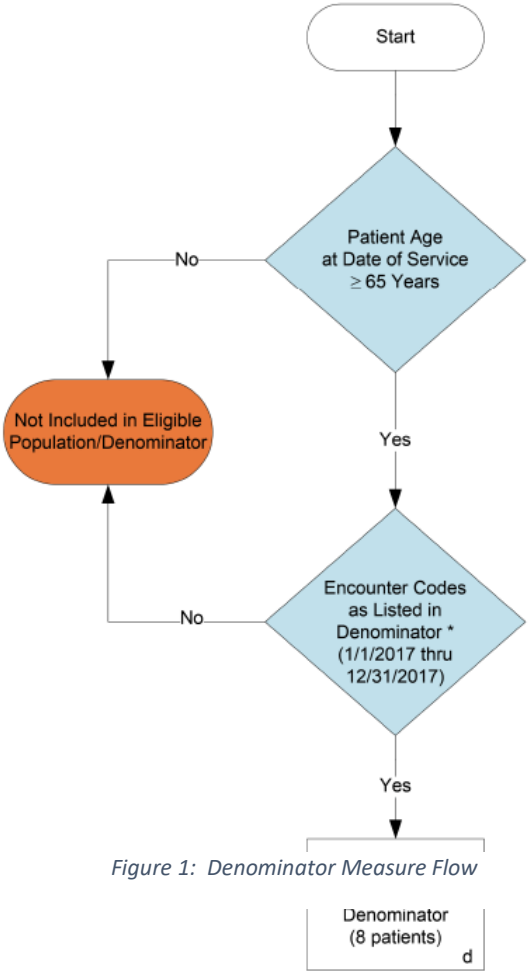

Figure 1: Denominator Measure Flow

Follow these steps to avoid the penalty:

Step 1: Select a Medicare part B patient (not Advantage Plan type) where you will be billing regular Medicare that is 65 or older on the date of the encounter.

AND

Step 2: Verify that you will be billing one of these CPT (Diag/ICD10 codes are not relevant) codes for the visit: 99201, 99202, 99203, 99204, 99205,99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

If you are not going to bill one of the above codes, stop here and find another patient in Step 1.

AND

<u>Step 3</u>: Pay special attention to the 2017 Claims Individual Measure Flow on page 5 under Numerator. *(Figure 2 on the right).* Perform one of the following 2 performance options:

A. (1123F) Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record, OR
B. (1124F) Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

If you cannot perform either A or B above, stop here and find another patient in Step 1.

AND

<u>Step 4</u>: When you prepare your claim, add a separate additional service line with either 1123F or 1124F from Step 3 as a procedure on your claim with the same date of service as the code you are billing from Step 2. Bill for one unit and charge one cent ($0.01). In the DxPointer box, point to the same ICD10 codes you did in Step 2.

AND

<u>Step 5:</u> Send out your claim. Watch for the EOB to come back. Note:

1. If your claim gets rejected, this patient will not count (start over with Step 1)
2. If the EOB comes back and you do not see the 1123F nor the 1124F on it, either try again with another patient or call Medicare and ask them why.

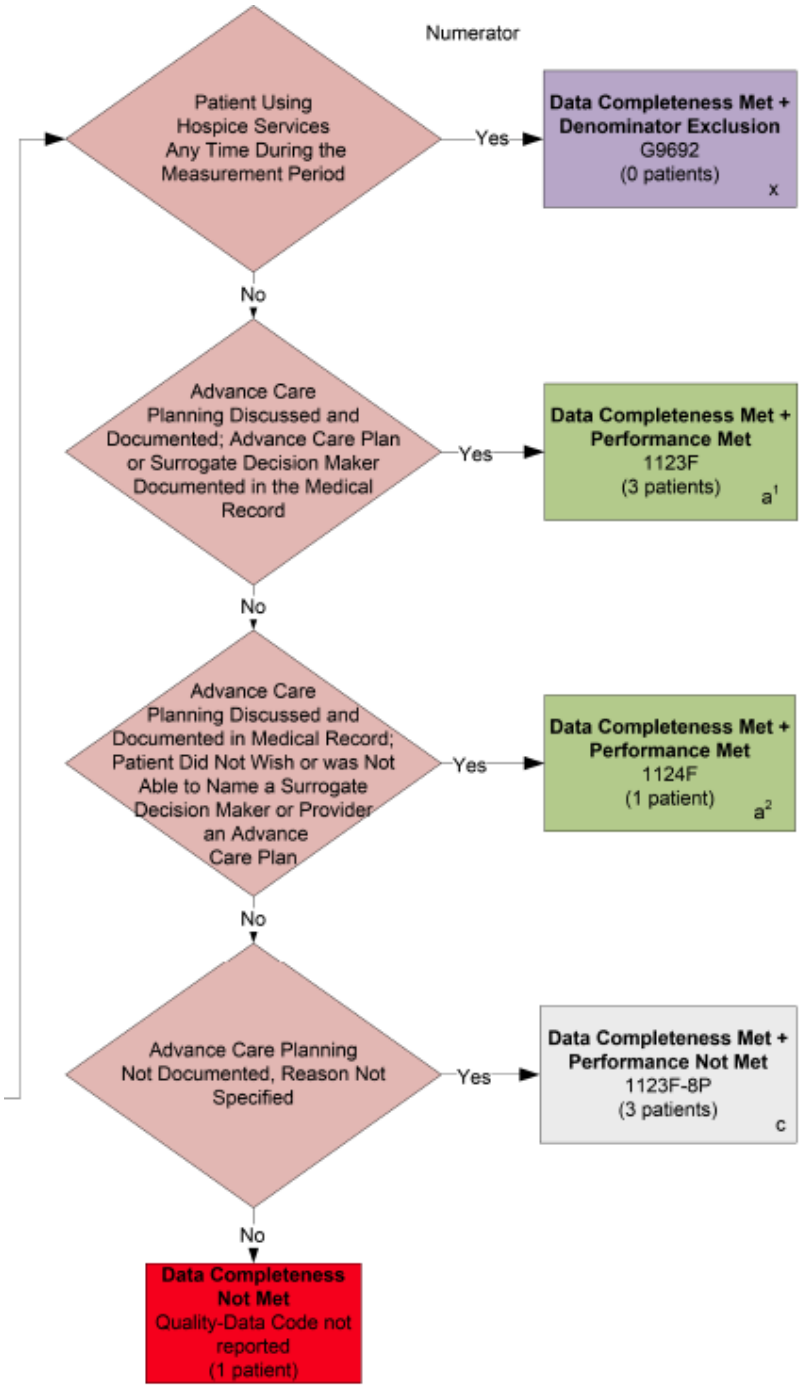

Figure 2: Numerator Measure Flow

You're done! Keep in mind, though – better safe than sorry! We strongly recommend that although the minimum requirement is one, do 2 or 3 (or more) just to give yourself a buffer.