

MIPS Data Reporting Guide

2023 Performance Year

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Introduction

The Merit-based Incentive Payment System asks clinicians to participate in and submit data for up to three performance categories. In 2023, these categories are Promoting Interoperability (PI), Quality, and Improvement Activities. The Cost performance category does not require data submission.

MIPS allows clinicians to submit data as individuals or, if in a practice of > 1 clinician, as a group. **That decision, however, must remain consistent across all performance categories. A clinician cannot report as an individual for Promoting Interoperability, for example, and then as a group for Quality. If the clinician elects to report as an individual, they must report as an individual for each performance category.**

A clinician/group can report data over different date ranges (aka performance period) for Promoting Interoperability and Improvement Activities. In other words, the same date range is not required for each 90-day performance category. The ultimate decision about the ideal ranges for each category is up to the clinician/group.

The MIPS-PI (Stage 3) and MIPS-Quality scorecards in RevolutionEHR are designed to assist clinicians in determining the optimal way to report data (individual vs. group, which 90-day period, etc.) Running the scorecards discussed in this guide over various time ranges and as individuals or group can help zero in on the optimal way to report data to the Centers for Medicare and Medicaid Services (CMS).

This guide is intended to assist clinicians using RevolutionEHR and participating in MIPS to understand how to generate the proper reports and submit their performance data. Within the Quality category, this includes the creation of an electronic file of scores for submission to CMS. Background information related to MIPS eligibility and participation can be found in our [MIPS Resource Center on RevolutionEHR's Knowledge Base](#)

Of critical importance to the data reporting/submission process is to register the practice for Quality Payment Program portal access. **If you don't have these credentials, you can't report your data.** Fortunately, CMS has created a series of documents to help you with registration through their system named HARP. That series can be downloaded as a zip file [found here](#).

If the prospect of data analysis and submission is overwhelming, RevolutionEHR offers the RevAspire service as a potential partner. The RevAspire team analyzes data to determine the optimal performance period, submits data for providers, and serves as first responders in the event of a MIPS audit. More information on RevAspire [can be found at RevolutionEHR.com](#) or by contacting revaspire@revolutionehr.com.

MIPS Data Reporting Key Points

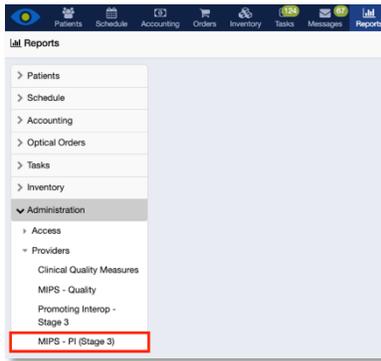
- 2023 performance data must be submitted by **March 31, 2023**
- Data submission will take place through the Quality Payment Program portal at qpp.cms.gov
- The Quality Payment Program portal requires credentials for log in. CMS's official resources can help you through the process and [can be downloaded here.](#)
- Clinicians who are required to report MIPS or who opt-in for 2023 will receive a MIPS payment adjustment in 2025 based on their performance. A final score of 75 or more is necessary to avoid downward payment adjustments.
- Please submit questions to the "Ask about MIPS" link within RevolutionEHR's Help menu or to qualityreporting@revolutionehr.com

Data Collection in RevolutionEHR

Promoting Interoperability

***Note for 2023 MIPS:** Clinicians in small practices will have their MIPS - PI category score automatically reweighted and do not need to submit data for this category. A small practice is defined as 15 or fewer providers billing under the same TIN.

The MIPS-PI (Stage 3) scorecard can be found through Reports > Administration > Providers > MIPS – PI (Stage 3):



The MIPS-PI (Stage 3) scorecard header looks like this:

MIPS - PI (Stage 3) ✕

Provider(s) - All Providers - Location Tax Id 111111111 Date 04/01/2019 to 06/30/2019

Field	Function
Provider(s)	<p>Allows the user to choose the providers included in the statistical report. This is “All Providers” by default but can be changed to any individual provider in the practice through the dropdown menu.</p> <p>“All Providers” = reporting all performance data for a specific location tax Id. This is known as “Group” reporting. Selecting an individual provider = reporting for an individual provider at a specific location tax Id. This is known as “Individual” reporting.</p> <p><i>Note: If an individual provider has been selected, clicking the small “X” next to the name will return the Provider(s) selection to “All Providers”.</i></p>
Location Tax Id	Allows the user to choose the specific business entity for the report. Since MIPS requires each Tax ID to be represented with data, a practice with more than one

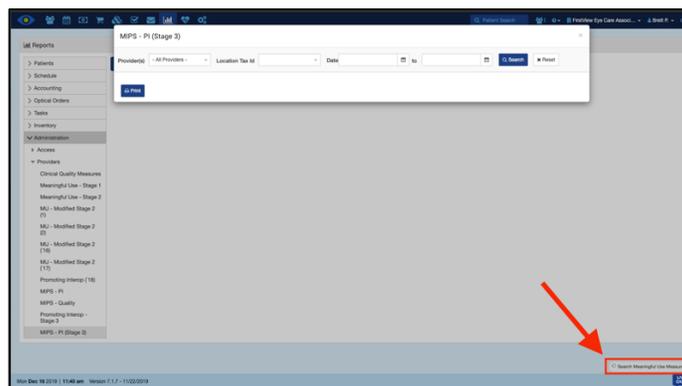
	Tax ID will need to use the Location Tax Id field to generate separate reports for each Tax ID.
Date	Allows the user to choose the Start and End dates for their PI performance period.
Search	Allows the user to run the report.
Reset	Allows the user to return the scorecard to the default state/settings.

Note that when the scorecard is first loaded, default data (YTD performance for “All Providers” at a specific Location Tax Id) is presented. If the desired parameters are different, the user can configure the ideal criteria and run the scorecard again.

To run the MIPS-PI (Stage 3) scorecard:

1. Select “Provider(s)” of interest
 - a. Selecting “All Providers” = Group reporting
 - b. Selecting an individual provider = Individual reporting
2. Select “Location Tax Id” of interest
3. Enter Start and End dates for the performance period of interest. **This must be at least 90 consecutive days for a 2023 performance period.**
4. Select “Search” to run the scorecard

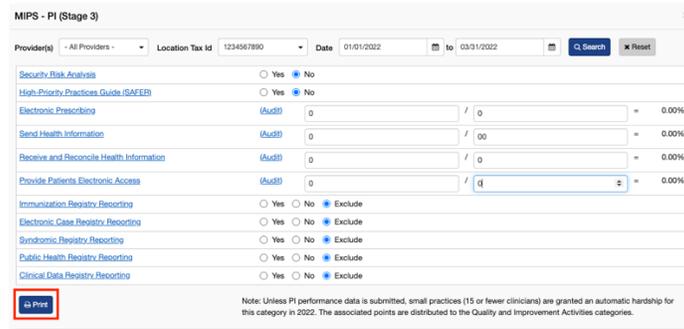
The scorecard should not be considered an accurate reflection of performance until the “Search Meaningful Use Measures” message at the bottom of the screen has disappeared as this is an indication that the search is complete:



Once the scorecard has returned data and the “Search Meaningful Use Measures” message has disappeared, the Security Risk Analysis and Registry measures’ Yes/No buttons can be manually changed, as appropriate, prior to saving for attestation. As an example, if the clinician was actively engaged with a clinical data registry such as AOA MORE or at least one doctor in a group practice electing to report as a group was actively engaged with AOA MORE, the “Clinical Data Registry Reporting” selection could be changed to “Yes”:

Immunization Registry Reporting	<input type="radio"/> Yes	<input type="radio"/> No	<input checked="" type="radio"/> Exclude
Syndromic Registry Reporting	<input type="radio"/> Yes	<input type="radio"/> No	<input checked="" type="radio"/> Exclude
Electronic Case Registry Reporting	<input type="radio"/> Yes	<input type="radio"/> No	<input checked="" type="radio"/> Exclude
Public Health Registry Reporting	<input type="radio"/> Yes	<input type="radio"/> No	<input checked="" type="radio"/> Exclude
Clinical Data Registry Reporting	<input checked="" type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Exclude

With all Yes/No measures updated, the “Print” button in the lower left of the scorecard can be used to save the file for attestation and future audit support:



MIPS - PI (Stage 3)

Provider(s) All Providers Location Tax Id 1234567890 Date 01/01/2022 to 03/31/2022 Search Reset

Security Risk Analysis Yes No

High Priority Practices Guide (SAFER) Yes No

Electronic Prescribing (AudIt) 0 / 0 = 0.00%

Send Health Information (AudIt) 0 / 00 = 0.00%

Receive and Reconcile Health Information (AudIt) 0 / 0 = 0.00%

Provide Patients Electronic Access (AudIt) 0 / 0 = 0.00%

Immunization Registry Reporting Yes No Exclude

Electronic Case Registry Reporting Yes No Exclude

Syndromic Registry Reporting Yes No Exclude

Public Health Registry Reporting Yes No Exclude

Clinical Data Registry Reporting Yes No Exclude

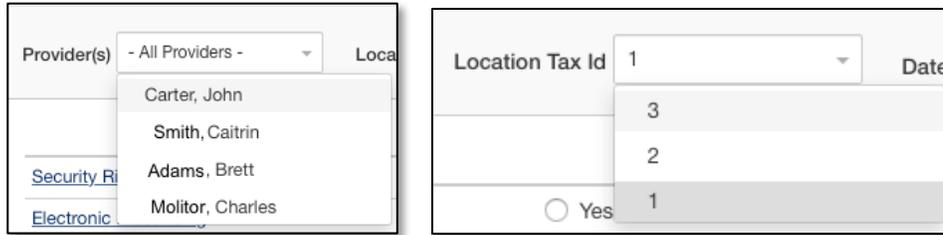
Note: Unless PI performance data is submitted, small practices (15 or fewer clinicians) are granted an automatic hardship for this category in 2022. The associated points are distributed to the Quality and Improvement Activities categories.

The decision about whether to report as an individual or, if in a practice of > 1 clinician, a group can be based on many factors including final scoring, Part B Medicare volume per provider, etc. It is beyond the scope of this guide to assist with that decision. However, the MIPS-PI (Stage 3) scorecard allows clinicians to analyze their practice at both individual and group levels to assist in the decision-making process.

Remember:

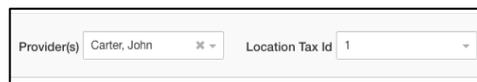
- Each Location Tax ID is viewed by MIPS as its own entity. In other words, each Location Tax ID needs to have eligibility considered and, when necessary, have data reported.
- Each Location Tax ID can be represented by data at the level of the individual provider(s) or at the level of the group. The MIPS-PI (Stage 3) scorecard makes this possible through the **Provider(s)** and **Location Tax Id** fields.
- The decision of individual vs. group reporting at a given Location Tax ID must remain consistent across all performance categories. Thus, if “Group” is selected for Promoting Interoperability, “Group” must be selected for Quality and Improvement Activities, as well.

Let’s look at a pair of examples. This hypothetical practice consists of 4 individually eligible providers across 3 locations. Each location has its own Tax ID as displayed in the Location Tax Id dropdown:



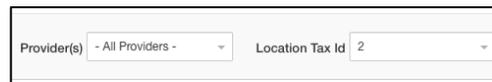
The image shows two screenshots of a web interface. The left screenshot shows a dropdown menu for 'Provider(s)' with the following options: Carter, John; Smith, Caitrin; Adams, Brett; and Molitor, Charles. The right screenshot shows a dropdown menu for 'Location Tax Id' with the following options: 1, 3, 2, and 1. Below the 'Location Tax Id' dropdown is a radio button labeled 'Yes'.

If the practice determined that it would be best to report for location 1 as **Individuals**, the scorecard would need to be run 4 times for that location: 1 time for each provider in the Provider(s) list associated to Location Tax Id “1”. Running the scorecard this way returns data at the individual level for care provided at location 1. Here’s an example for Dr. Carter:



The image shows a screenshot of the web interface with the 'Provider(s)' dropdown menu set to 'Carter, John' and the 'Location Tax Id' dropdown menu set to '1'.

If the practice then determined that it would be best to report for location 2 as a **Group**, the scorecard would only need to be run one time for that location. The Provider(s) selection would be set to “All Providers” and the Location Tax Id would be set to “2”:



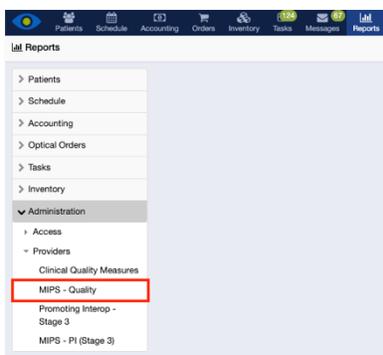
The image shows a screenshot of the web interface with the 'Provider(s)' dropdown menu set to '- All Providers -' and the 'Location Tax Id' dropdown menu set to '2'.

A video walkthrough of the MIPS-PI scorecard and discussion of scorecard configuration [is available here](#).

Quality

Note: The electronic Clinical Quality Measures (eCQMs) available via the MIPS- Quality scorecard are not the same as Part B claims quality measures you may document via the Quality Alert.

The MIPS-Quality scorecard can be found through Reports > Administration > Providers > MIPS – Quality:



The MIPS-Quality scorecard header looks like this:



The screenshot shows the header of the MIPS - Quality report. It includes a search bar with 'Search' and 'Clear' buttons. Below the search bar are several filters: 'Provider' set to 'All Providers', 'Location Tax ID' set to '123456789', and 'Type' with radio buttons for 'eCQM Primary' (selected) and 'eCQM Extended'. There is also a 'Date Range' field with 'mm/dd/...' placeholders and calendar icons.

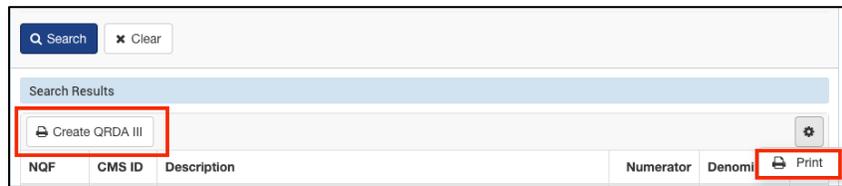
Field	Function
Provider	<p>Allows the user to choose the providers included in the statistical report. This is “All Providers” by default but can be changed to any individual provider in the practice through the dropdown menu.</p> <p>“All Providers” = reporting all performance data for a specific location tax Id. This is known as “Group” reporting. Selecting an individual provider = reporting for an individual provider at a specific location tax Id. This is known as “Individual” reporting.</p> <p><i>Note: If an individual provider has been selected, clicking the small “X” next to the name will return the Provider(s) selection to “All Providers”.</i></p>
Location Tax Id	<p>Allows the user to choose the specific business entity for the report. Since MIPS requires each Tax ID to be represented with data, a practice with more than one Tax ID will need to use the Location Tax Id field to generate separate reports for each Tax ID.</p>
Type	<p>Allows the user to choose measure set. For MIPS, this should not be changed from the default indication of “eCQM Primary”.</p>

Date Range	Allows the user to choose the Start and End dates for their Quality performance period.
Clear	Removes the entries in the start and end Date Range fields.
Search	Allows the user to run the report.

To run the MIPS-Quality scorecard:

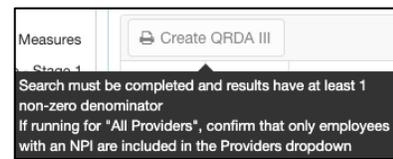
1. Select “Provider” of interest
 - a. Selecting “All Providers” = Group reporting
 - b. Selecting an individual provider = Individual reporting
2. Select “Location Tax Id” of interest
3. Enter Start and End dates for the performance period of interest. **This should be 1/1/2023 – 12/31/2023 for the 2023 performance period.**

Once Quality performance data has been returned on the scorecard, the user can select the “Create QRDA III” button on the upper left of the scorecard or “Print” via the gear icon on the upper right of the scorecard:

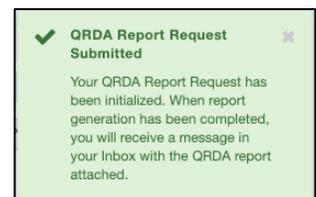


Clinicians or groups aiming to submit their data to CMS will need to select the “Create QRDA III” button. Please note that the creation of a QRDA file requires several conditions to be met (list available by hovering over a greyed-out “Create QRDA III” button):

- at least 1 non-zero measure denominator
- practice NPI cannot be blank
- provider NPI cannot be blank
- Location Tax Id must be selected

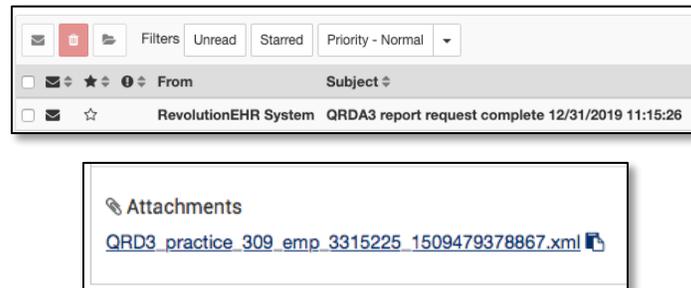


A common reason for the “Create QRDA III” button to be greyed out is that the practice has configured employees other than doctors to be “Providers”. These employee profiles will need to be temporarily adjusted by removing the “Employee is also a provider” designation. Once the file has been requested, the designation can be returned to its original state.



Once the scorecard has been run and “Create QRDA III” is active and selected, a message is displayed alerting the user to the initiation of the file creation process.

Files are processed in the order requests are received. As an example, if a request is made and is 10th in line, the other 9 files will need to be written before it is addressed. As such, the time it takes for file creation will vary based on when the request is made. You are free to continue working inside RevolutionEHR or leave the system after requesting a file. When completed, the requested QRDA3 file will be delivered as an attachment to the user's Messages module and can be downloaded to a workstation by selecting the link:



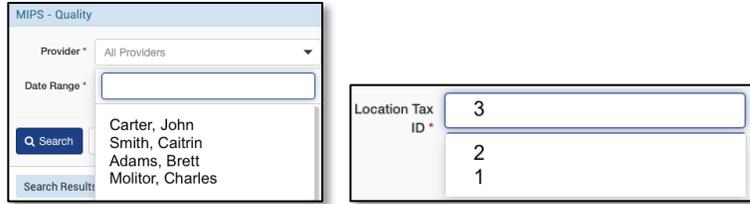
Once the necessary file(s) have been created and downloaded to a workstation, Quality data collection within RevolutionEHR is complete.

The decision about whether to report as an individual or, if in a practice of > 1 clinician, a group can be based on many factors including final scoring, Part B Medicare volume per provider, etc. It is beyond the scope of this guide to assist with that decision. However, the MIPS-Quality scorecard allows clinicians to analyze their practice at both individual and group levels to assist in the decision-making process.

Remember:

- Each Location Tax ID is viewed by MIPS as its own entity. In other words, each Location Tax ID needs to have eligibility considered and, when necessary, have data reported.
- Each Location Tax ID can be represented by data at the level of the individual provider(s) or at the level of the group. The MIPS-Quality scorecard makes this possible through the **Provider(s)** and **Location Tax Id** fields.
- The decision of Individual vs. Group reporting at a given Location Tax ID must remain consistent across all performance categories. Thus, if "Group" is selected for Quality, "Group" must be selected for Promoting Interoperability and Improvement Activities, as well.

Let's look at a pair of examples. This hypothetical practice consists of 4 individually eligible providers across 3 locations. Each location has its own Tax ID as displayed in the Location Tax Id dropdown:



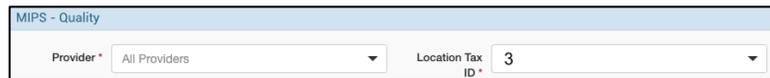
The screenshot shows two parts of the MIPS - Quality interface. On the left, a 'Provider *' dropdown menu is open, showing a search bar and a list of providers: Carter, John; Smith, Caitrin; Adams, Brett; and Molitor, Charles. On the right, a 'Location Tax ID *' dropdown menu is open, showing three options: 3, 2, and 1.

If the practice determined that it would be best to report for location 1 as **Individuals**, the scorecard would need to be run 4 times for that location: 1 time for each provider in the Provider(s) list associated to Location Tax Id “1”. Running the scorecard this way returns data at the individual level for care provided at location 1. Here’s an example for Dr. Carter:



The screenshot shows the MIPS - Quality interface with the 'Provider *' dropdown menu set to 'Carter, John' and the 'Location Tax ID *' dropdown menu set to '1'.

If the practice then determined that it would be best to report for location 3 as a **Group**, the scorecard would only need to be run one time for that location. The Provider(s) selection would be set to “All Providers” and the Location Tax Id would be set to “3”:



The screenshot shows the MIPS - Quality interface with the 'Provider *' dropdown menu set to 'All Providers' and the 'Location Tax ID *' dropdown menu set to '3'.

A video walkthrough and discussion of configuring the MIPS – Quality scorecard [is available here](#).

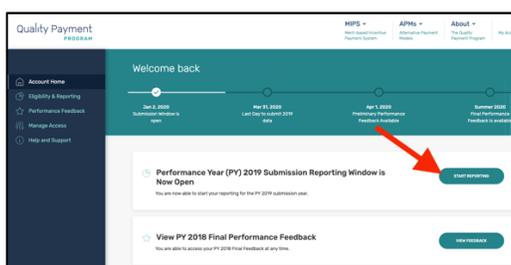
Working in the Quality Payment Program Portal

Getting in Position to Report Data

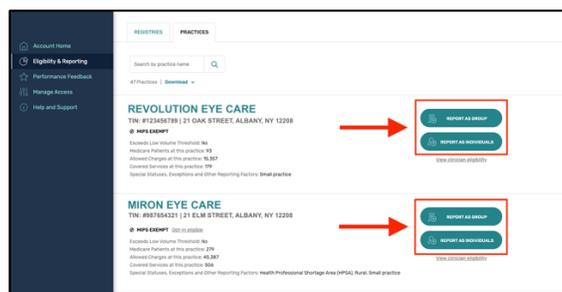
As noted in the introduction to this guide, all MIPS performance data (outside of Quality data submitted on a per-claim basis) can be submitted through the Quality Payment Program web portal at qpp.cms.gov. Access to the Quality Payment Program portal requires a username and password. [These references can guide through the registration process](#), if needed. (Note: references will download to your computer as a zip file)

Once a user with the proper authority is logged into the Quality Payment Program portal, the following workflow can be followed:

1. On the *Account Home* page, select “Start Reporting”:



2. The user will be able to see each practice they are associated to within the QPP system. For each practice, the user has the ability to select to:
 - a. “Report As Group”, or
 - b. “Report As Individuals”



Remember that the selection made here for each practice must remain consistent for each performance category of MIPS (PI, Quality, Improvement Activities). In other words, you cannot report as a group for PI and as an individual for Quality and

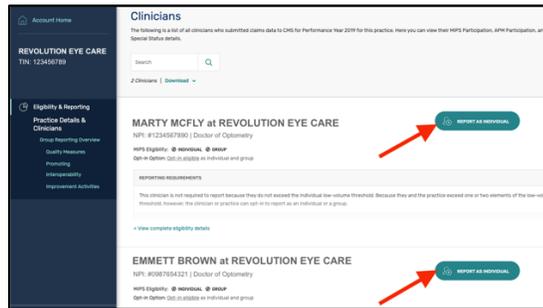
Improvement Activities. You can, however, choose to report as “Individuals” in one practice and as a “Group” at another if that is your preference.

3. If you intend to report for the doctors in the practice as individuals, select “Report as Individuals” and follow steps 4-10

If you intend to pool data for all doctors in the practice together and report it as a group, select “Report as Group” and follow steps 11-13

Individual Reporter: Declaring Opt-in vs Voluntary Reporting

4. After selecting “Report as Individuals” the user will arrive at a *Clinicians* page highlighting the eligibility status for each clinician in the practice as well as a “Report as Individual” button. Select the “Report as Individual” button for the first clinician the user intends to submit data for:

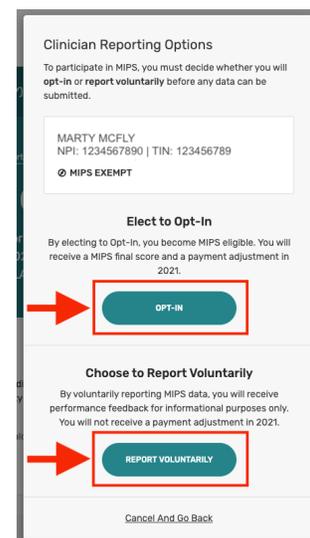


5. If the selected clinician is required to submit data, the system will take the user to the *Reporting Overview* page. Head to the discussion of performance category reporting beginning on page 18.

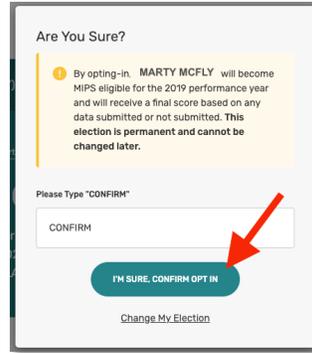
6. If the selected clinician is not required to submit data, a modal will appear and prompt the user to formally declare their intent to opt-in or voluntarily report data. Remember:

- a. “**Opt-In**”: the user is electing for the clinician to receive a MIPS final score and payment adjustment
- b. “**Report Voluntarily**”: the user is electing for the clinician to receive performance feedback but DOES NOT want to be considered for payment adjustment

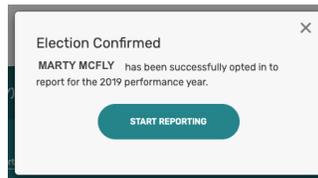
Choose the desired option.



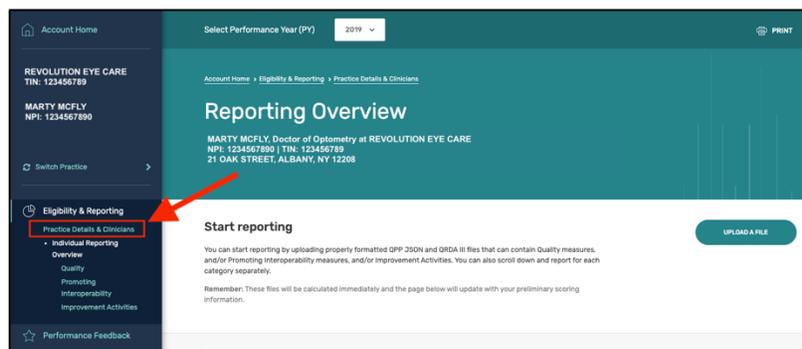
- The user will then be prompted to confirm their selection by typing the word “Confirm” in the text box. Please note that the user can still cancel their decision at this point through the “Change My Election” link. Once “Confirm” is entered, the decision is irrevocable for the 2023 performance year.



- The election is then confirmed, and the user is presented with a “Start Reporting” button. Selection of the “Start Reporting” button takes the user to the *Reporting Overview* page discussed on page 18.



- At this point, the user can either start to submit data for the clinician (as discussed starting on page 18) or return to the *Clinicians* page and follow the steps above for each clinician for whom they intend to submit data. For the purposes of this guide, we’ll make the formal declarations for each clinician we intend to submit data for prior to submitting any data. Select the “Practice Details & Clinicians” link in the menu to the left of the page:



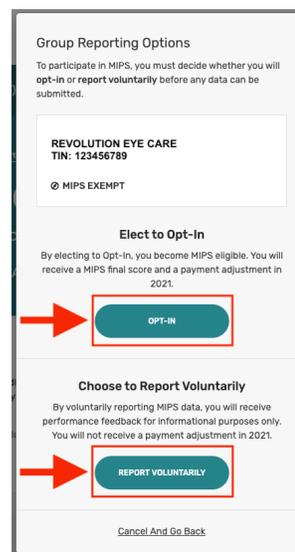
- Repeat steps 4-9 for each clinician in the practice for whom data is to be submitted. Then proceed to page 18 to begin data entry.

Group Reporter: Declaring Opt-in vs Voluntary Reporting

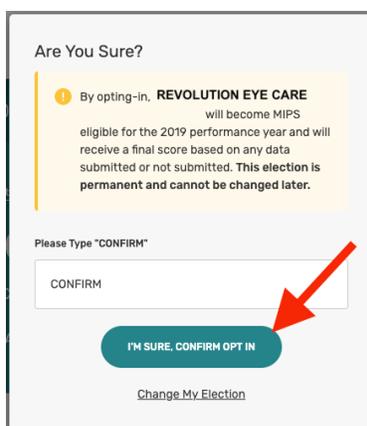
- After selecting “Report as Group” the user will either be taken directly to the *Reporting Overview* page (head to discussion of performance category reporting beginning on page 18) or a “Group Reporting Options” modal. The modal will prompt the user to formally declare their intent to opt-in or voluntarily report data. Remember:

- “**Opt-In**”: the user is electing for all eligible doctors in the practice to receive a MIPS final score and payment adjustment
- “**Report Voluntarily**”: the user is electing for all doctors in the practice to receive performance feedback but DOES NOT want to them be considered for payment adjustment

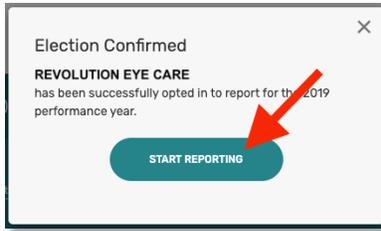
Choose the desired option.



- The user will then be prompted to confirm their selection by typing the word “Confirm” in the text box and selecting the button. Please note that the user can still cancel their decision at this point through the “Change My Election” link. Once “Confirm” is entered, the decision is irrevocable for the 2023 performance year.



- The election is then confirmed, and the user is presented with a “Start Reporting” button. Selection of the “Start Reporting” button takes the user to the *Reporting Overview* page discussed on page 18.



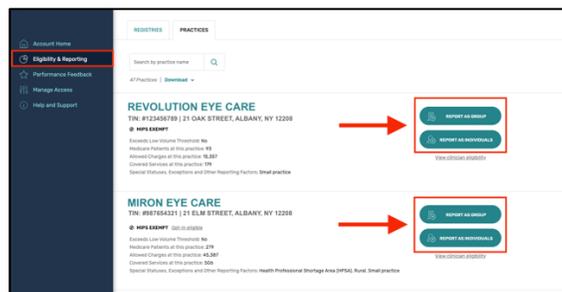
Summary

The above steps allow the user to position the doctors within a practice (if individual reporting) or the practice itself (if group reporting) to report data to the Quality Payment Program. The same considerations and process should be applied to any additional practices on their *Eligibility & Reporting* screen for which the user intends to report data.

Let's move on to reporting data for each of the MIPS performance categories.

Performance Category Reporting

MIPS performance data entry begins by either progressing to that step after making the opt-in vs. voluntary reporting declaration covered earlier or by heading to the *Eligibility & Reporting* page via menu in the left margin. On that page, the user will again see the practices for which they have access and the ability to “Report As Group” or “Report As Individuals” for each one:

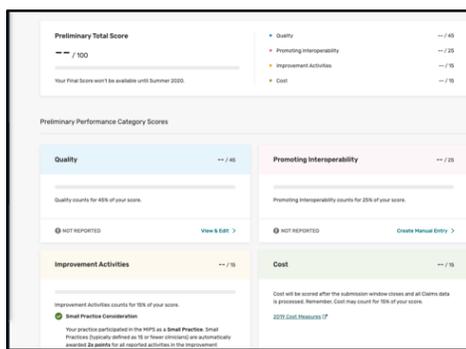


Regardless of decision, the data entry process with the portal is the very similar for reporting as an individual vs. group. The key difference is really in how the statistics are collected within RevolutionEHR and that process was covered earlier in this guide.

Once the selection of “Report As Group” or “Report As Individuals” has been made, the user will arrive at the *Reporting Overview* screen:

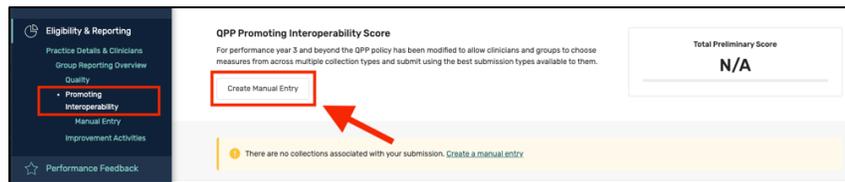
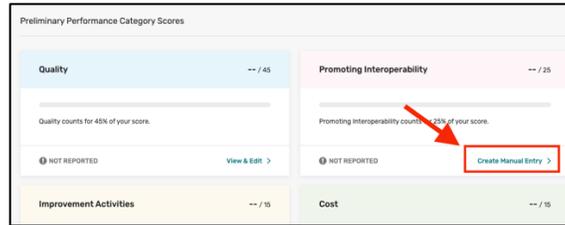


Scrolling down on the *Reporting Overview* screen allows the user to see a preliminary final score, each of the four performance categories, and if data has been submitted:

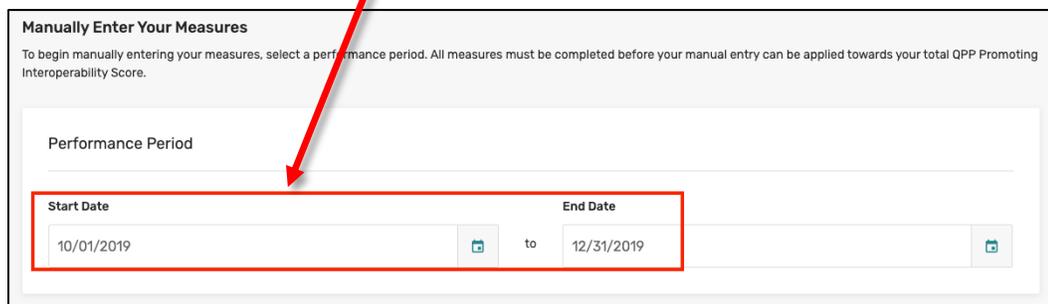
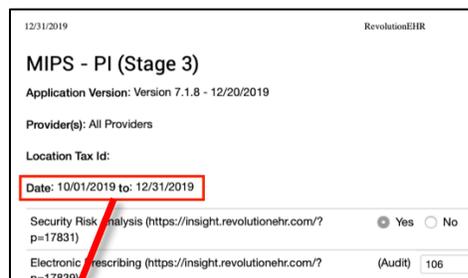


Promoting Interoperability Data Reporting

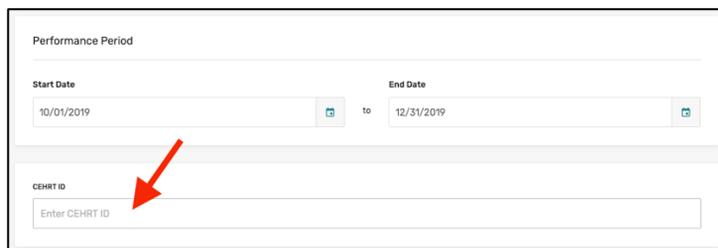
14. To begin submission of Promoting Interoperability performance data, select “Create Manual Entry” on the *Reporting Overview* and/or *Promoting Interoperability* page:



15. The user will now be on the *Manual Entry* screen. Scroll down and enter the performance period that matches the date range on the MIPS – PI (Stage 3) scorecard in RevolutionEHR from which statistics will be transcribed. Remember that this date range must be at least 90 days long.



16. Enter the certified EHR technology ID that represents the combination of systems used during the performance period. These IDs are created on the [ONC's Certified Health IT Product List \(CHPL\)](#).



Performance Period

Start Date: 10/01/2019 to End Date: 12/31/2019

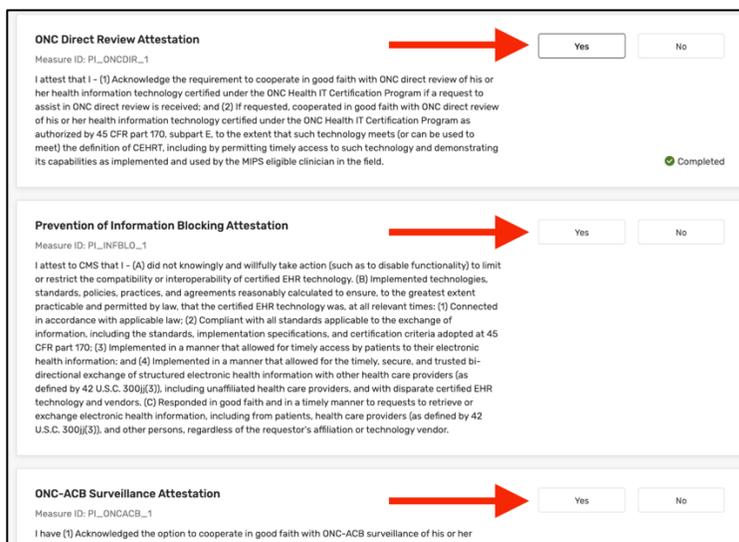
CEHRT ID: Enter CEHRT ID

For most, this number is either:

- RevolutionEHR version 7 (if not e-prescribing): **0015CGV92009S35**
- RevolutionEHR version 7 + RxNT EHR version 7.2 (if e-prescribing with RxNT): **0015C7Q9S6WHA10**

If you e-prescribed during your 2023 performance period and used a system other than RxNT, please email qualityreporting@revolutionehr.com for assistance with your ID.

17. The system will then present the user with three attestation statements to be answered as appropriate. “Yes” indications are required for the first two statements, while a “Yes” to the third is optional. Selecting the “Yes” or “No” box will save that indication while selecting a second time will remove the indication.

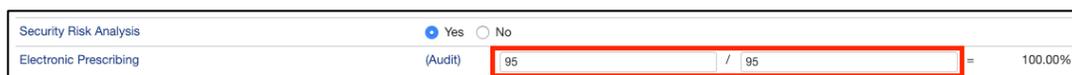


ONC Direct Review Attestation
Measure ID: PL_ONCDIR_1
I attest that I - (1) Acknowledge the requirement to cooperate in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and (2) if requested, cooperated in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the MIPS eligible clinician in the field. Completed

Prevention of Information Blocking Attestation
Measure ID: PL_INFBLD_1
I attest to CMS that I - (A) did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology; (B) implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times; (1) Connected in accordance with applicable law; (2) Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170; (3) Implemented in a manner that allowed for timely access by patients to their electronic health information; and (4) Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300j(3)), including unaffiliated health care providers, and with disparate certified EHR technology and vendors; (C) Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300j(3)), and other persons, regardless of the requestor's affiliation or technology vendor.

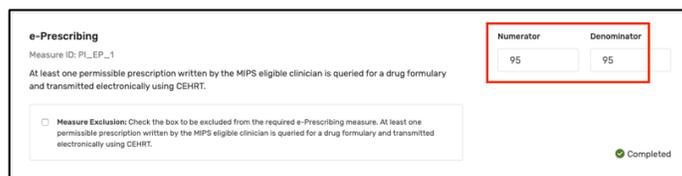
ONC-ACB Surveillance Attestation
Measure ID: PL_ONCACB_1
I have (1) Acknowledged the option to cooperate in good faith with ONC-ACB surveillance of his or her

18. Proceed to the list of measures below the attestation statements and transcribe information for each measure from the MIPS – PI (Stage 3) scorecard in RevolutionEHR. As an example, the clinician below had a MIPS – PI (stage 3) scorecard which showed 95/95 for electronic prescribing:



Security Risk Analysis Yes No
 Electronic Prescribing (Audit) 95 / 95 = 100.00%

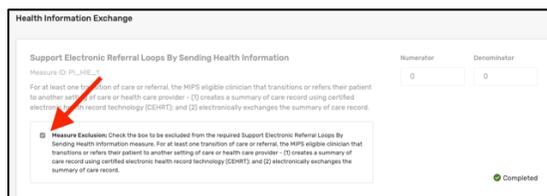
That information would then be entered into the QPP system for that measure:



e-Prescribing
 Measure ID: PL_EP_1
 At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.
 Measure Exclusion: Check the box to be excluded from the required e-Prescribing measure. At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.
 Numerator: 95 Denominator: 95
 Completed

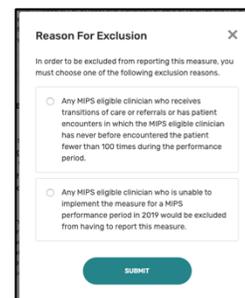
19. Follow the same process for each of the measures listed in the Quality Payment Program system, transcribing data from your RevolutionEHR scorecard. Notes of interest:

- a. E-Prescribing offers two opportunities for bonus points in the event actions were taken related to the clinician’s or group’s prescribing of schedule II opioid medications. If these haven’t been prescribed, the bonus measures are not options for the clinician or group.
- b. e-Prescribing, Support Electronic Referral Loops by Sending Health Information, and Support Electronic Referral Loops by Receiving and Incorporating Health Information offer opportunities for exclusion if the denominator is less than 100. These can be claimed by checking the “Proposed Measure Exclusion” checkbox:



Health Information Exchange
 Support Electronic Referral Loops by Sending Health Information
 Measure ID: PL_HE_1
 For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider: (1) creates a summary of care record using certified electronic health record technology (CEHRT); and (2) electronically exchanges the summary of care record.
 Measure Exclusion: Check the box to be excluded from the required Support Electronic Referral Loops by Sending Health Information measure. For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider: (1) creates a summary of care record using certified electronic health record technology (CEHRT); and (2) electronically exchanges the summary of care record.
 Numerator: 0 Denominator: 0
 Completed

- c. In the event the “Measure Exclusion” box is checked for Support Electronic Referral Loops by Receiving and Incorporating Health Information, a modal will appear asking the user to specify the reason. Choose the one that applies and select “Submit”:



Reason For Exclusion X
 In order to be excluded from reporting this measure, you must choose one of the following exclusion reasons.
 Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.
 Any MIPS eligible clinician who is unable to implement the measure for a MIPS performance period in 2019 would be excluded from having to report this measure.
 SUBMIT

- d. There are five measures associated to Public Health and Clinical Data Exchange and each offers the ability to say “Yes”, “No”, or claim the measure exclusion. Note that an answer of “No” to any of these will result in a score of 0 in the Promoting Interoperability category:



Clinical Data Registry Reporting

Measure ID: PI_PHCDRR_5

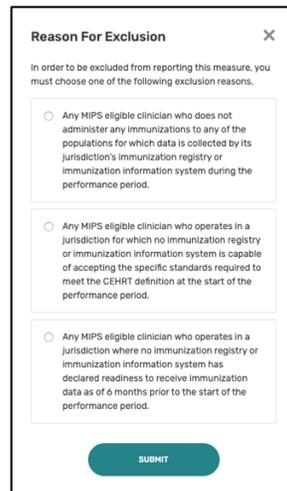
The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.

Measure Exclusion: Check the box to be excluded from the required Clinical Data Registry Reporting measure. The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.

Yes No

Report measure again

The selection of “Measure Exclusion” for any of the registry measures will ask the user to indicate which of three exclusion criteria applied to their decision:



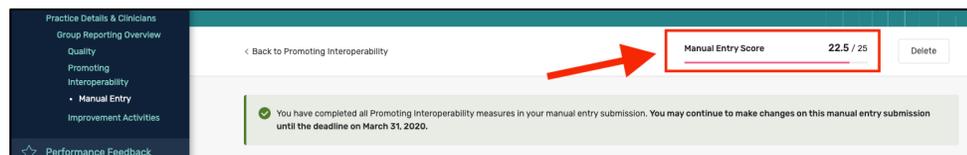
Reason For Exclusion

In order to be excluded from reporting this measure, you must choose one of the following exclusion reasons.

- Any MIPS eligible clinician who does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period.
- Any MIPS eligible clinician who operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the performance period.
- Any MIPS eligible clinician who operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the performance period.

SUBMIT

- e. Once data for all measures has been entered, a “Manual Entry Score” can be found near the top of the screen:



Practice Details & Clinicians
Group Reporting Overview
Quality
Promoting Interoperability
Manual Entry
Improvement Activities
Performance Feedback

< Back to Promoting Interoperability

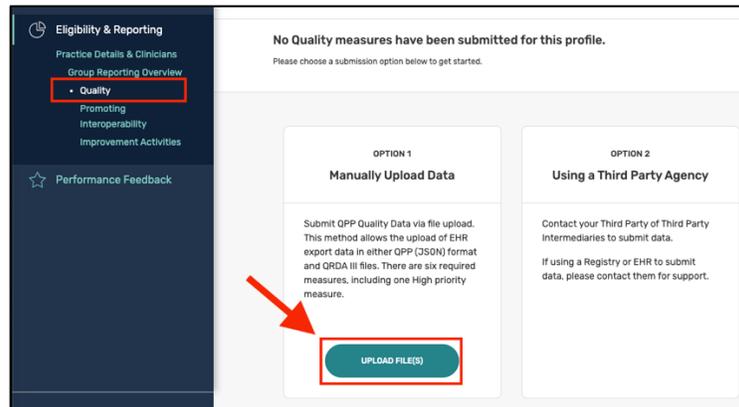
Manual Entry Score 22.5 / 25 Delete

✓ You have completed all Promoting Interoperability measures in your manual entry submission. You may continue to make changes on this manual entry submission until the deadline on March 31, 2020.

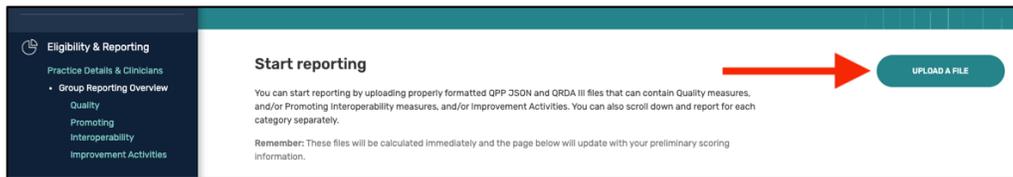
- f. There is no “Save” or “Submit” button once data entry is complete. Instead, data is saved as it is entered. Actual submission of the data occurs when the portal officially closes at the end of the reporting window. Until then, a user can log back in an edit data at any time.

Quality Data Reporting

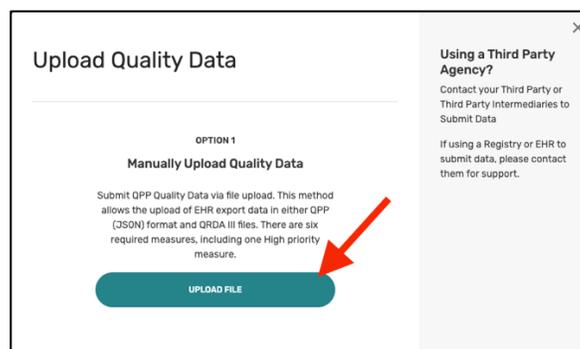
20. To begin submission of Quality performance data, either select the “Quality” link from the left margin and then “Upload File(s)” on the page that loads to the right:



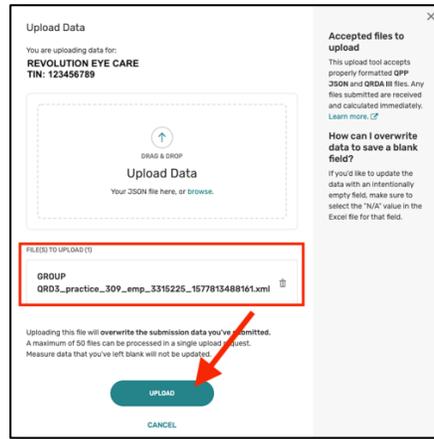
- Or select “Upload A File” on the *Reporting Overview* page:



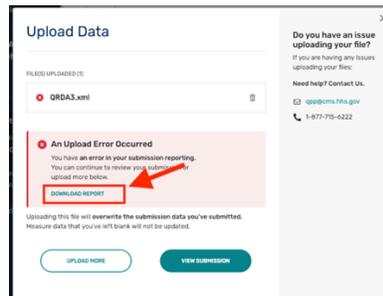
21. Select the “Upload File” button in the resulting window:



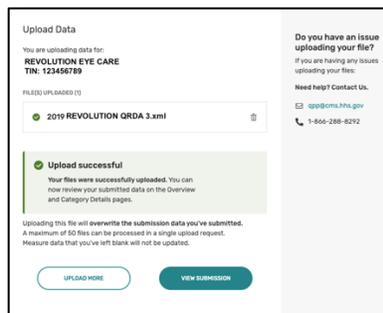
22. The next modal allows the user to “drag and drop” or browse and attach the RevolutionEHR QRDA3 file created on pages 9-12 of this guide. Once attached (your file name will be different), select “Upload”:



23. File validation occurs immediately with an invalid file failing upload. Please contact RevolutionEHR through the “Ask about MIPS” link within the Help menu if this occurs and relay the findings of the “Download Report” link:



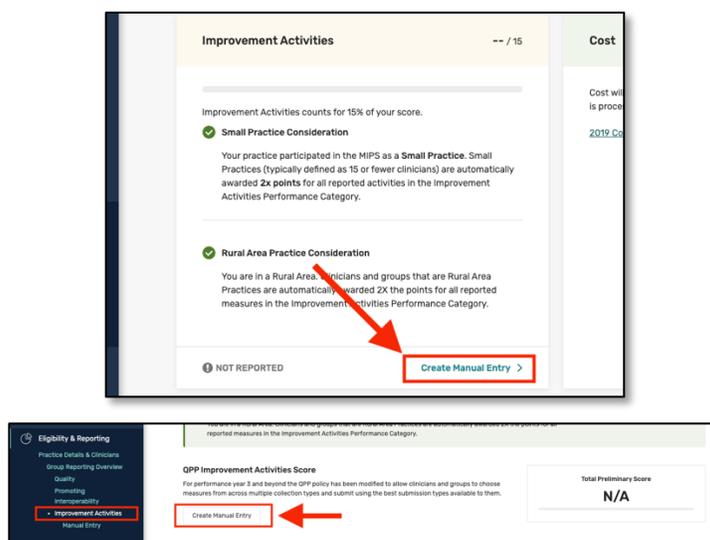
24. Successful file upload will allow an immediate review of performance scoring by selecting “View Submission”



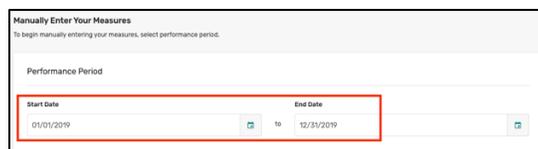
25. There is no “Save” or “Submit” button once Quality performance category data has been uploaded. Instead, data is saved as it is entered. Actual submission of data occurs when the reporting period closes. Until then, a user can upload files as often as necessary.

Improvement Activities Data Reporting

26. To begin submission of Improvement Activities performance data, select “Create Manual Entry” on the *Reporting Overview* and/or *Improvement Activities* page:

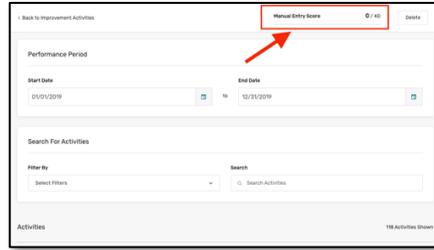


27. Enter a start and end date for the performance period. Note that since this category does not require use of an EHR, the user will not find a scorecard within RevolutionEHR from which to transcribe data. Also note that the while the performance period entered for this category must be at least 90 days it **does not** need to match the period(s) selected for Promoting Interoperability:

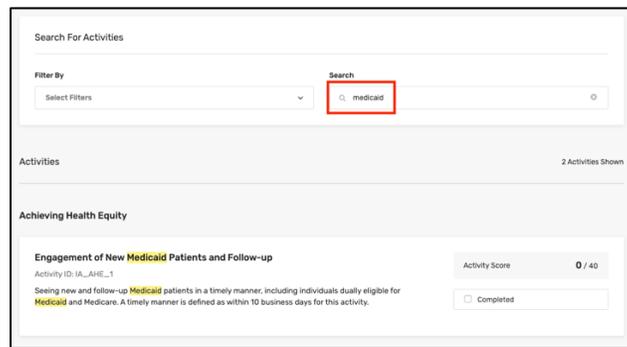


The screenshot shows the 'Manually Enter Your Measures' form. The 'Performance Period' section has 'Start Date' and 'End Date' fields highlighted in red. The 'Start Date' is 01/01/2019 and the 'End Date' is 12/31/2019.

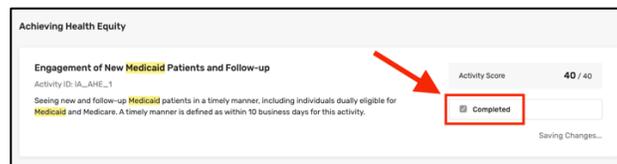
28. Once a performance period has been specified, all improvement activities will become available for attestation. Note that the top of the screen provides a running total of score in the category:



29. There are two options to find your chosen activities:
- Scroll through the entire list until the activity of interest is located
 - Use the “Search” field to filter the list to just those activities containing your search term. In the example below, the user entered “Medicaid” as a search term knowing that their activity related to Medicaid patients:



30. To attest to successful participation in an improvement activity, select the “Completed” checkbox next to that activity:



31. Small practice status is considered automatically by the system and accurately displays associated scoring (i.e. point values doubled).
32. There is no “Save” or “Submit” button once Improvement Activity attestation is complete. Instead, data is saved as it is entered. Actual submission of data occurs when the reporting period closes. Until then, a user can edit data at any time.

Conclusion

Once data has been entered for each performance category the clinician or practice participated in and each practice has been represented, work within the Quality Payment Program portal is complete. As noted earlier, data is saved upon entry and can be edited anytime up to the closing of the submission window on March 31, 2023. Upon closure of the submission window the data within the portal is considered the final submission.

Please contact the RevolutionEHR Quality Reporting team if you have any questions about the processes discussed in this guide: qualityreporting@revolutionehr.com