STI Presents

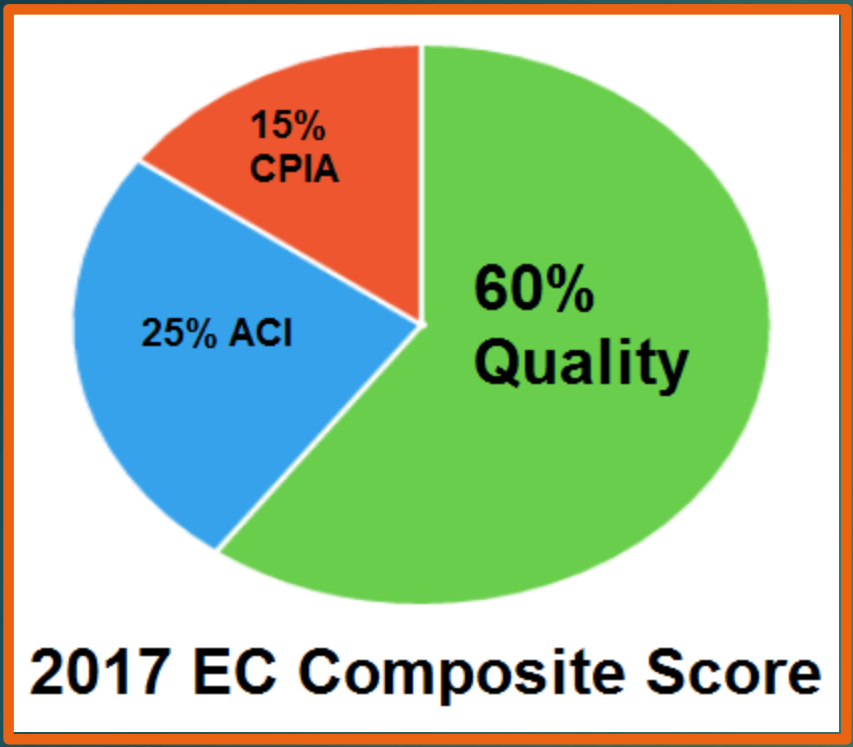
MIPS: SETTING UP QUALITY MEASURES

THIS PRESENTATION WILL BEGIN AT IT'S SCHEDULED TIME: 9AM

Today we will cover:

- 2017 Quality Category Requirements
- Selecting Quality Measures
- Setting up Quality Measures
  - Claims/Registry
  - eCQMs
- Quality Performance Scoring

2017 Quality Category Requirements



Select 6 Quality Measures

- 1 MUST be:
  - Outcome/Intermediate Outcome Measure OR
  - High Priority Measure:
    - Appropriate Use
    - Patient Experience
    - Patient Safety
    - Efficiency
    - Care Coordination
- Report for a minimum of 90 days

Groups (25 or more ECs) using CMS web interface: Report 15 quality measures for a full year. (Must register as a group by June 30, 2017)

Test Pace (1 of 3 reporting options): Report 1 quality measure to avoid 2019 negative payments.

Report as Individual or as a Group



Individual
EC will be identified using the combination of billing TIN/NPI.



Group
Two or more EC identified by their NPI who have reassigned their billing rights to a single TIN.

MIPS eligible clinicians and groups must use the same identifier for all performance categories

Choose ONE Data Submission Mechanism



Individual
- QCDR
- Qualified Registry
- EHR
- Claims



Group
- QCDR
- Qualified Registry
- EHR
- Administrative Claims
- CMS Web Interface
- CAHPS for MIPS Survey

MIPS Eligible Clinicians may only use ONE submission mechanism per category

Keep in Mind those **BONUS** Points!

EC will receive bonus points when reporting on additional:

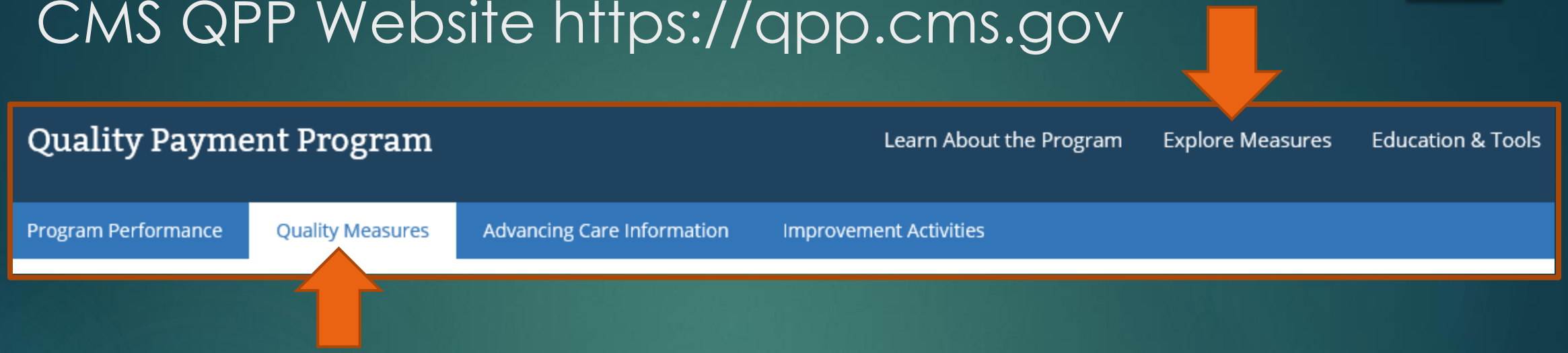
Outcome Measures = 2 points/measure

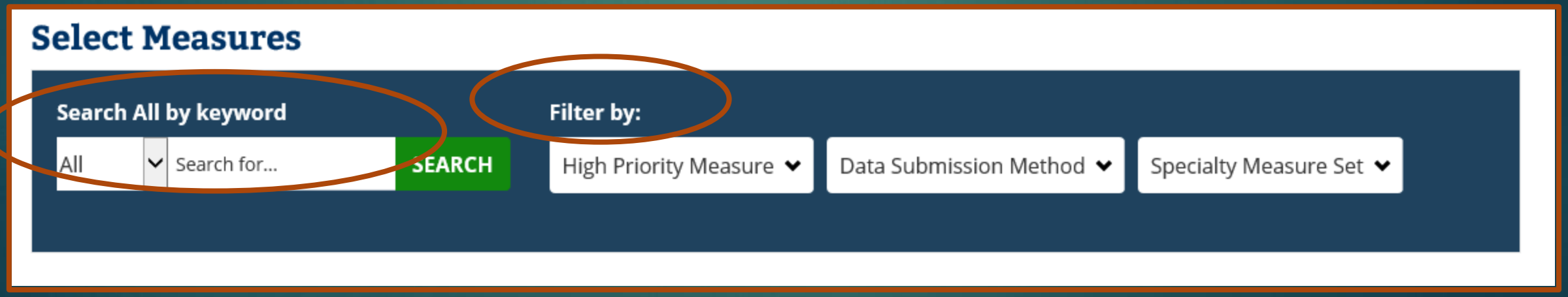
High Priority Measures = 1 point/measure

EC will receive bonus points when electing to submit thru:

EHR Reporting = 1 point/measure

Selecting Measures
CMS QPP Website https://qpp.cms.gov





MIPS Specialty Measure Sets

Allergy/Immunology/Rheumatology
Anesthesiology
Cardiology
    Electrophysiology Cardiac Specialist
Gastroenterology
Dermatology
Emergency Medicine
General Practice/Family Medicine
Internal Medicine
Obstetrics/Gynecology
Ophthalmology
Orthopedic Surgery
Otolaryngology
Pathology
Pediatric
Physical Medicine
Plastic Surgery
Preventative Medicine
Neurology
Mental Health
Radiology
    Diagnostic Radiology
    Interventional
Radiology
    Radiation Oncology
Surgery
    Vascular Surgery
    General Surgery
    Thoracic Surgery
Urology

Disclaimer
*MIPS eligible clinicians or groups are expected to report on applicable measures. "Applicable" is defined as measures relevant to a particular MIPS eligible clinician's services or care rendered. MIPS eligible clinicians can refer to the measures specifications to verify which measures are applicable. Not all measures in each Specialty Measure Set will be applicable to all clinicians in a given specialty. If the set includes less than six applicable measures, the eligible clinician should only report the measures that are applicable.

Outcome/Intermediate Outcome Measures

Quality ID #/Measure Name

1	Diabetes: Hemoglobin A1c Poor Control
122	Adult Kidney Disease: BP Mgmt.
141	POAG: Reduction of IOP by 15% or Document of Care Plan
164	CABG: Prolonged Intubation
165	CABG: Deep Sternal Wound Infection Rate
166	CABG: Stroke
167	CABG: Postoperative Renal Failure
168	CABG: Surgical Re-Exploration
191	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
217	Functional Status Change for Patients with Knee Impairments
218	Functional Status Change for Patients with Hip Impairments
219	Functional Status Change for Patients with Foot and Ankle Impairments
220	Functional Status Change for Patients with Lumbar Impairments
221	Functional Status Change for Patients with Shoulder Impairments
222	Functional Status Change for Patients with Elbow, Wrist and Hand Impairments
223	Functional Status Change for Patients with General Orthopedic Impairments
236	Controlling High Blood Pressure
258	Rate of Open Repair of Small or Moderate Non-Ruptured Intrarenal AAA without Major Complications
259	Rate of EVAR of Small or Moderate Non-Ruptured Infrarenal AAA without Major Complications
260	Rate of CEA for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Op Day #2)
303	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
304	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery
328	Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL
329	Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis
330	Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days

Outcome/Intermediate Outcome Measures

Quality ID#/Measure Name

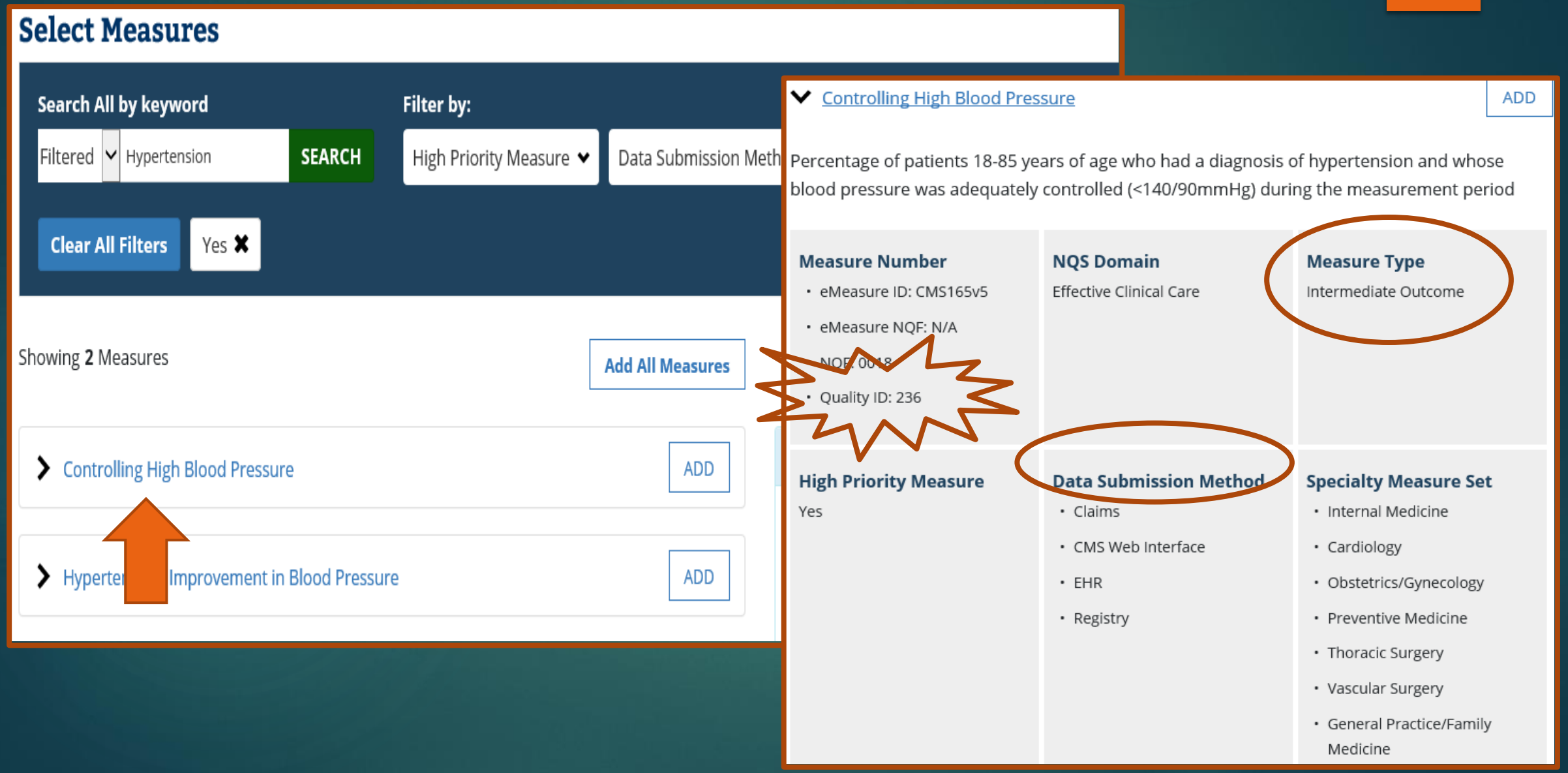
335 Maternity Care: Elective Delivery or Early Induction without Medical Indication at > or = 37 and < 39 Weeks (Overuse)
338 HIV Viral Load Suppression
342 Pain Brought Under Control within 48 Hours
343 Screening Colonoscopy Adenoma Detection Rate Measure
344 Rate of CAS for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Op Day #2)
345 Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing CAS
346 Rate of Post-Op Stroke or Death in Asymptomatic patients Undergoing Carotid CEA
347 Rate of EVAR of Small or Moderate Non-Ruptured Intrarenal AAA Who Die While in Hospital
348 HRS-3: ICD complications Rate
354 Anastomotic Leak Intervention
355 Unplanned Reoperation within the 30 Day Post-Op Period
356 Unplanned Hospital Readmission within 30 Days of Principal Procedure
357 Surgical Site Infection
370 Depression Remission at Twelve Months
373 Hypertension: Improvement in Blood Pressure
378 Children Who Have Dental Decay or Cavities
383 Adherence to Antipsychotic Medications for Individuals with Schizophrenia
384 Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room within 90 Days of Surgery
385 Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement within 90 Days of Surgery
388 Cataract Surgery with Intra-operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy
389 Cataract Surgery: Difference Between Planned and Final Refraction
392 HRS - 12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation
393 HRS-9: Infection within 180 Days of CIED Implantation, Replacement, or Revision
395 Lung Cancer Reporting (Biopsy/Cytology Specimens)
396 Lung Cancer Reporting (Resection Specimen)
397 Melanoma Reporting

Outcome/Intermediate Outcome Measures

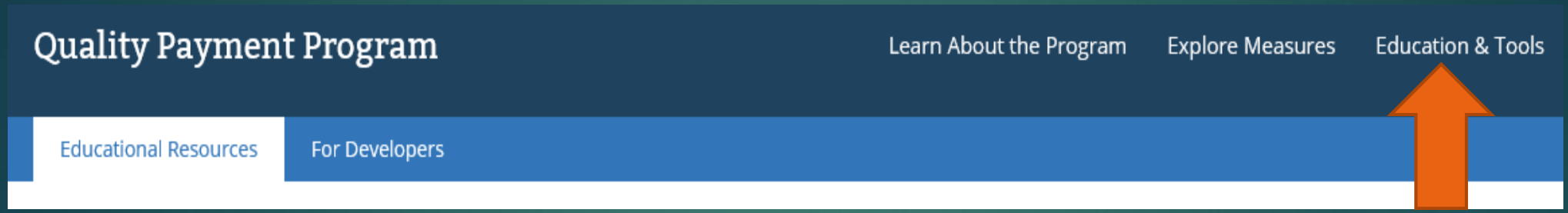
Quality ID#/Measure Name

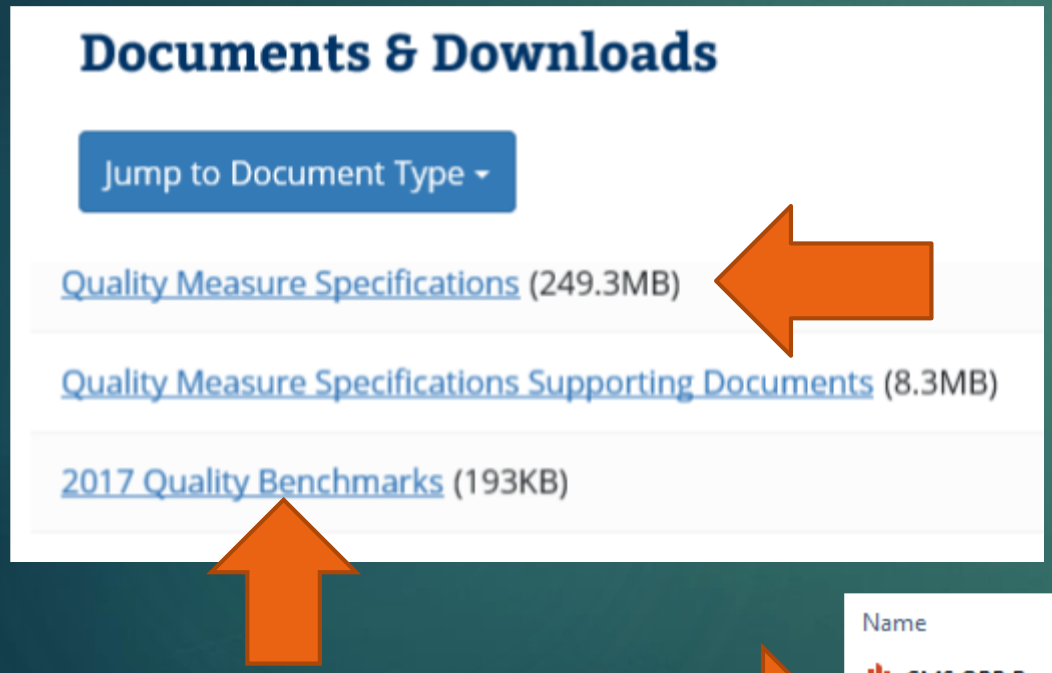
398 Optimal Asthma Control
404 Anesthesiology Smoking Abstinence
409 Clinical Outcome Post Endovascular Stroke
410 Psoriasis: Clinical Response to oral Systemic or Biologic Medications
411 Depression Remission at Six Months
413 Door to Puncture Time for Endovascular Stroke Treatment
417 Rate of Open Repair of Small or Moderate AAA Where Patients are Discharged Alive
420 Varicose Vein Treatment with Saphenous Ablation: Outcome Survey
424 Perioperative Temperature Management
432 Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair
433 Proportion of Patients Sustaining a Bowel Injury at the Time of any Pelvic Organ Prolapse Repair
434 Proportion of Patients Sustaining a Ureter Injury at the Time of any Pelvic Organ Prolapse Repair
435 Quality of Life Assessment for Patients with Primary Headache Disorder
437 Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure
441 Ischemic Vascular Disease All or None Outcome Measure (Optimal Control)
445 Risk-Adjusted Operative Mortality for CABG
446 Operative Mortality Stratified by the Five STS-EACTS Mortality Categories
454 Proportion of Patients who Died from Cancer with more than One Emergency Department Visit in the Last 30 Days of Life
455 Proportion Admitted to the Intensive Care Unit in the Last 30 Days of Life
457 Proportion Admitted to Hospice for less than

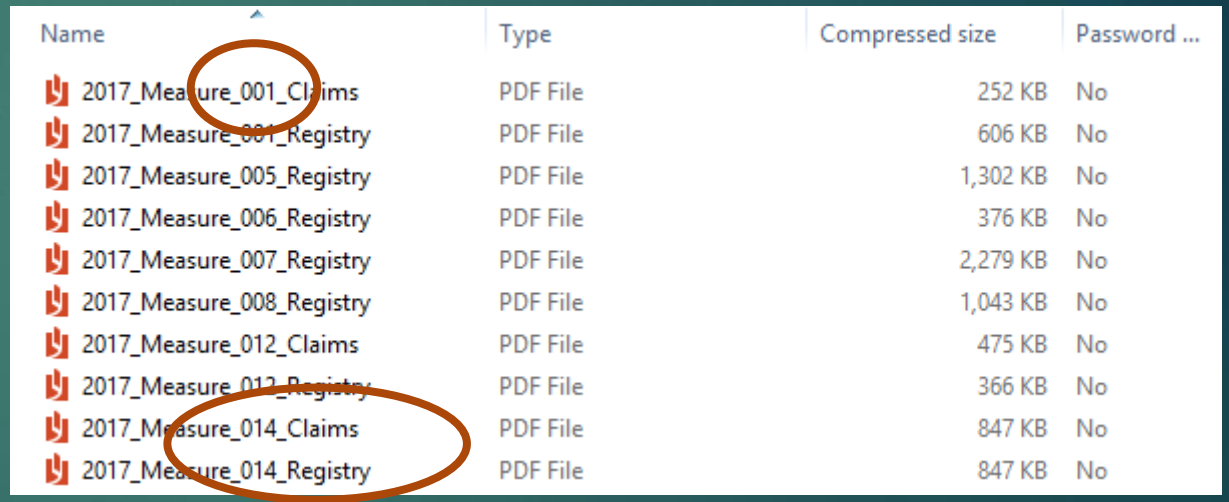
Selecting Measures
Example: Keyword – Hypertension; Filter by High Priority

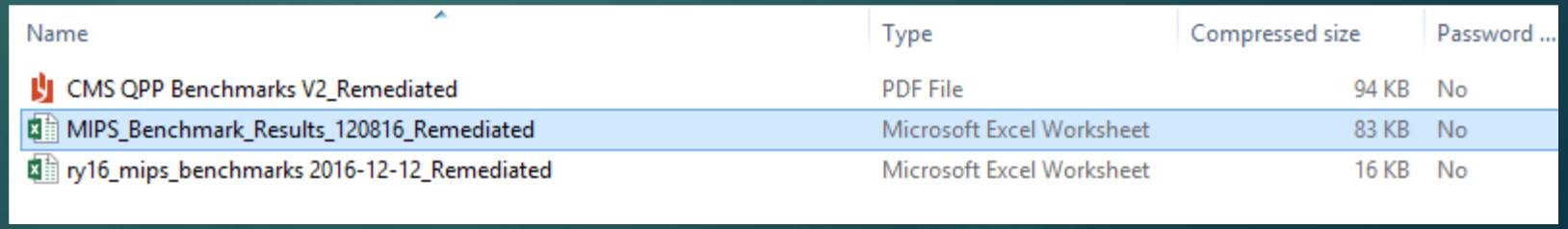


Selecting Measures
Additional Documents: Specification Fact Sheet & MIPS Benchmarks









Measure Specification Fact Sheet
Example: Quality ID# 236 - Controlling High Blood Pressure

Measure #236 (NQF 0018): Controlling High Blood Pressure – National Quality Strategy Domain: Effective Clinical Care

2017 OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS ONLY

MEASURE TYPE:
Intermediate Outcome

DESCRIPTION:
Percentage of patients 18 - 85 years of age who had a
adequately controlled (< 140/90 mmHg) during the me

INSTRUCTIONS:
This measure is to be reported a minimum of **once pe**
the performance period. The performance period for th
will be used for performance calculation. This measure
actions described in the measure based on the service

NOTE: *In reference to the numerator element, only bl*
office are acceptable for numerator compliance with th
following criteria:

- *Blood pressure readings from the patient's home (including readings directly fro*
- *Taken during an outpatient visit which was for the sole purpose of having a diag*
  procedure performed (e.g., sigmoidoscopy, removal of a mole).
- *Obtained the same day as a major diagnostic or surgical procedure (e.g., stress*
  contrast for a radiology procedure, endoscopy).

If no blood pressure is recorded during the measurement period, the patient's blood pres
controlled".

Measure Reporting:
The listed denominator criteria
included in this specification ar
should be reported on the clain

DENOMINATOR:
Patients 18-85 years of age wh
measurement period or any tim

Denominator Criteri
Patients18 to 85 years
AND
Diagnosis for hypert
AND
Patient encounter du
99212, 99213, 99214,
G0438, G0439

Numerator Quality-Data Coding Options:

Patient receiving Hospice Services, Patient Not Eligible:
***Denominator Exclusion:* G9740:** Hospice services given to patient any time during the measurement period

OR

Patient not Eligible for Recommended Blood Pressure Parameters for Documented Reasons
***Denominator Exclusion:* G9231:** Documentation of end stage renal disease (ESRD), dialysis, renal transplant before or during the measurement period or pregnancy during the measurement period

OR

Most Recent Blood Pressure Measurement Performed
Systolic pressure ***(Select one (1) code from this section):***
***Performance Met:* G8752:** Most recent systolic blood pressure < 140 mmHg

OR

***Performance Not Met:* G8753:** Most recent systolic blood pressure ≥ 140 mmHg

AND

Diastolic pressure ***(Select one (1) code from this section):***
***Performance Met:* G8754:** Most recent diastolic blood pressure < 90 mmHg

OR

***Performance Not Met:* G8755:** Most recent diastolic blood pressure ≥ 90 mmHg

OR

Blood Pressure Measurement not Documented, Reason not Given
***Performance Not Met:* G8756:** No documentation of blood pressure measurement, reason not given

STEPS IN SELECTING MEASURES

1. Select a tentative list of quality measures.
   Remember: 1 required Outcome or High Priority Measure.
   Additional outcome and high priority measures will yield bonus points.

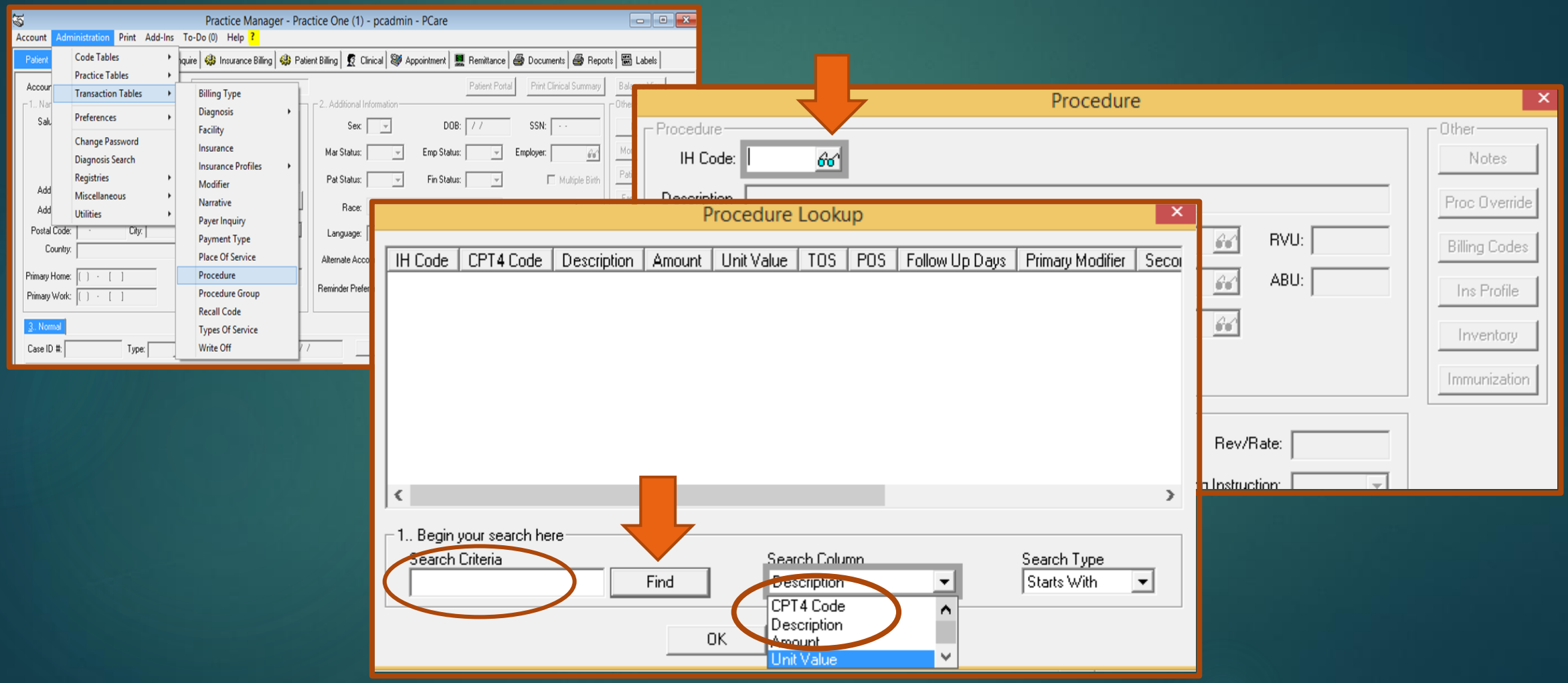
2. Review Measure Specification Fact Sheet to confirm the measure if applicable to your specialty.

3. Make sure there is a benchmark for each measure you selected

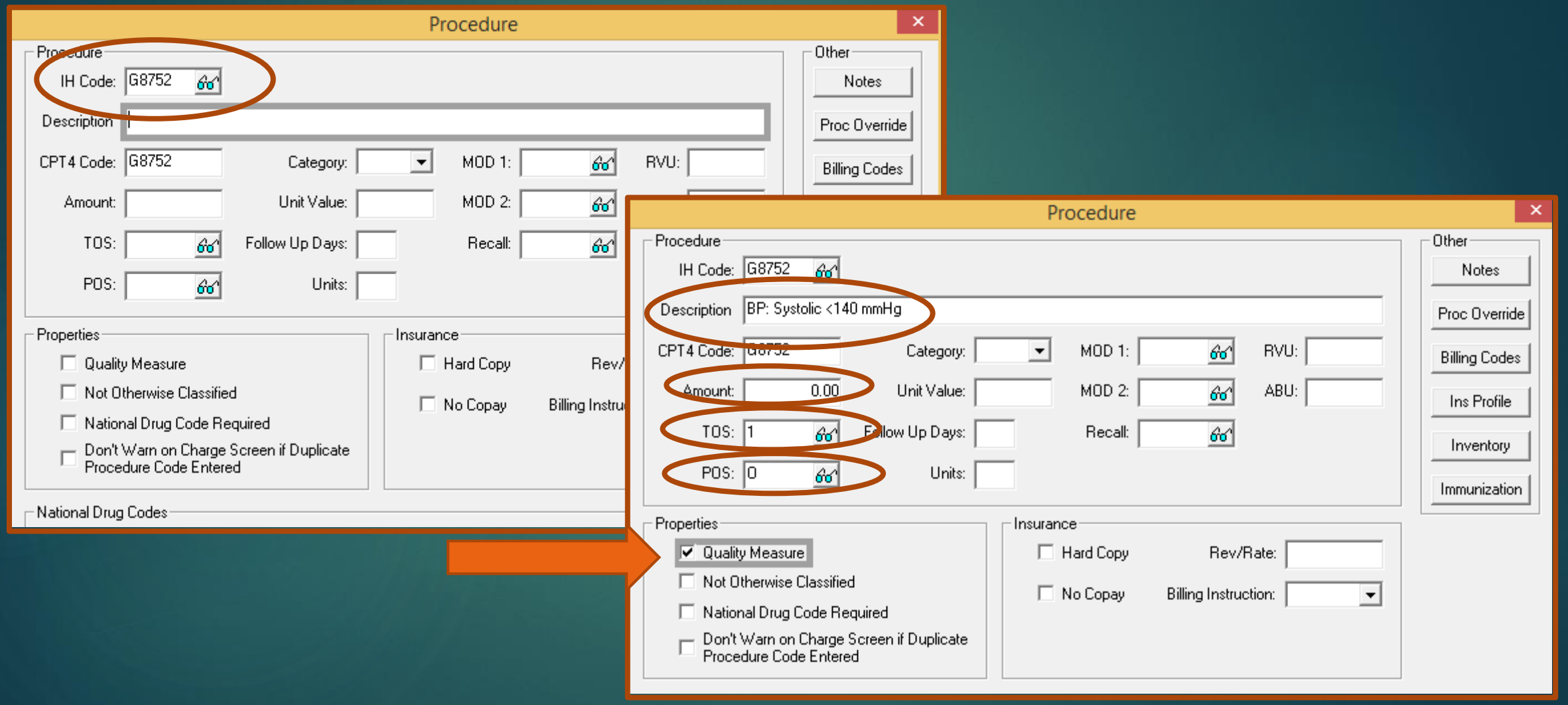
Setting Up the Measures Claims or Registry

Check Codes in Practice Manager

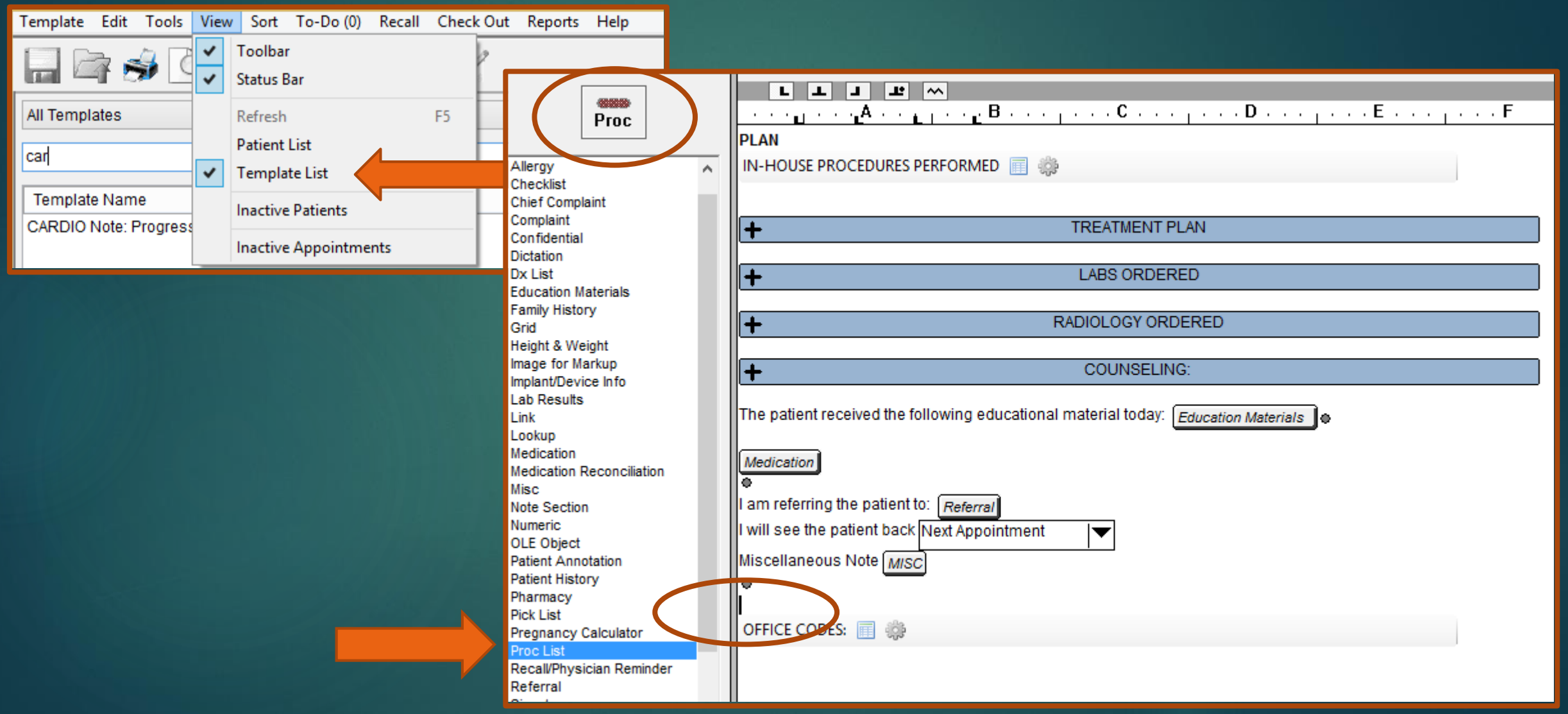
Administration>Transaction Tables>Procedure



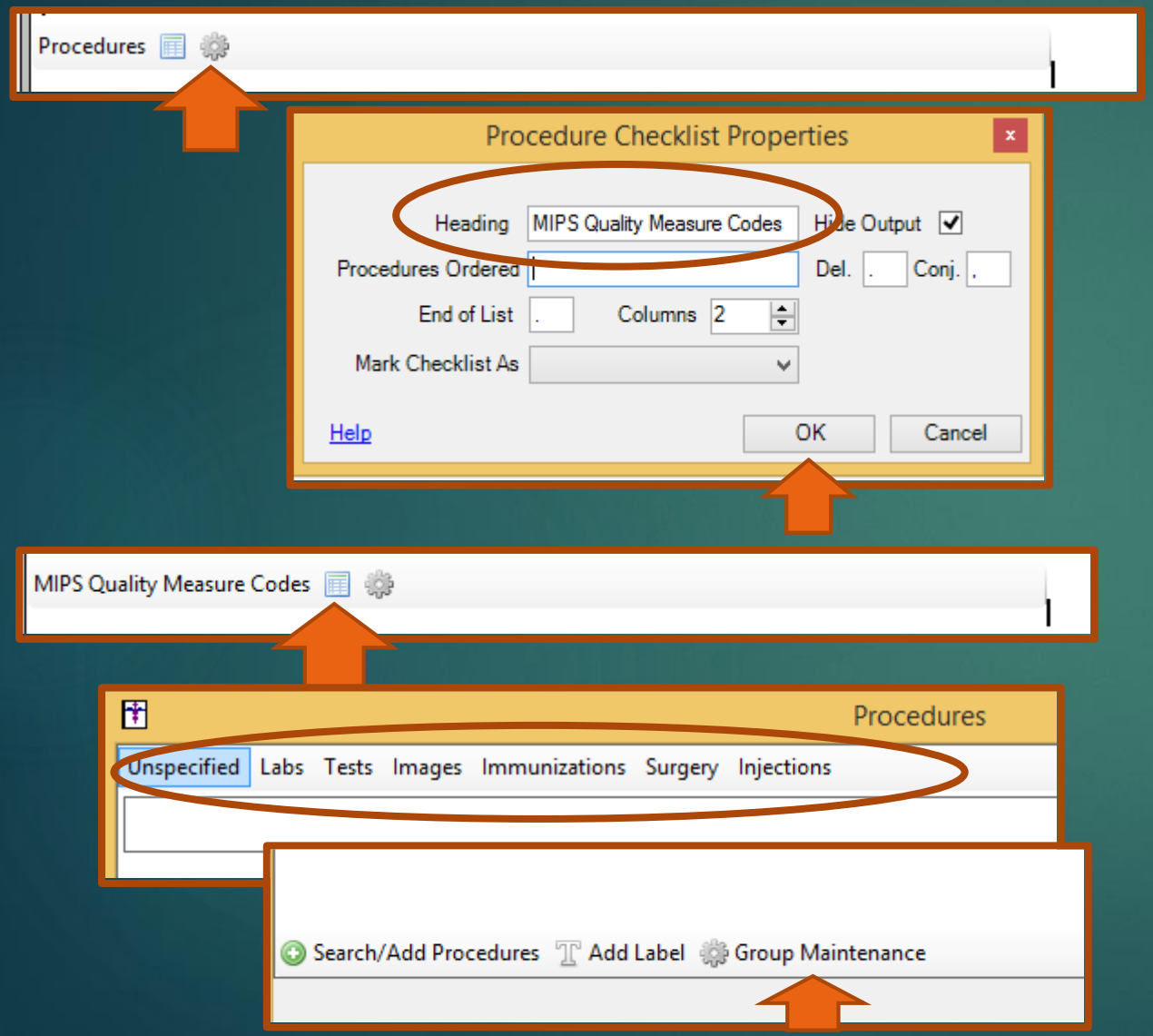
Adding New Codes in Practice Manager

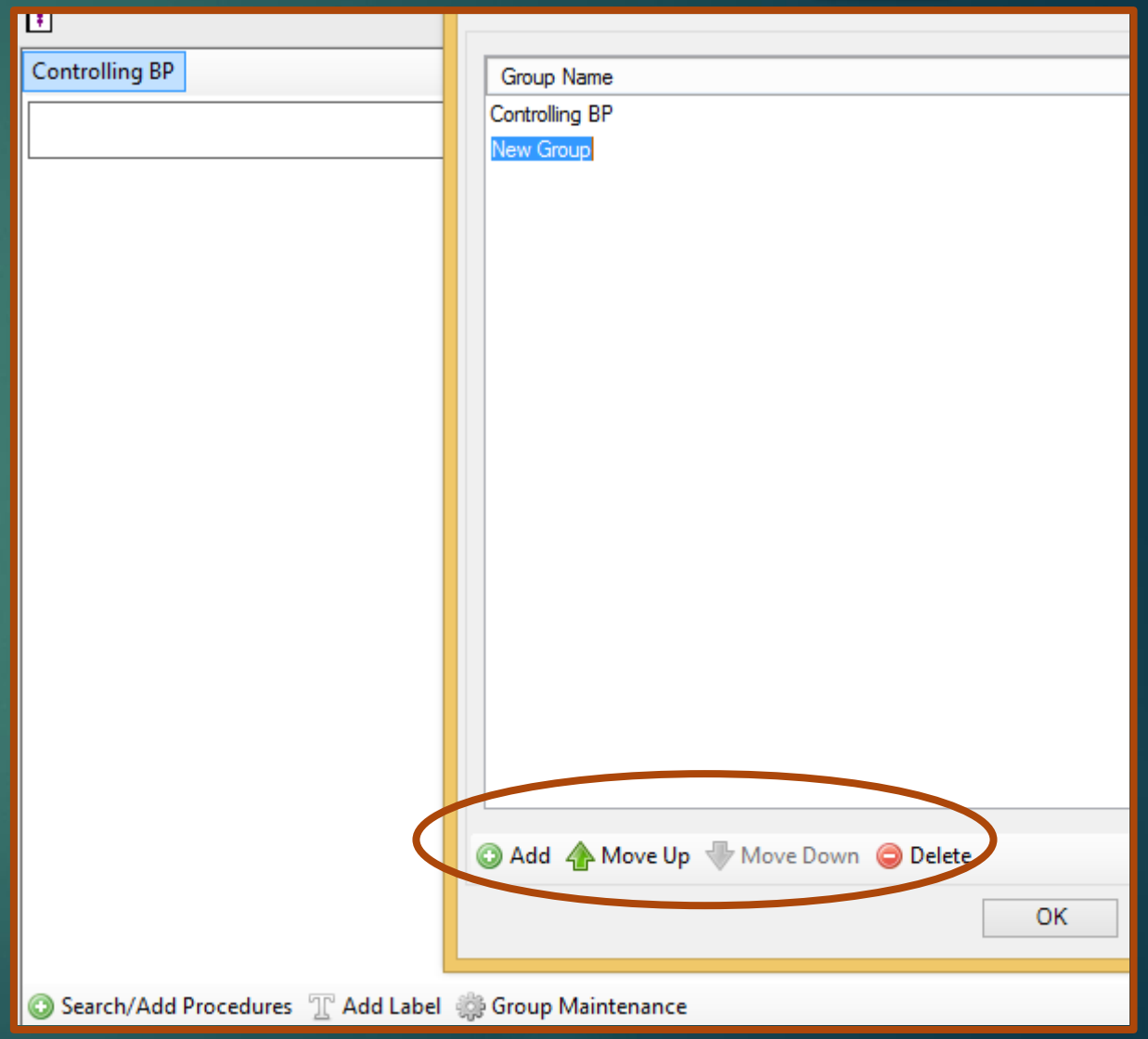


Add Procedure Checklist in Chartmaker

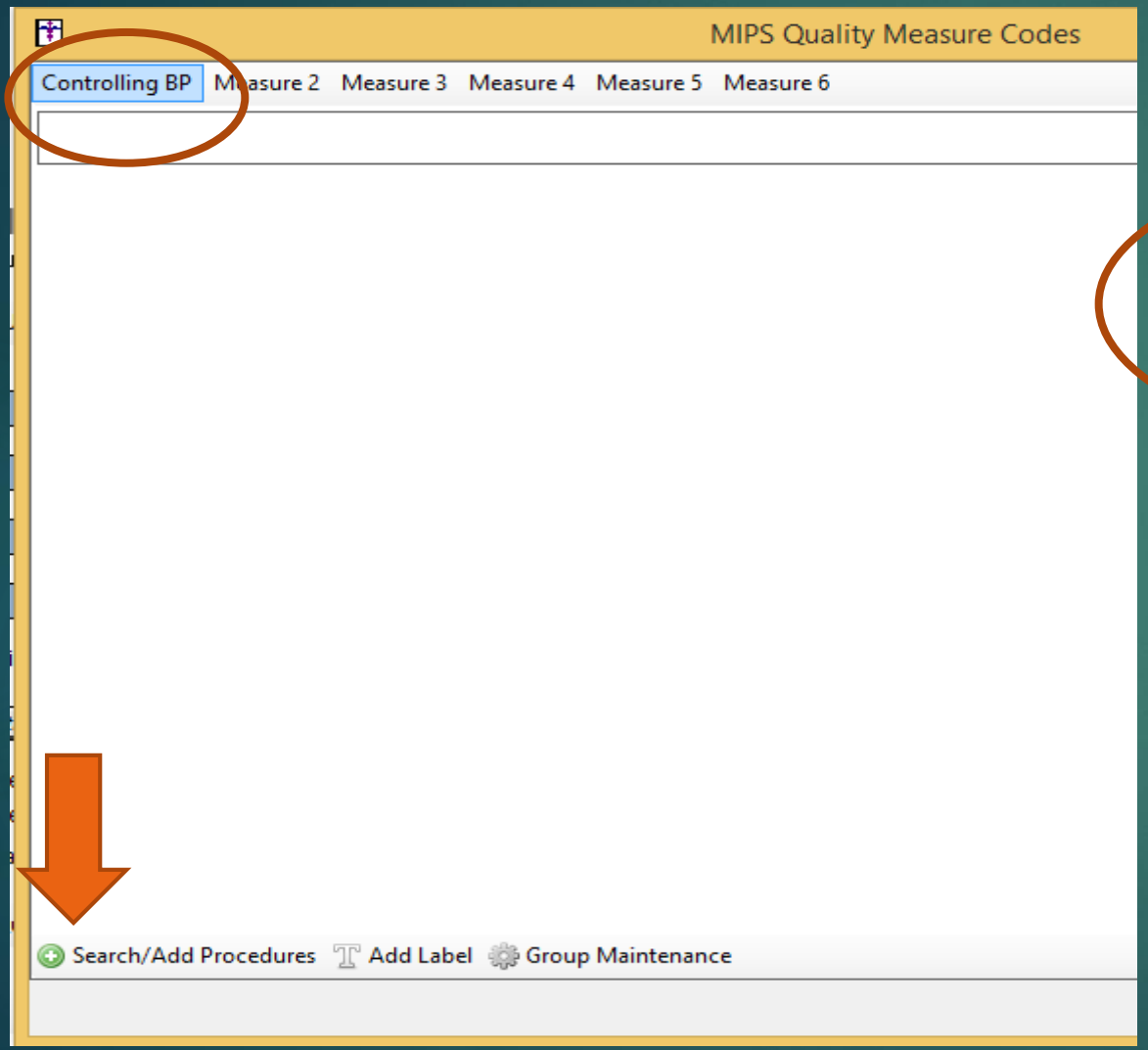


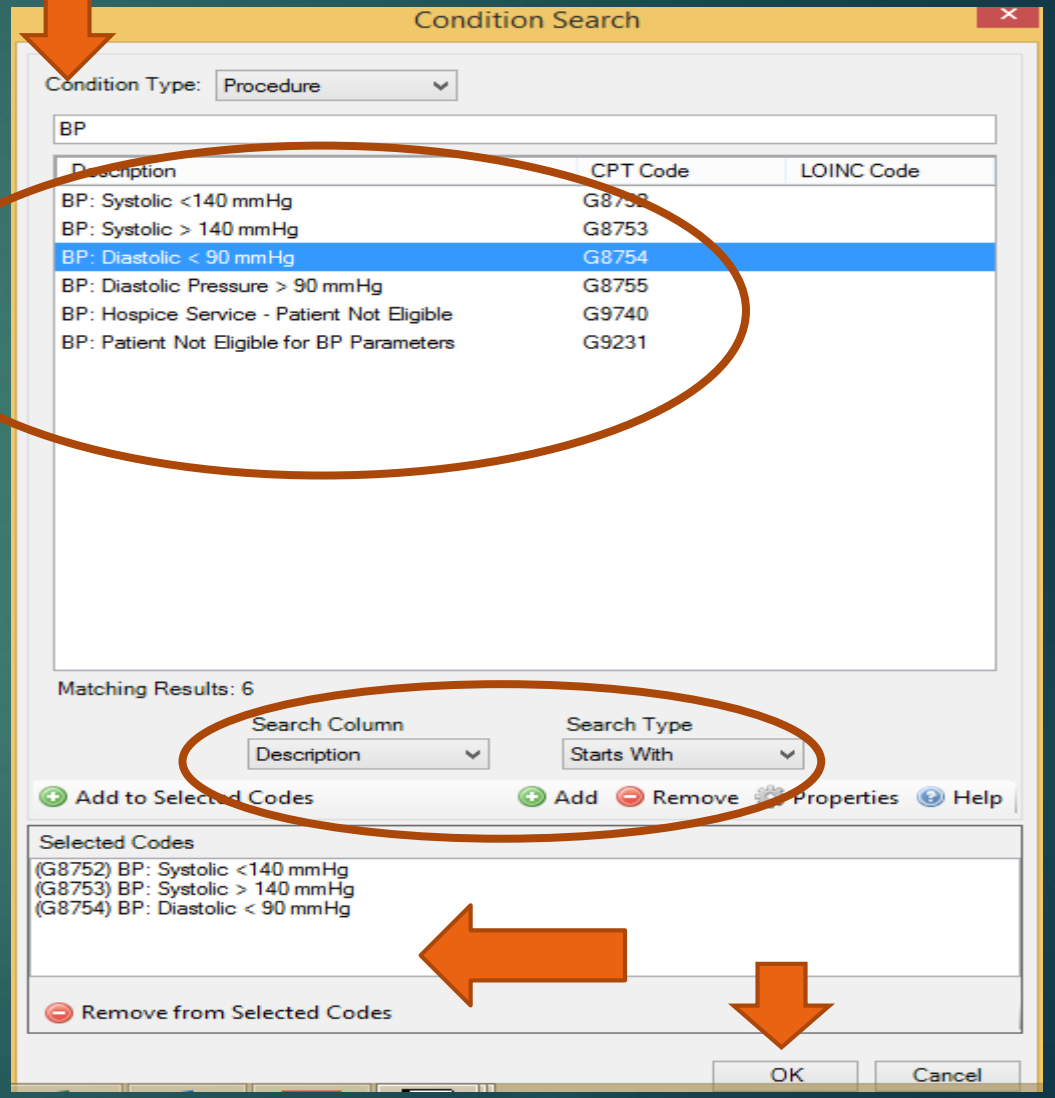
Procedure Checklist Set Up



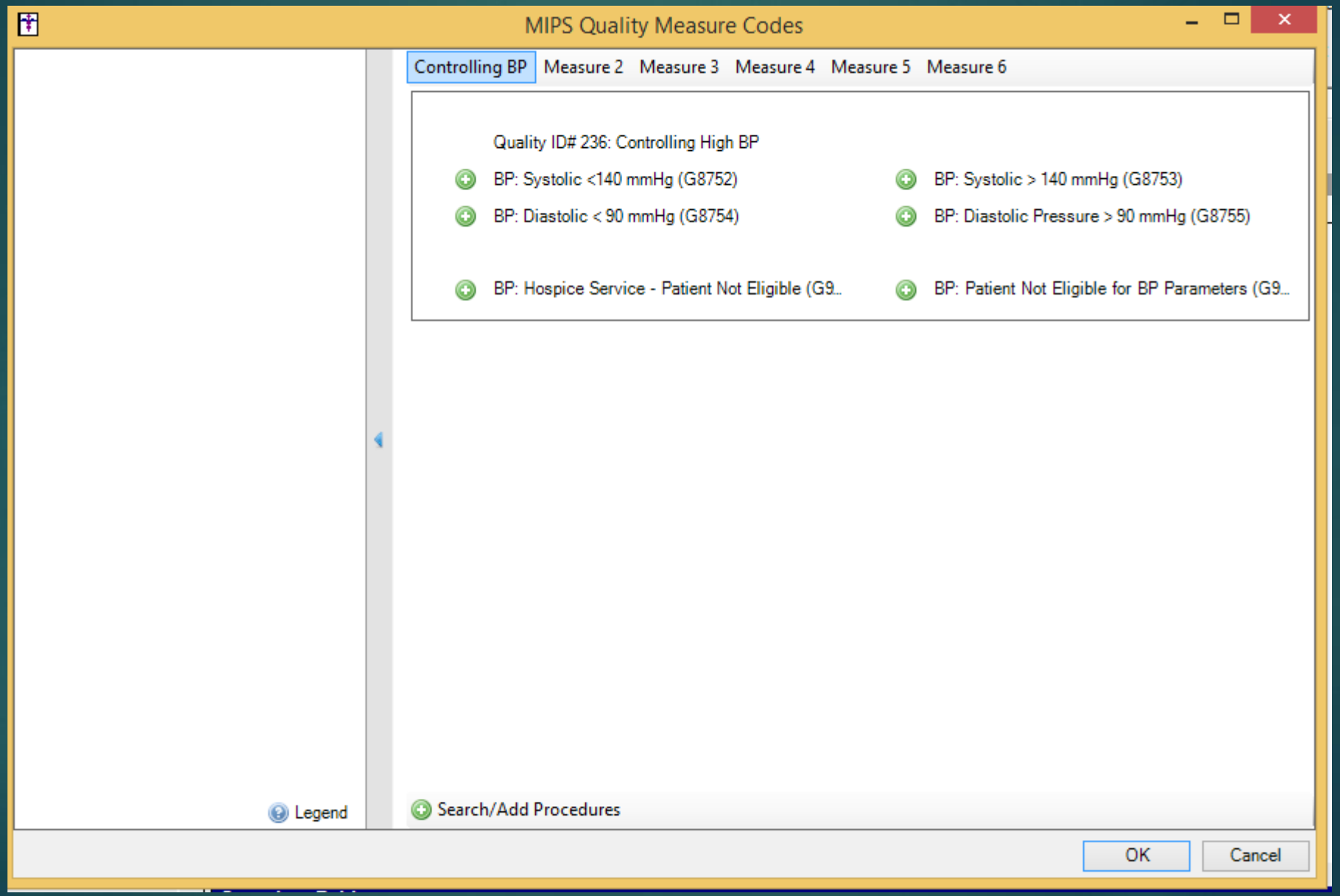


Procedure Checklist Set Up





MIPS Procedure Checklist



Setting Up the Measures!
eCQMs
(Electronic Clinical Quality Measures)

Clinical Quality Measures (CQM 2016 version) 2017 performance year

NQF#/Quality ID#	Measure Name
TBD/377	Functional Status Assessment for CHF
0022/238	Use of High Risk Medications in the Elderly
0419/130	Documentation of Current Medications in the Medical Record
0024/239	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents
0028/226	Preventative Care & Screening Tobacco Use: Screening & Cessation Intervention
0033/310	Chlamydia Screening for Women
0041/110	Preventative Care & Screening: Influenza Immunization
0421/128	Preventative Care & Screening: Body Mass Index (BMI) Screening and Follow Up
TBD/066	Appropriate Testing for Children with Pharyngitis
0052/312	Use of Imaging Studies for Low Back Pain
0069/065	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
0018/236	Controlling High Blood Pressure
2372/112	Breast Cancer Screening
0032/309	Cervical Cancer Screening
0034/113	Colorectal Cancer Screening
TBD/281	Dementia: Cognitive Assessment

Clinical Quality Measures (CQM 2016 version) 2017 performance year

NQF#/Quality ID#	Measure Name
0043/111	Pneumococcal Vaccination Status for Older Adults
0055/117	Diabetes: Eye Exam
0056/163	Diabetes: Foot Exam
0059/001	Diabetes: Hemoglobin A1c Poor Control (>9%)
0062/119	Medical Attention for Nephropathy
0081/005	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0083/008	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0088/018	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
0108/366	ADHD: Follow-Up Care for Children Prescribe Attention-Deficit Hyperactivity Disorder (ADHD) Medication
TBD/378	Children who have Dental Decay or Cavities
TBD/373	Hypertension: Improvement in Blood Pressure
TBD/374	Closing the Referral Loop: Receipt of Specialist Report
0101/318	Falls: Screening for Future Falls Risk

eCQM Specifications
http://sticomputer.com



eCQM Specifications

Measure:	CMS / NQF:	Domain:
Closing the Referral Loop: Receipt of Specialist Report	50 / XX	
HIV/AIDS: Medical Visit*	62 / XX	
Hypertension: Improvement in Blood Pressure*	65 / XX	
Documentation of Current Medications in the Medical Record*	68 / 04	
Preventive Care and Screening Screening and Follow-Up Plan*		
Children Who Have Dental Dec		
Functional Status Assessment Conditions*		
Diabetes: Hemoglobin A1c Poc		

Diabetes: Hemoglobin A1c Poor Control

CMS / NQF #:	122 / 0059

with Diabetes (type 1 or type 2)
ement period.

e most recent documented HbA1c
reater than 9.0%.

1 or Type 2) and an encounter

In ChartMaker Clinical:

In order to qualify for this measure, the provider must have seen the patient (age 18 to 75) at least one time during the reporting period and have the appropriate information documented in the chart:

Required Data Elements for the Denominator:

- **Office Visit or Face-to-Face Interaction (SNOMED) Code during the measurement period** +
- **Diabetes Diagnosis or SNOMED Code that starts before or during the measurement period and remains active throughout** +

Required Data Elements for the Numerator:

- **HbA1c Lab Result (LOINC) Code that occurs during the measurement period with an result of > 9% (OR no occurrence of the code)** +

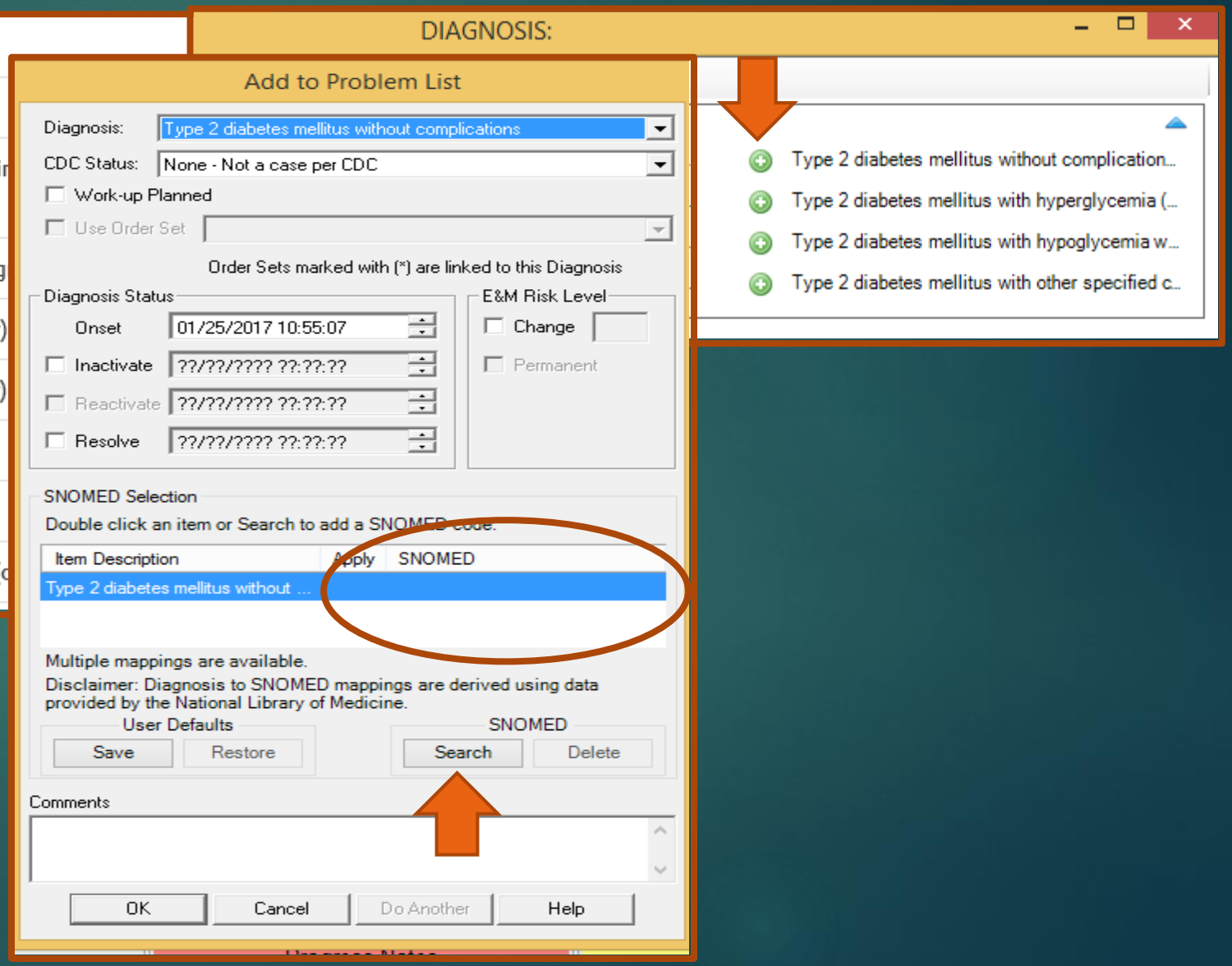
Adding SNOMED Codes

- You can only attach SNOMED Codes to procedure and diagnosis codes when you are in a chart note.
- You must set up for each user.

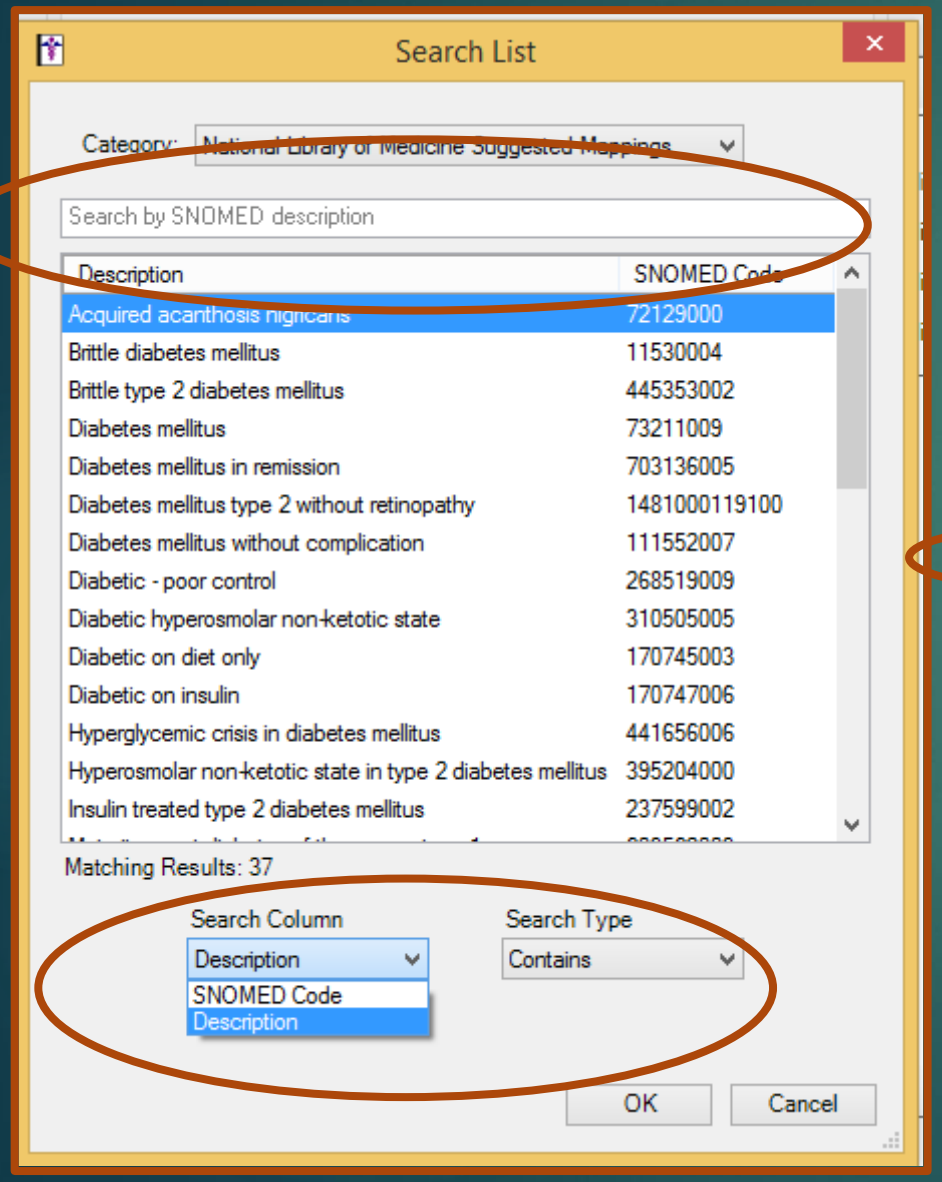
Adding SNOMED Codes to (ICD 10) Diagnosis Codes

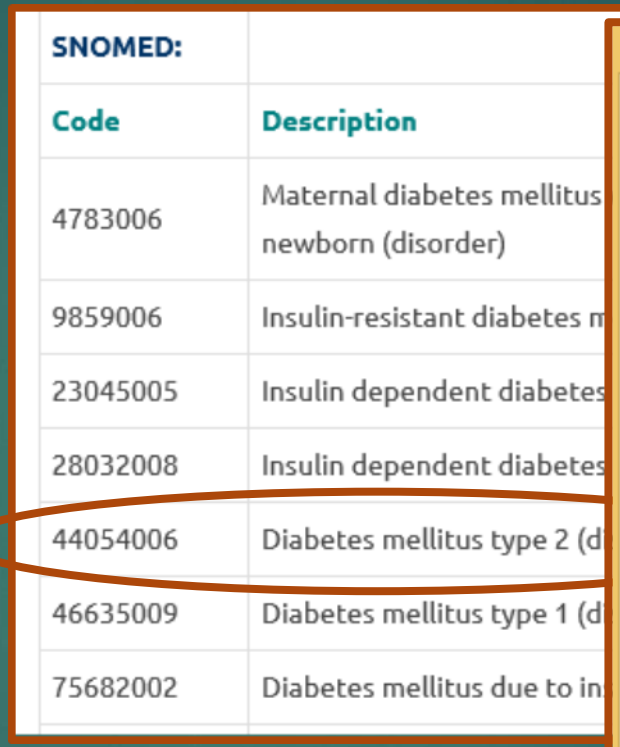
SNOMED:

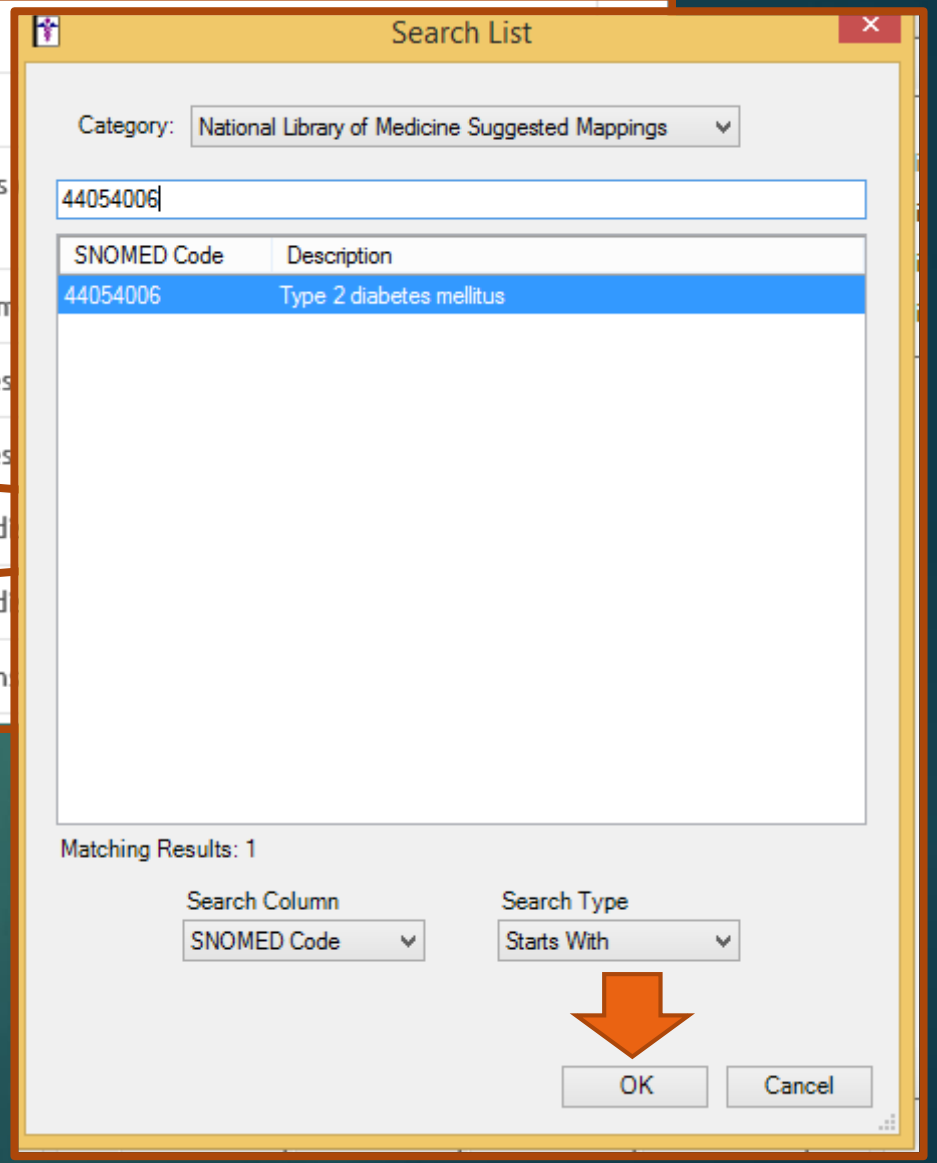
Code	Description
4783006	Maternal diabetes mellitus with hypoglycemia affecti… newborn (disorder)
9859006	Insulin-resistant diabetes mellitus AND acanthosis nig…
23045005	Insulin dependent diabetes mellitus type IA (disorder)
28032008	Insulin dependent diabetes mellitus type IB (disorder)
44054006	Diabetes mellitus type 2 (disorder)
46635009	Diabetes mellitus type 1 (disorder)
75682002	Diabetes mellitus due to insulin receptor antibodies (…



Adding SNOMED Codes to (ICD 10) Diagnosis Codes

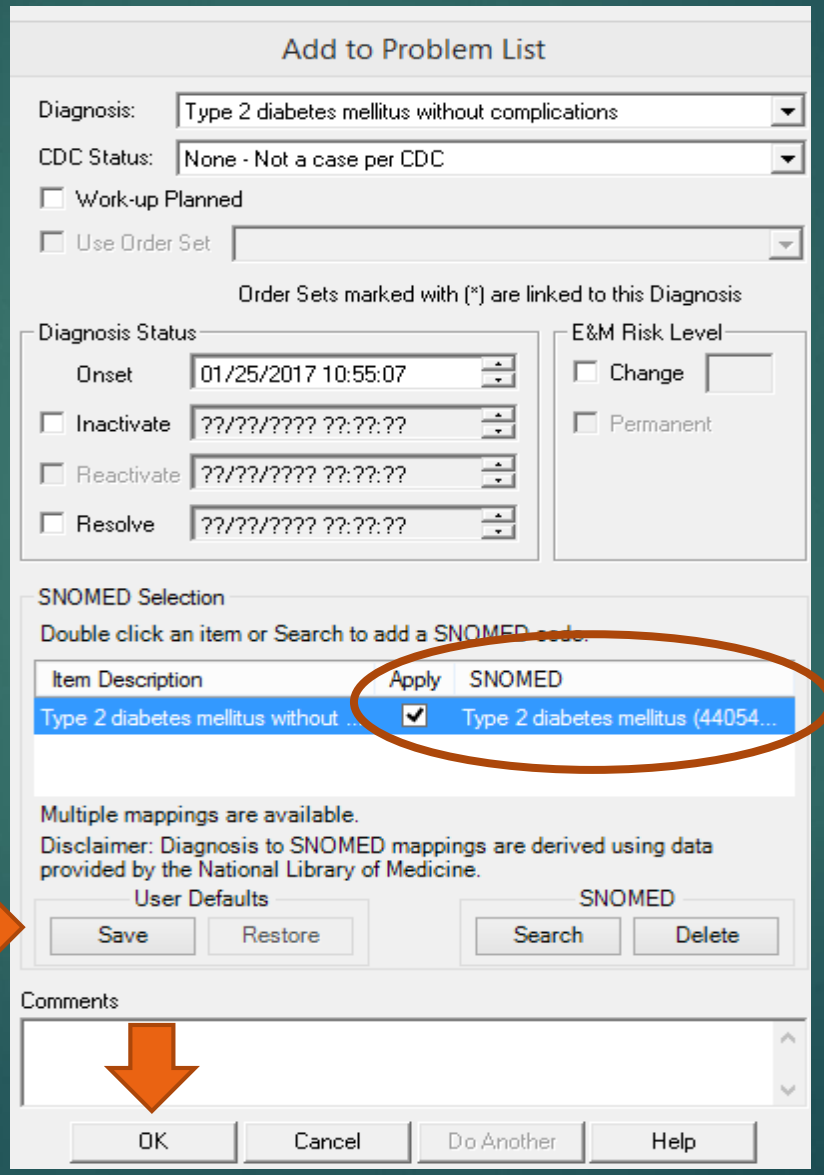






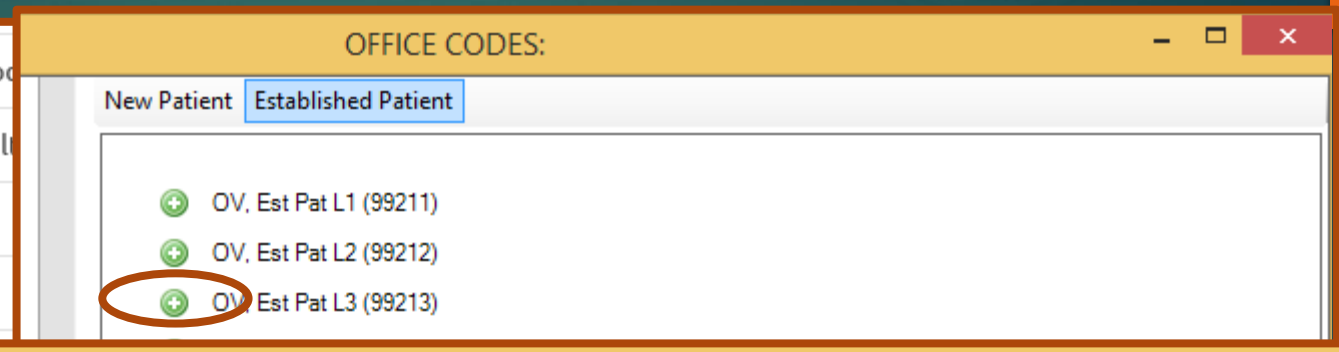
Adding SNOMED Codes to (ICD 10) Diagnosis Codes

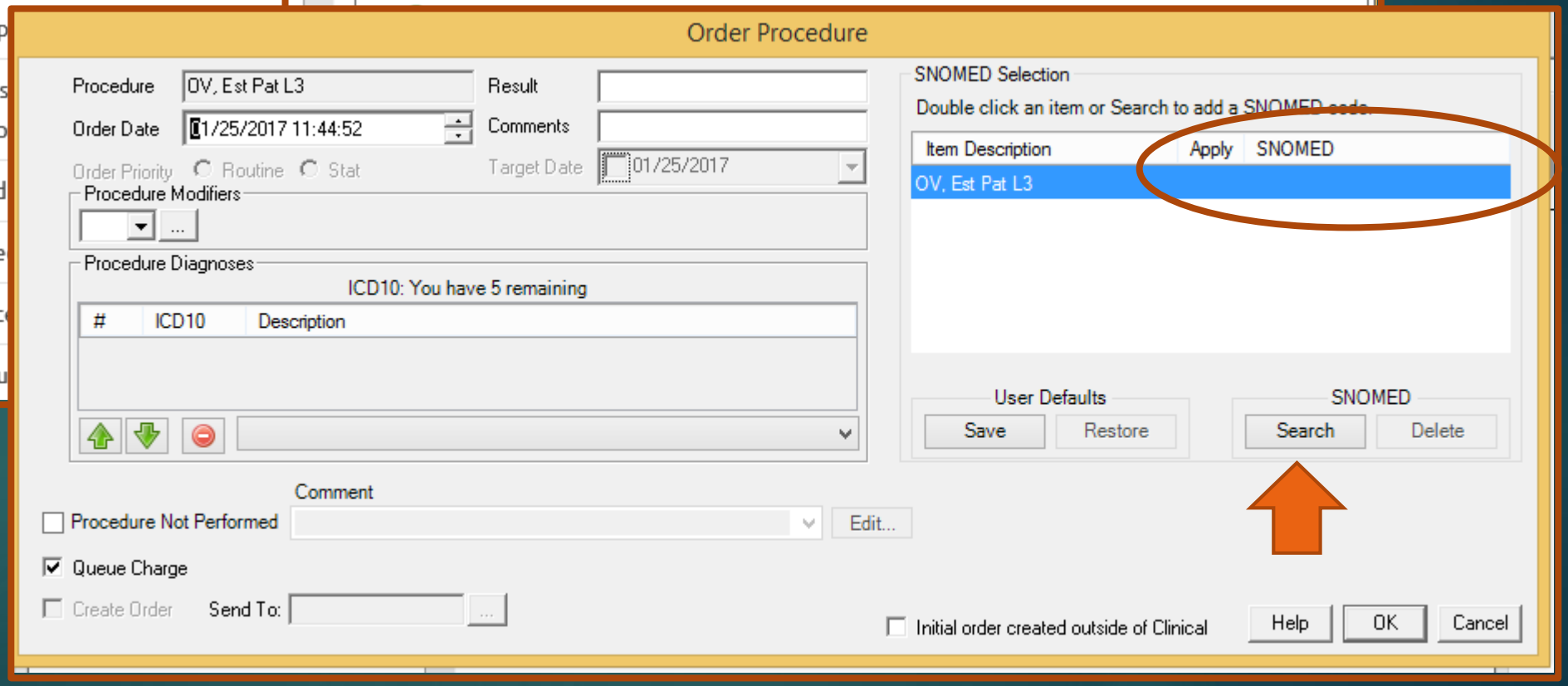
Important:
Click "Save" as User Defaults



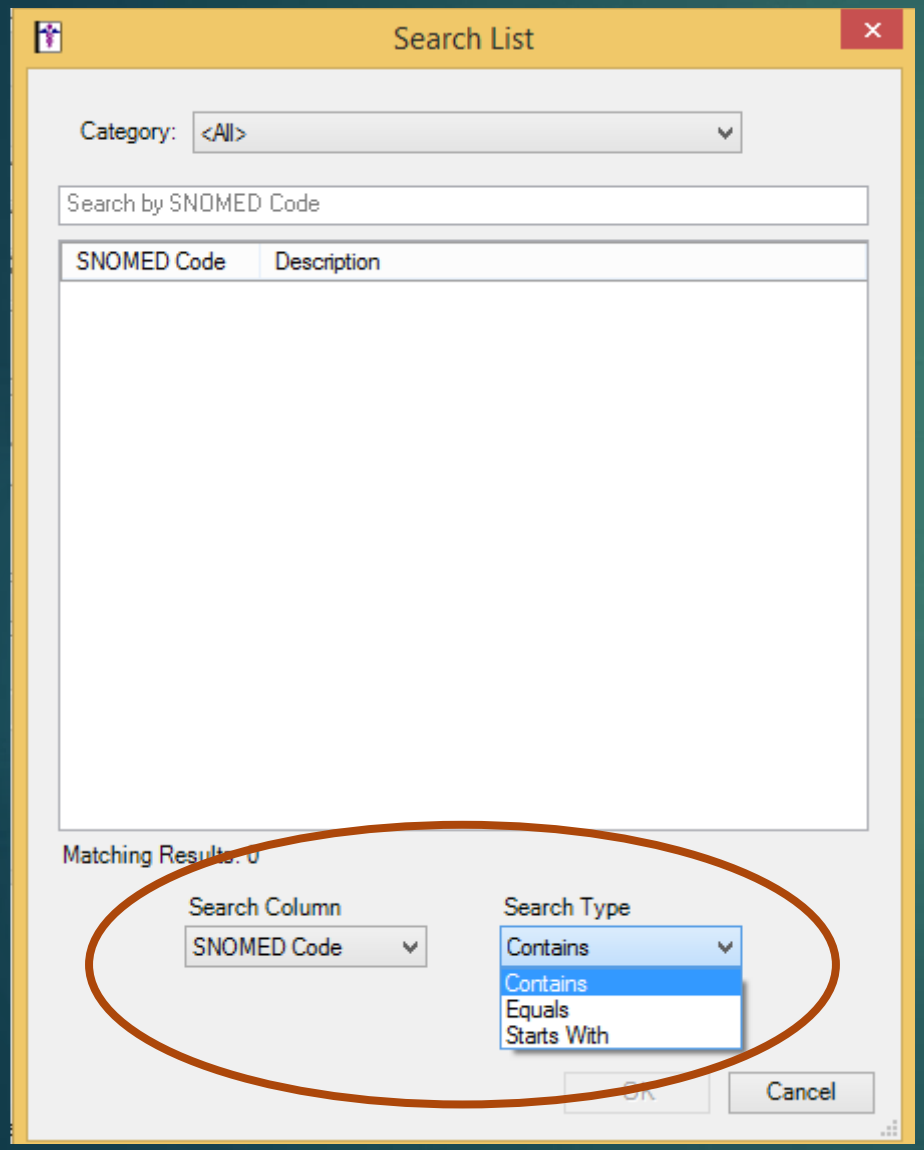
Adding SNOMED Codes to (CPT) Procedural Codes

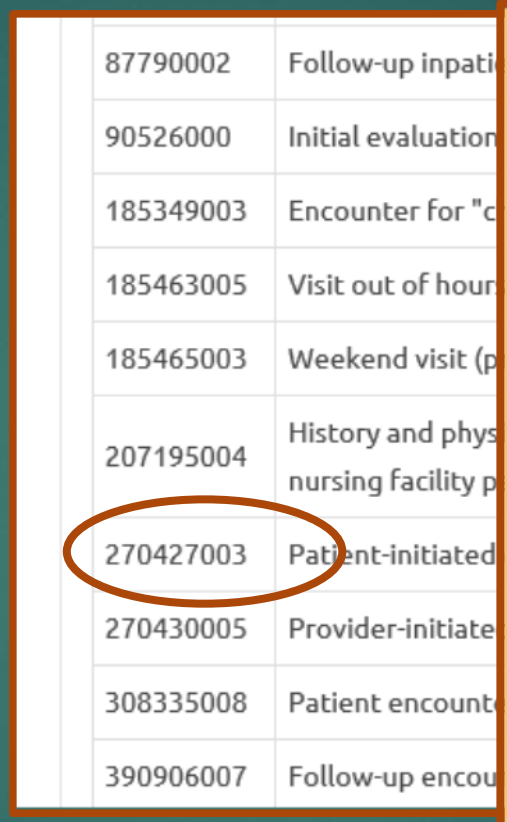
87790002	Follow-up inpatient consultation visit (proc
90526000	Initial evaluation and management of healt
185349003	Encounter for "check-up" (procedure)
185463005	Visit out of hours (procedure)
185465003	Weekend visit (p
207195004	History and phys nursing facility p
270427003	Patient-initiated
270430005	Provider-initiate
308335008	Patient encount
390906007	Follow-up encou

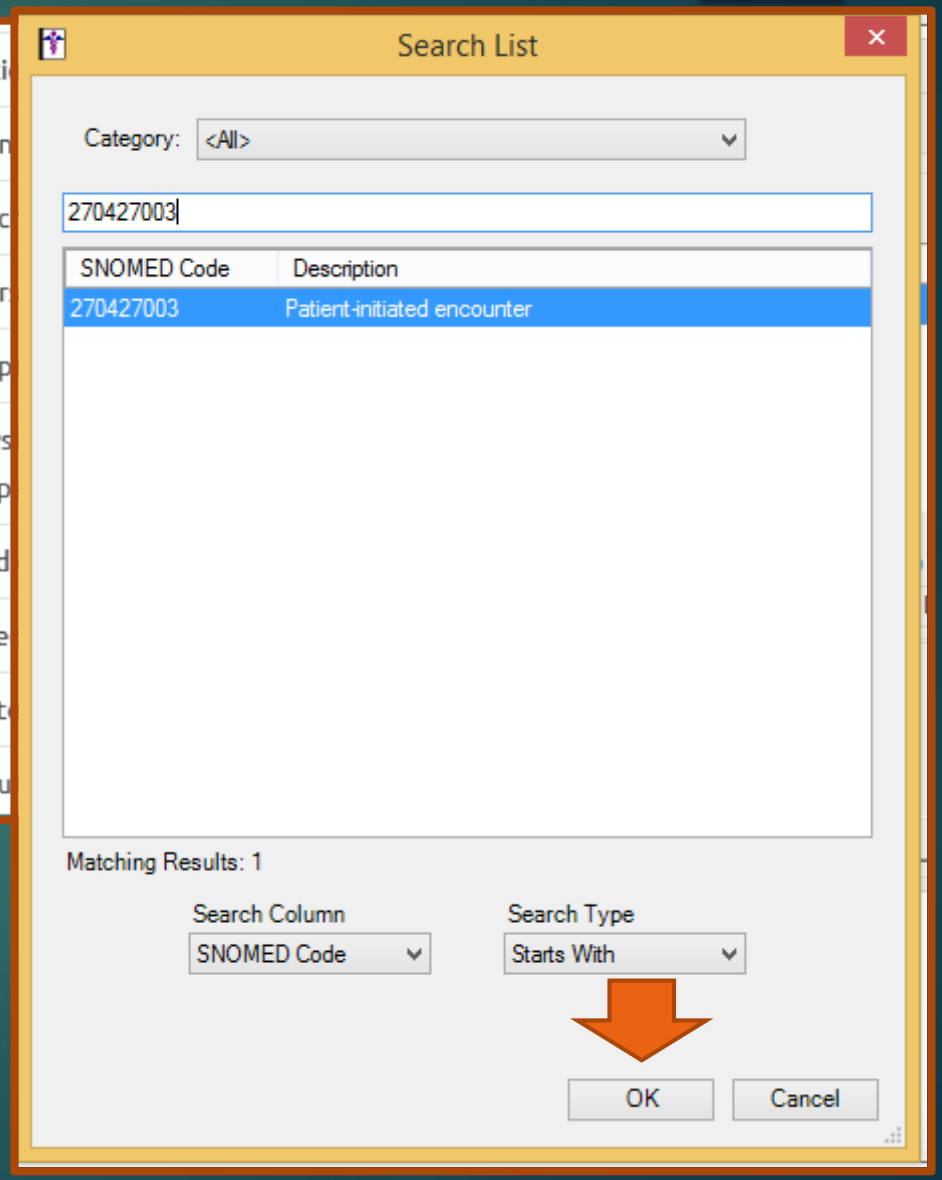




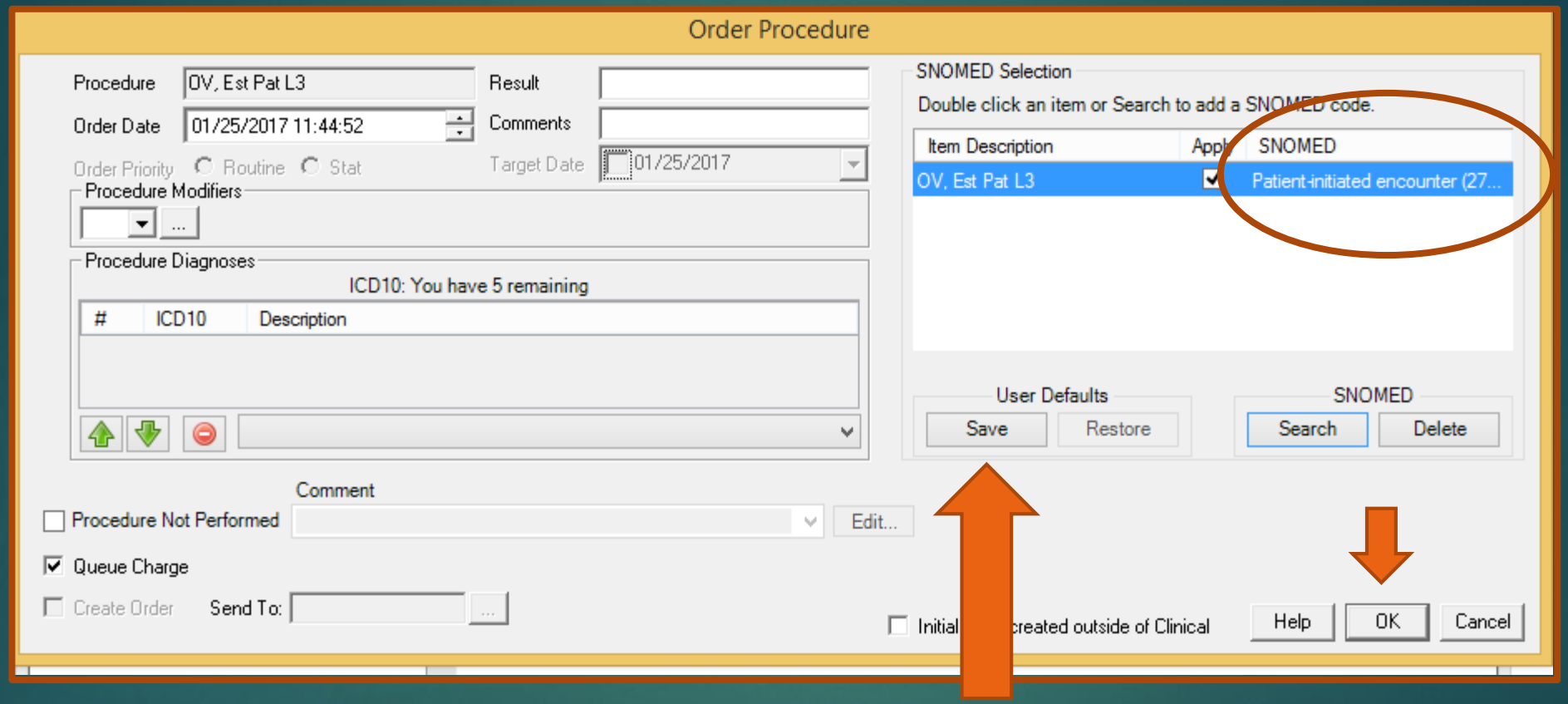
Adding SNOMED Codes to (CPT) Procedural Codes







Adding SNOMED Codes to (CPT) Procedural Codes



IMPORTANT!:
Check on the "**Save**" as User Defaults

Adding LOINC Codes

In ChartMaker Clinical:

In order to qualify for this measure, the provider must have seen the patient (ag
time during the reporting period and have the appropriate information documer

Required Data Elements for the Denominator:

- **Office Visit or Face-to-Face Interaction (SNOMED) Code during the mea**
- **Diabetes Diagnosis or SNOMED Code that starts before or during the me period and remains active throughout**

Required Data Elements for the Numerator:

- **HbA1c Lab Result (LOINC) Code that occurs during the measurement per result of > 9% (OR no occurrence of the code)**

Required Data Elements for the Numerator:

- **HbA1c Lab Result (LOINC) Code that occurs during the measurement period with an result of > 9% (OR no occurrence of the code)**

If a HbA1c laboratory test was performed, it can be captured by:

- An electronic lab result with a valid LOINC code,
- Adding a numeric result with a valid LOINC code using a numeric control in a note,

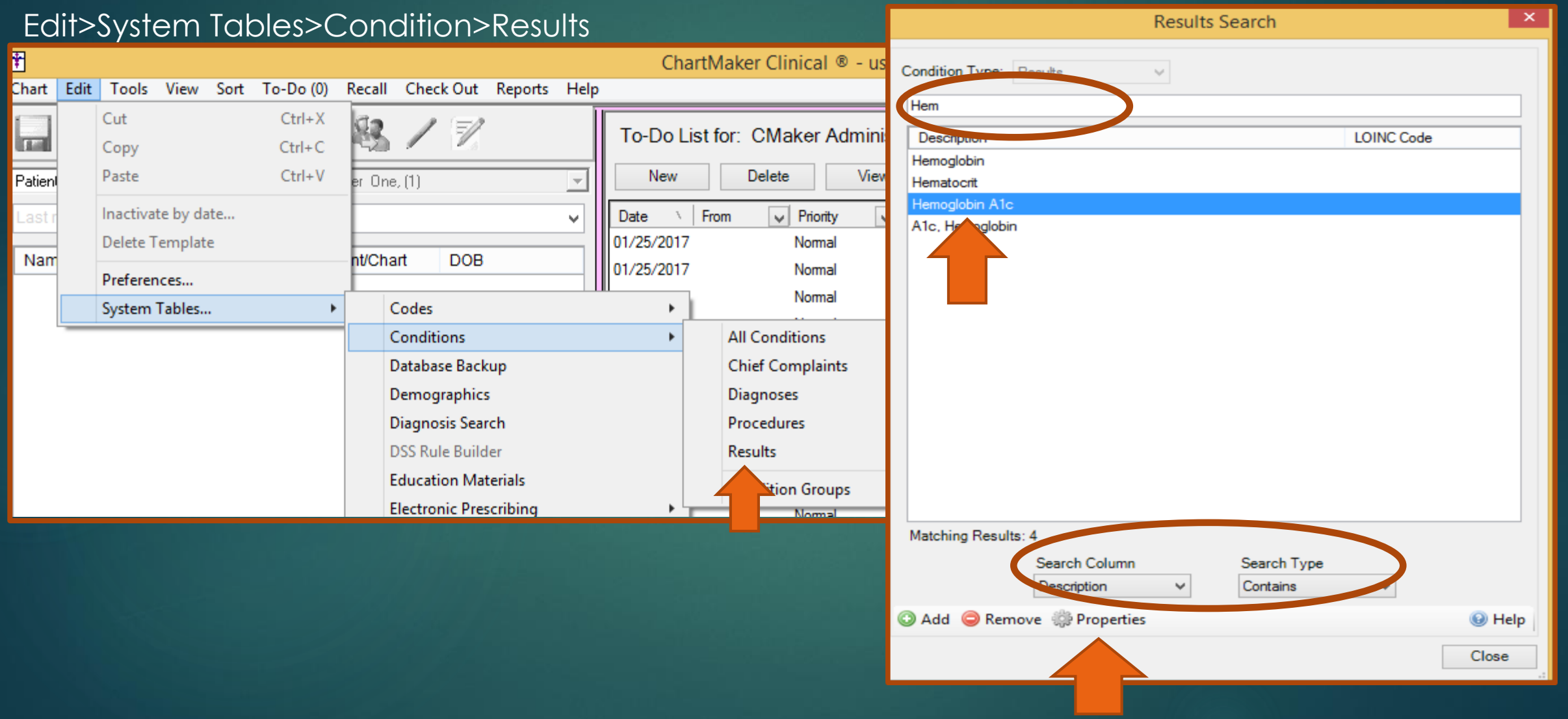
or

- Adding a procedure with a valid LOINC code using the Procedure widget in a note

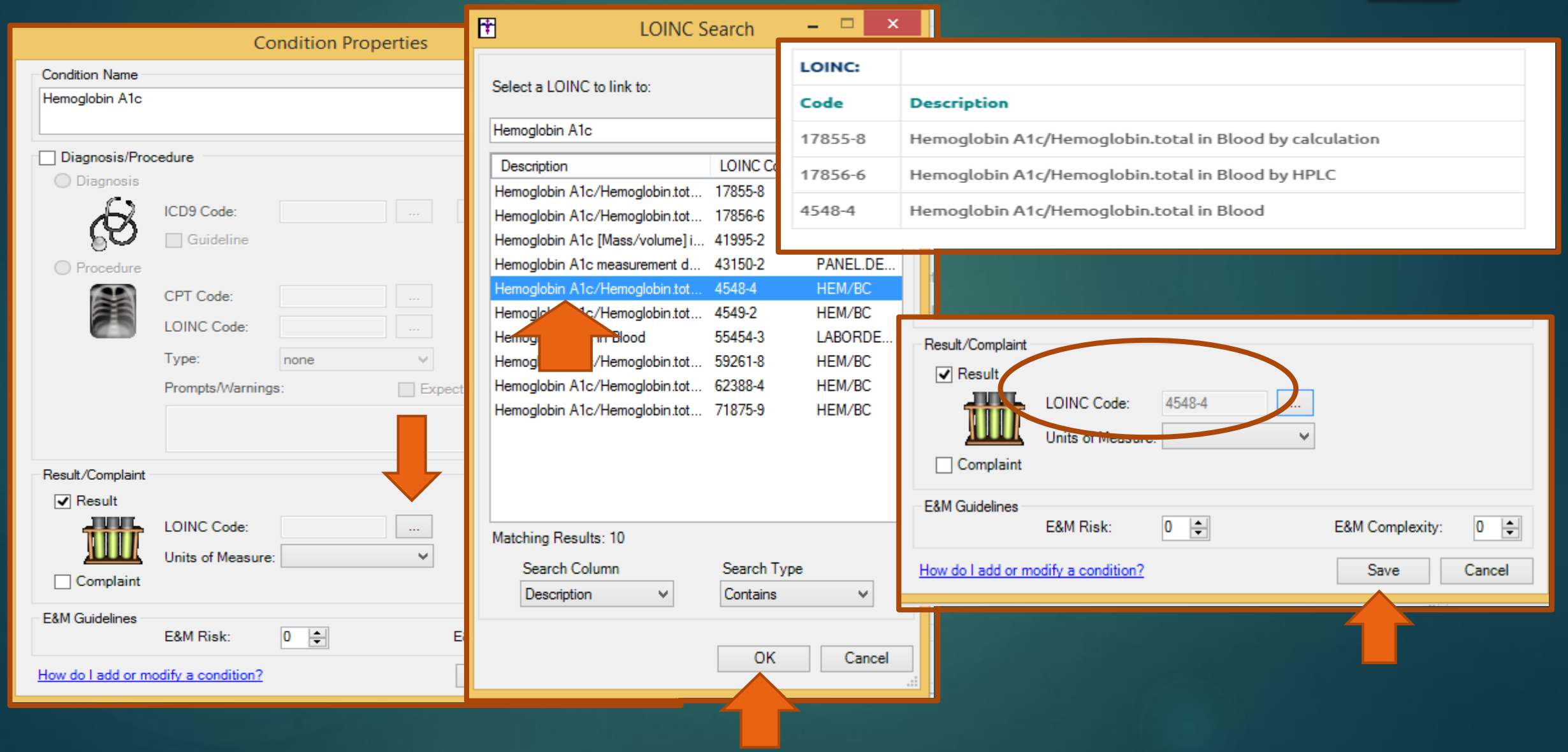
LOINC:	
Code	**Description**
17855-8	Hemoglobin A1c/Hemoglobin.total in Blood by calculation
17856-6	Hemoglobin A1c/Hemoglobin.total in Blood by HPLC
4548-4	Hemoglobin A1c/Hemoglobin.total in Blood

Adding LOINC Codes Electronic Lab Results

Edit>System Tables>Condition>Results

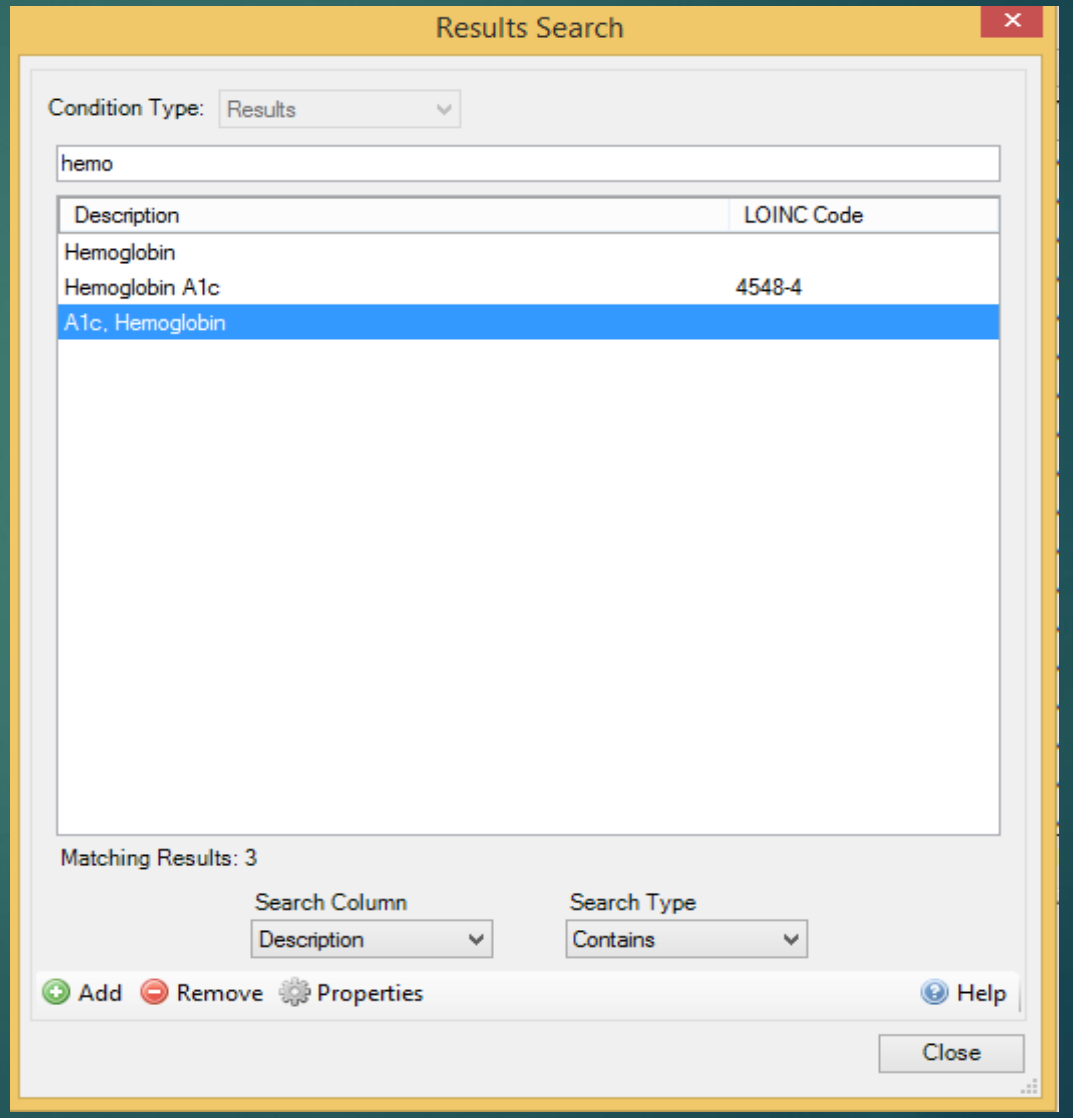


Adding LOINC Codes Electronic Lab Results



Adding LOINC Codes Electronic Lab Results

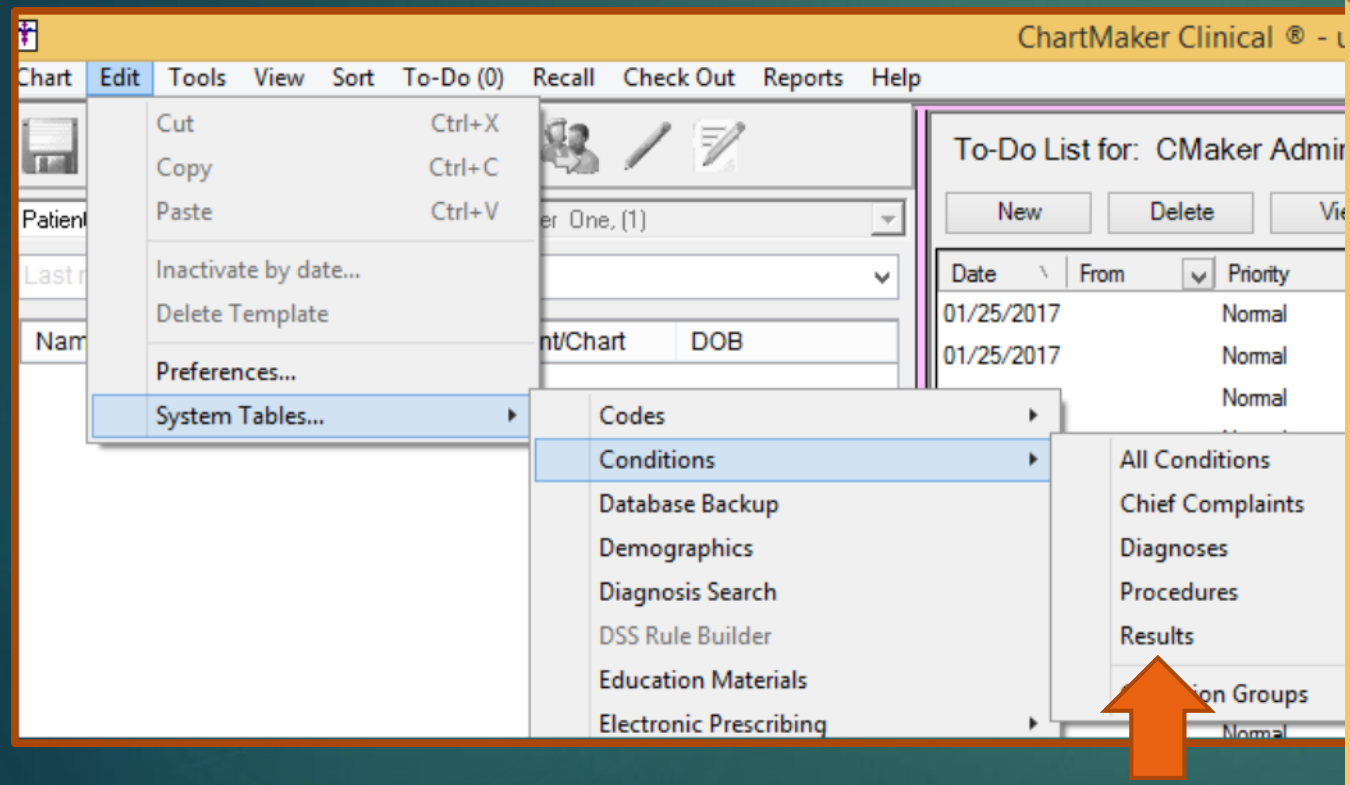
Reminder: If you are interfaced with multiple labs, you will need to attach the LOINC code to each Lab's test.

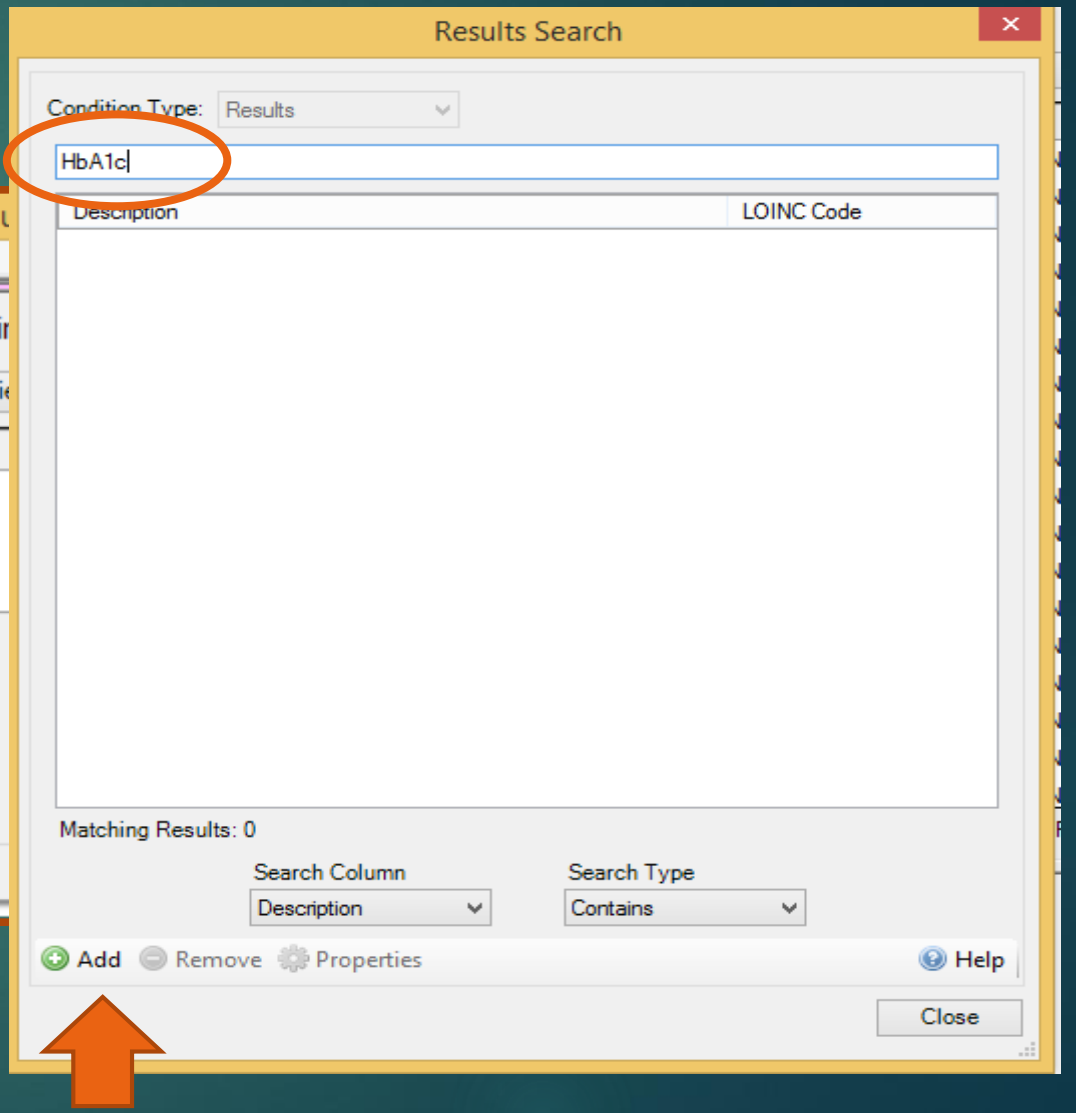


Adding LOINC Codes
Manually Entered Lab Results

Adding a Condition

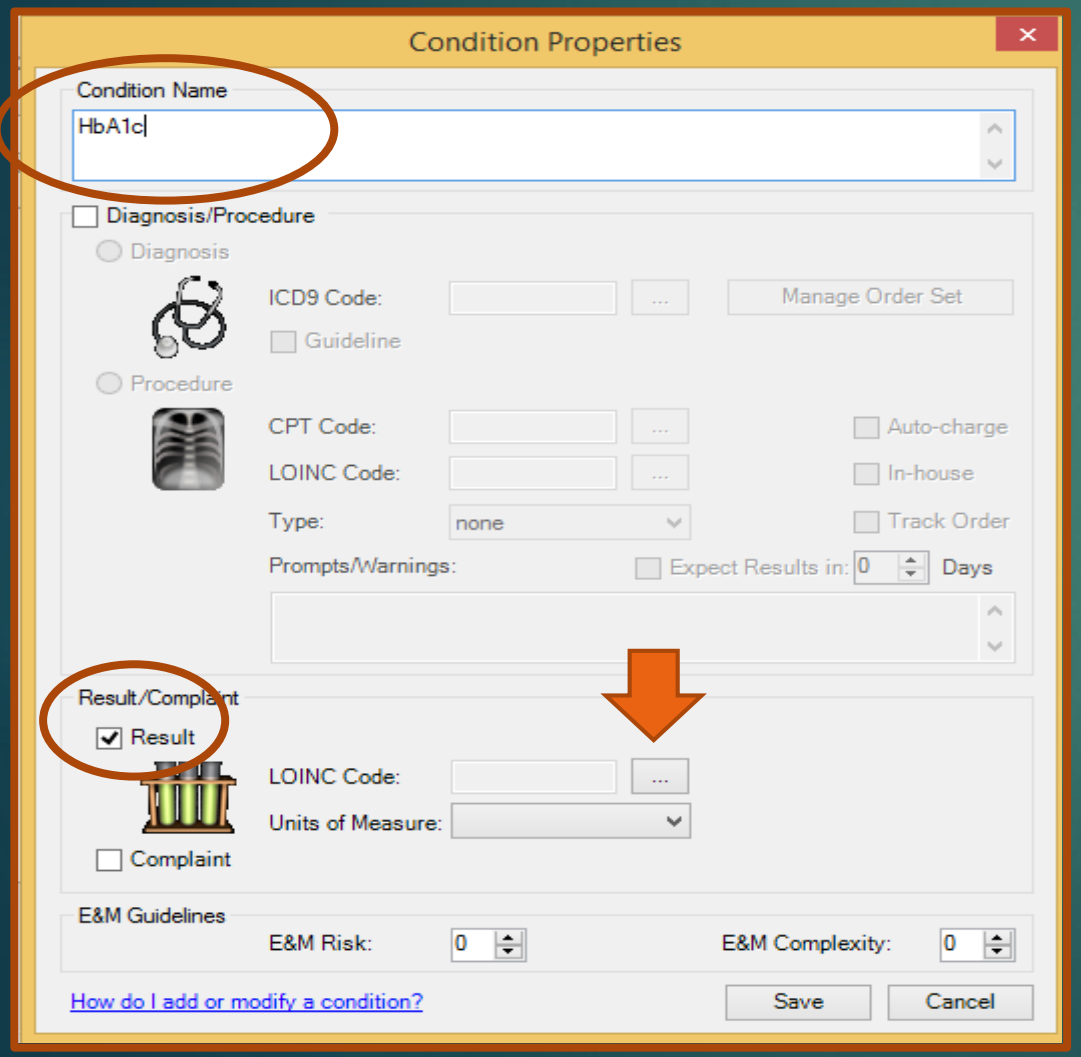
Edit>System Tables>Condition>Results



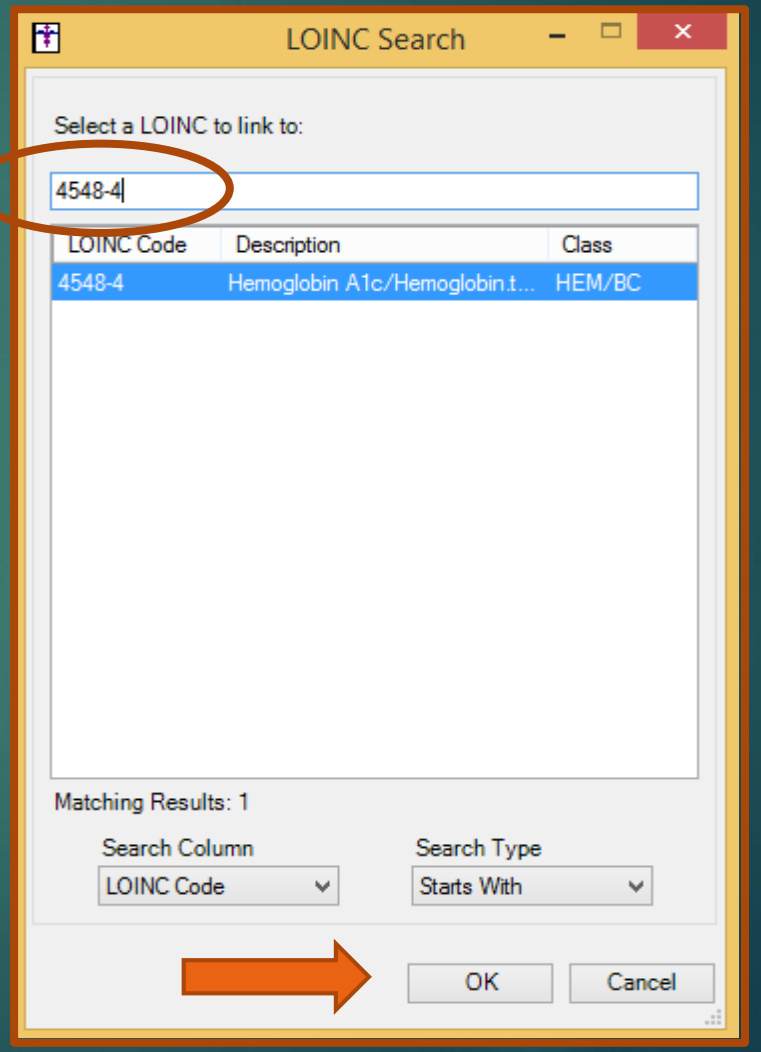


Adding LOINC Codes
Manually Entered Lab Results

Adding a Condition

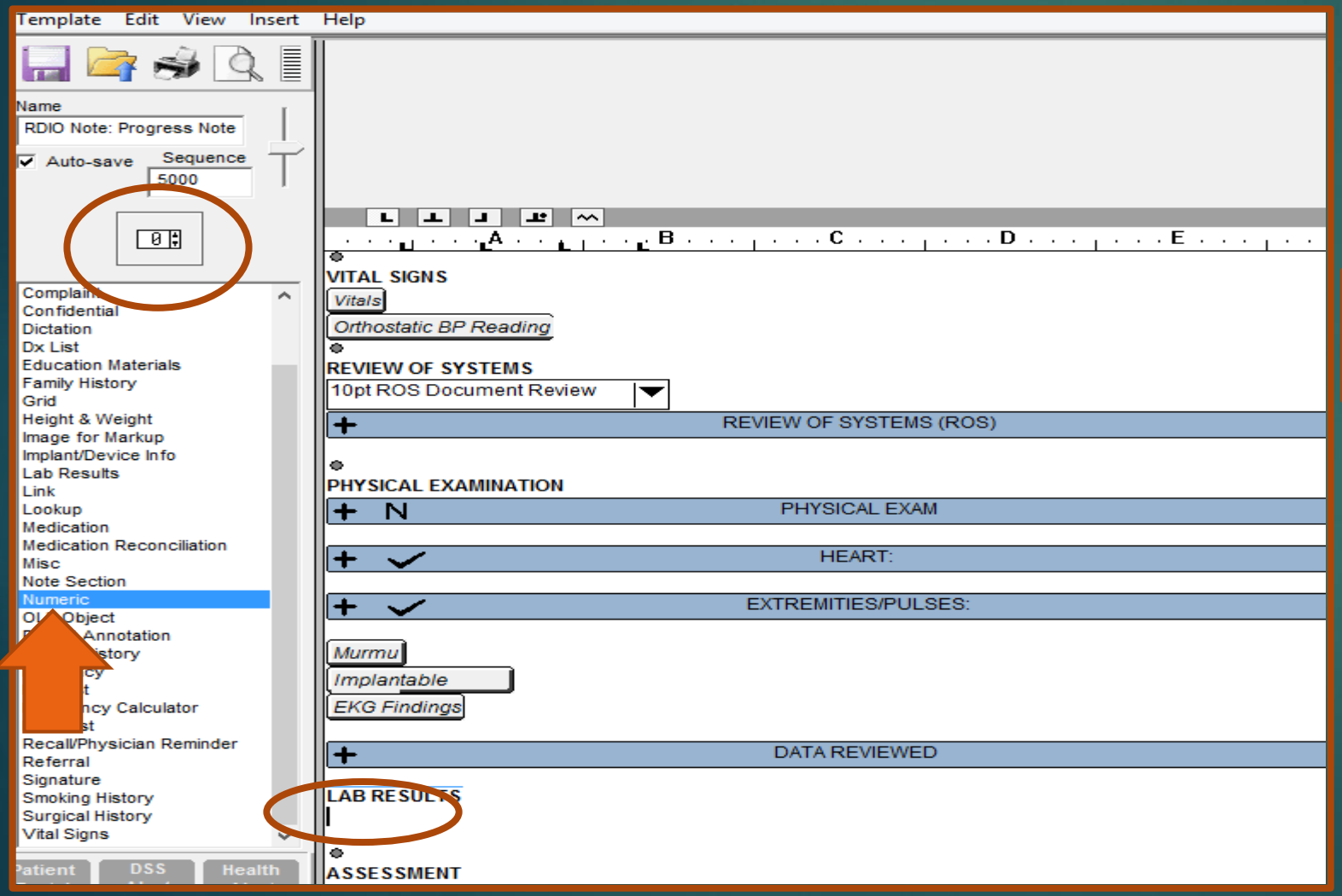


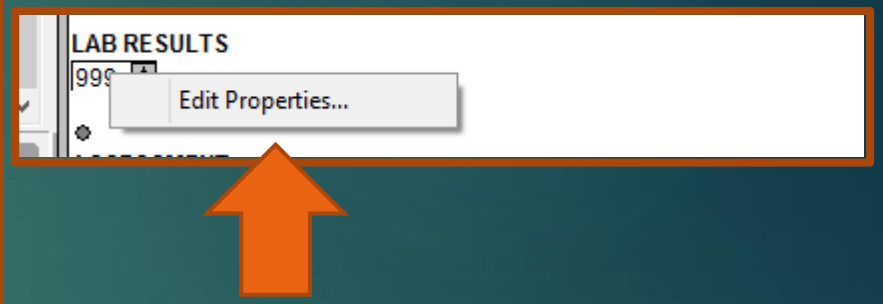
Link the LOINC Code



Adding LOINC Codes
Manually Entered Lab Results

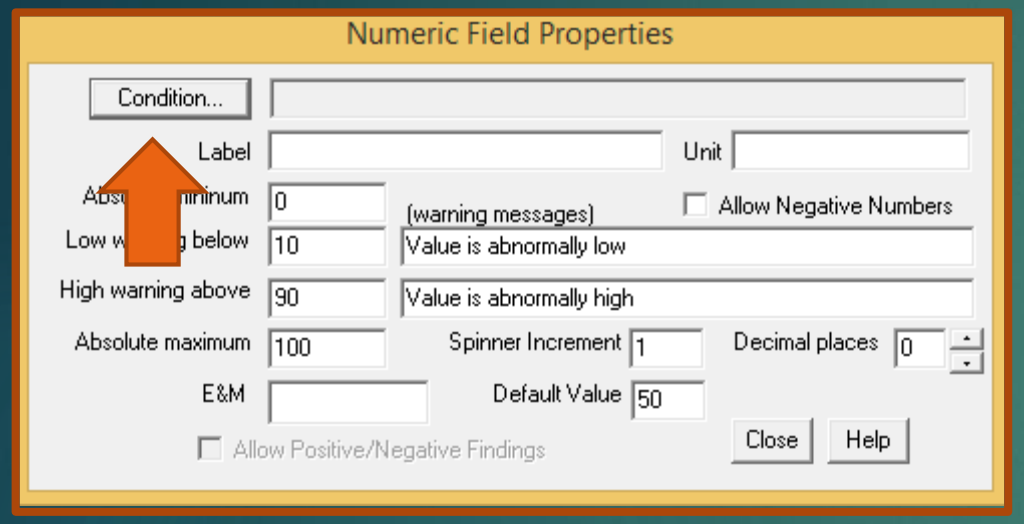
Adding Numeric Field in Template

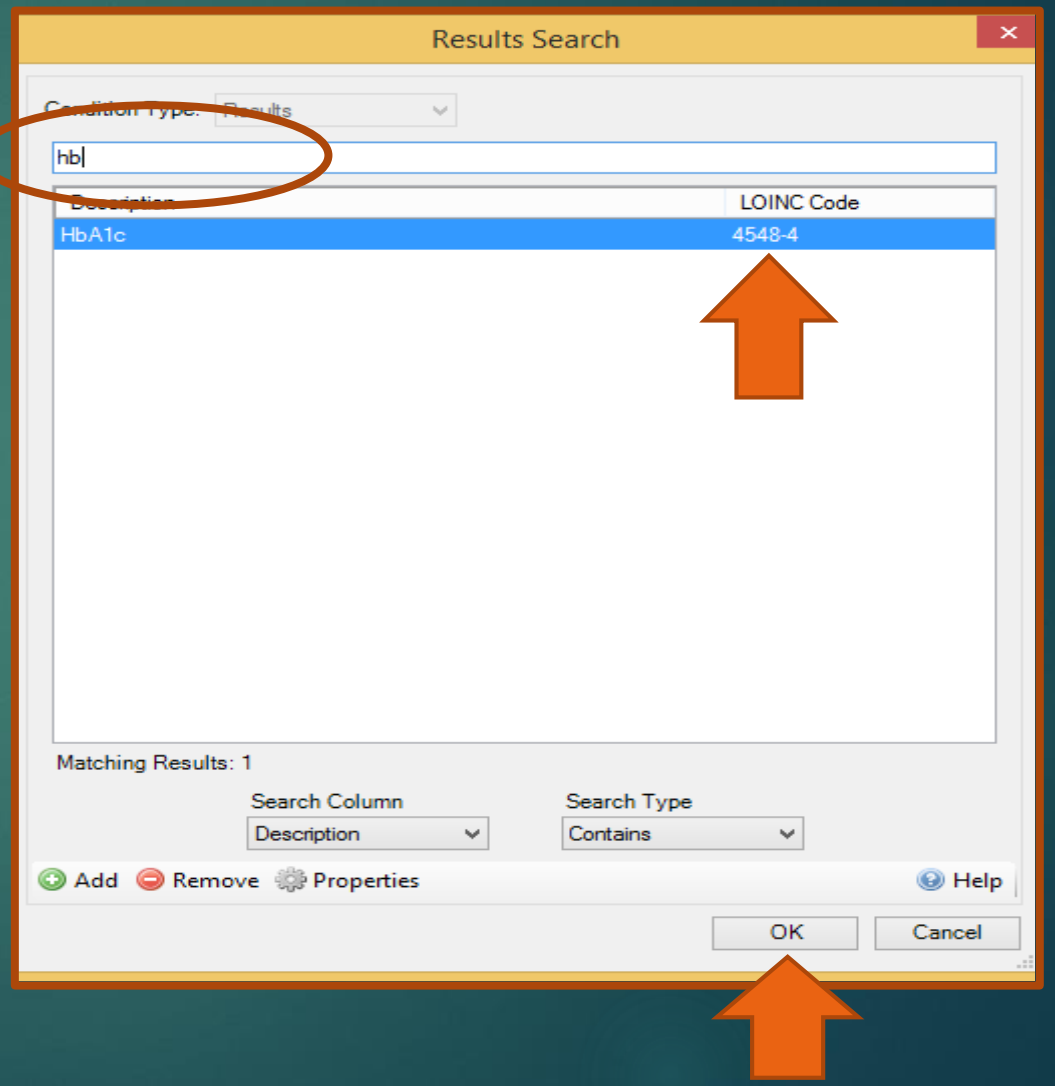




Adding LOINC Codes
Manually Entered Lab Results

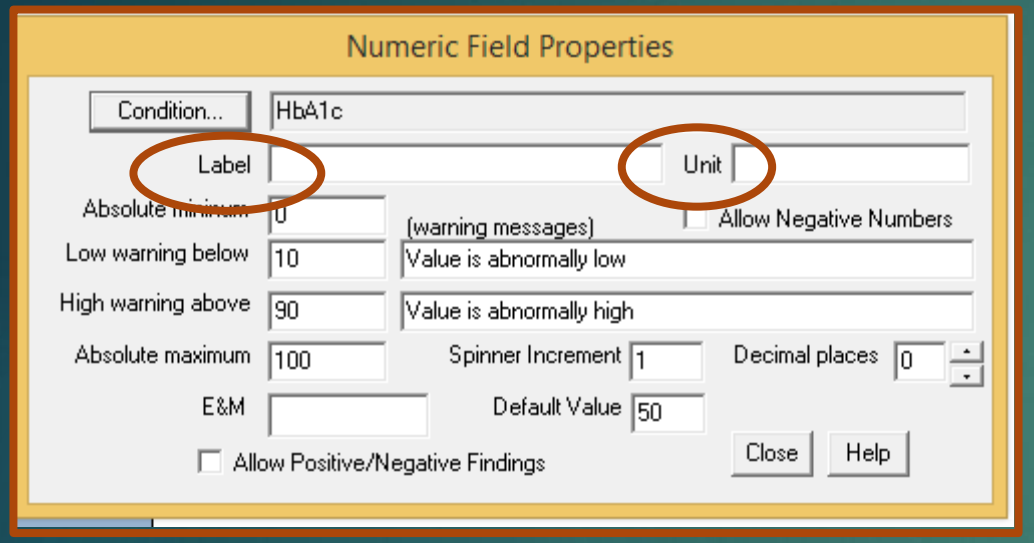
Setting the Properties of Numeric Tool

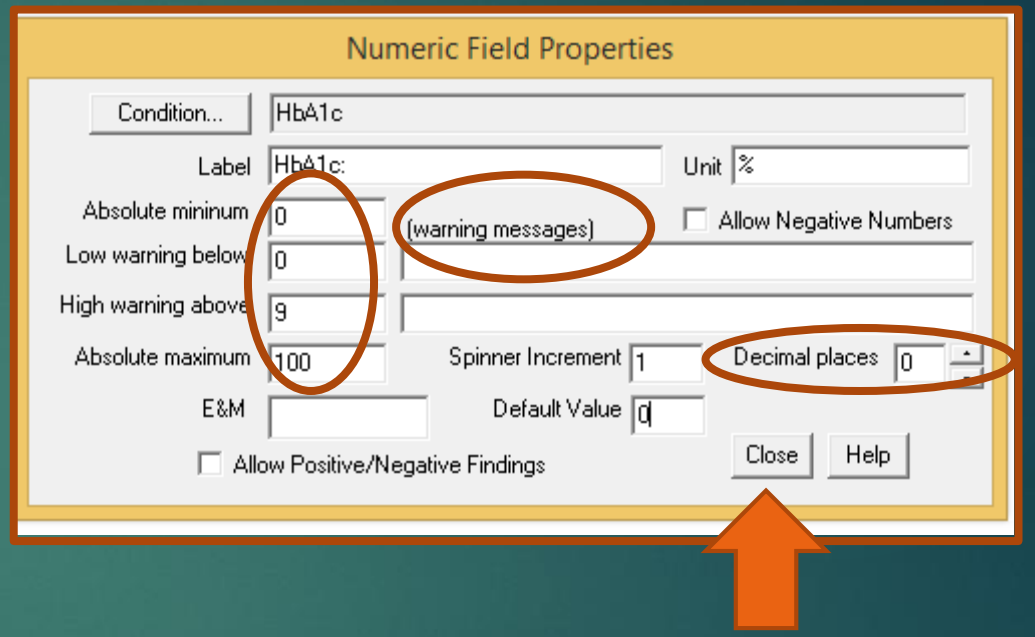


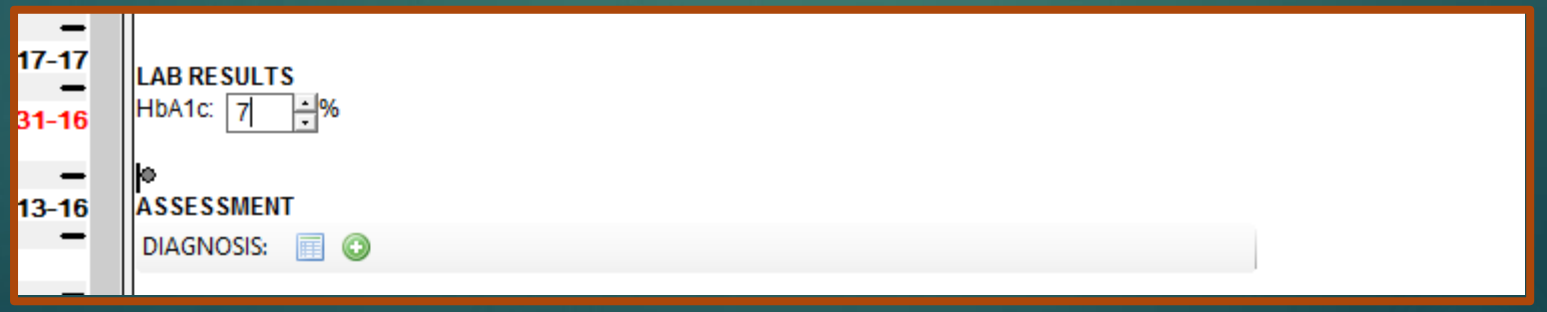


Adding LOINC Codes
Manually Entered Lab Results

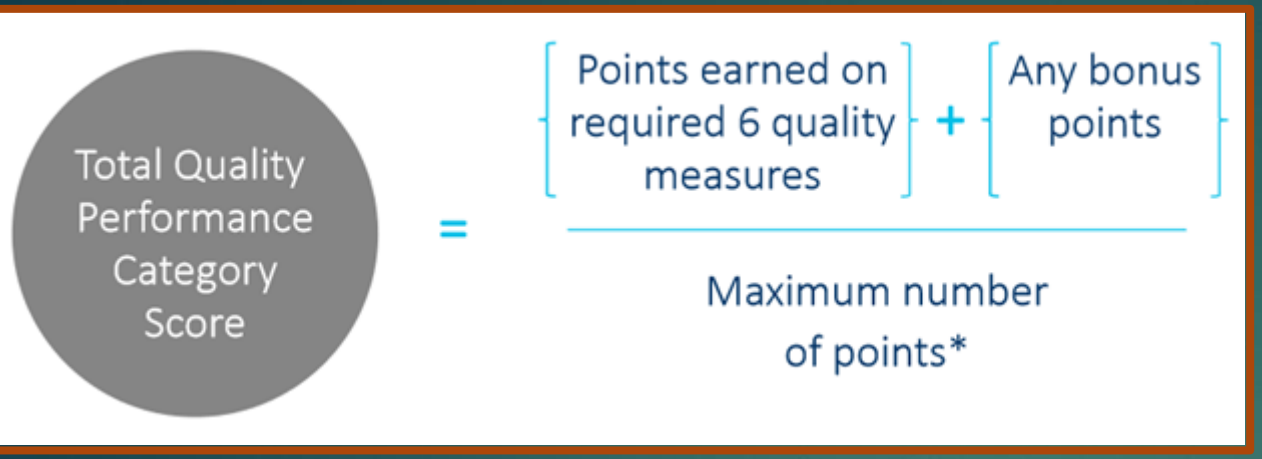
Setting the Properties of Numeric Tool







SCORING QUALITY MEASURES



*Maximum Number of Points
- 60 points – Without the "All-cause Readmission Measure"
- 70 points – With the "All-cause Readmission Measure"

All-cause Readmission Measure

- Will Only be score for Groups (16 or more EC) who have beneficiaries attributed to them and meet the minimum case requirement.
- The 30-day All-cause Hospital Readmission measure is risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized at a short-stay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge.
- Does NOT Require Data Submission – Administrative Claims

ECs will automatically receive 3 points for completing and submitting a measure(s)

If a measure can be reliably scored, then the EC can receive 3-10 points.
Reliable score means:

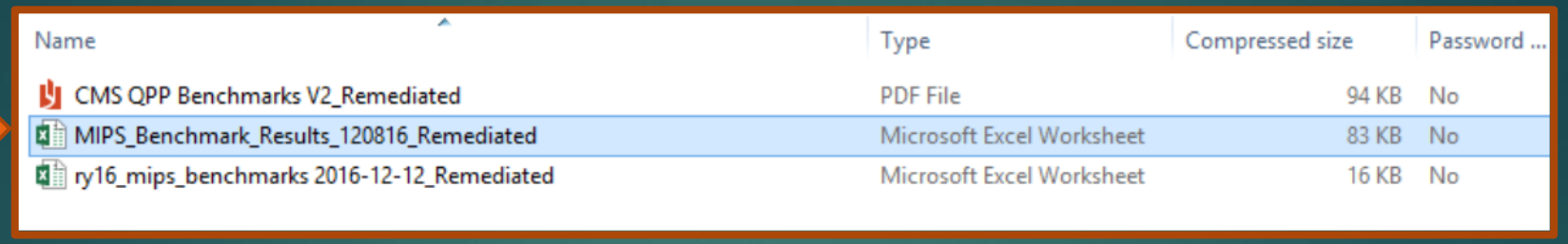
- Benchmarks exists
- Sufficient case volume (>= 20 cases (for most measures); >= 200 cases for readmission measure
- Data completeness met: Data elements were captured (Numerator) for at least 50% of the measures intended population (Denominator)
  - Claims: 50% of Medicare Part B patients for the performance period
  - QCDR, QR, EHR: 50% of patients across all-payers, including 1 Medicare patient, for the performance period.

Easier for a EC to participate longer (>90 days) to meet the case volume and data completeness criteria needed to receive more than 3 points

Measure without a benchmark, the EC receives 3 points.

- New Measures
- Existing Measure with substantive change for 2017 reporting

2017 Quality Benchmarks
QPP Website: Education/Tools>Documents/Downloads



Name	Type	Compressed size	Password ...
CMS QPP Benchmarks V2_Remediated	PDF File	94 KB	No
MIPS_Benchmark_Results_120816_Remediated	Microsoft Excel Worksheet	83 KB	No
ry16_mips_benchmarks 2016-12-12_Remediated	Microsoft Excel Worksheet	16 KB	No

Table 2: MIPS Benchmark Results

Measure_Name	leasur_e	bmission_Meth	Measure_Type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Diabetes: Hemoglobin A1c Poor Control	1	Claims	Outcome	Y	35.00 - 25.72	25.71 - 20.32	20.31 - 16.23	16.22 - 13.05	[illegible]	10.00 - 7.42	7.41 - 4.01	<= 4.00	No
Diabetes: Hemoglobin A1c Poor Control	1	EHR	Outcome	Y	54.67 - 35.91	35.90 - 25.63	25.62 - 19.34	19.33 - 14.1[illegible]	14.14 - 9.10	[illegible]09 - 3.34	3.33 - 0.01	0	No
Diabetes: Hemoglobin A1c Poor Control	1	Registry/QCDR	Outcome	Y	83.10 - 68.19	68.18 - 53.14	53.13 - 40.66	40.65 - 30.[illegible]	30.19 - 22.74	22.73 - 16.82	16.81 - 10.33	<= 10.32	No

*

This Decile Scale is for Non-Inverse Quality Measures to estimate possible points.

Decile	Number of Points Assigned for the 2017 MIPS Performance Period
Below Decile 3	3 points
Decile 3	3-3.9 points
Decile 4	4-4.9 points
Decile 5	5-5.9 points
Decile 6	6-6.9 points
Decile 7	7-7.9 points
Decile 8	8-8.9 points
Decile 9	9-9.9 points
Decile 10	10 points

*For Inverse Measures, the order would be reversed.
Decile #10 = 3 points

Quality Scoring: Basics





Quality Performance Category Score

60% is applied to the EC's Composite Score

STI's MIPS Assistance Program

The coaches are working with the practices to:

- Educate them on the program and it's details
- Quality measures
  - Help them select the 6 measures & Configure the measures
  - Train them on how to document them in Clinical
- Advancing Care Information
  - Make decisions about what measures they will comply with
  - Make any necessary changes in Clinical accordingly
- Clinical Practice Improvement Activities
  - Review the options & Help them select CPIAs
  - Make changes in system to support CPIA as necessary
- Quality Registry Portal
  - Get them access to the portal
  - Familiarize them with the portal functionality
  - Show them how to review and make any corrections to the data
- Touch-base calls during the year to answer questions & assess your progress
- Assist with MIPS Attestation

STI MIPS Assistance Program

The cost of the MIPS Assistance Program is $3750 for the 1st provider in the practice and $1875 for each additional provider.

http://sticomputer.com/mips-enrollment

STI Quality Registry

The cost for the Quality Registry is $590 per provider, per year.
But it's free for **MIPS Assistance Program clients.**

Additional Help!

- Call QPP Service Center:

  1-866-288-8292

  Available: Monday – Friday 8am-8pm
- Send Questions:

  QPP@CMS.hhs.gov