Documentation Tips for Quality Measures

Electronic health records (EHRs) collect and organize notes, medication lists, and patient information using various formats. With providers also documenting this information in unique ways, this can potentially cause confusion and an increased timeline for measure mapping with DataDerm. This tip sheet can help you manage reporting requirements for performance measures and streamline standard documentation practices to allow seamless data pull into DataDerm.

The DataDerm team will work with you to connect DataDerm with your EHR to extract data. To make that as smooth as possible, it helps to document key elements of patient care. DataDerm cannot read scanned images of any kind, including scanned images for labs, letters to physicians, pathology reports, follow-up plans, and dates. If you have scanned images with information needed for your measures, please add a note in your chart with the date and required patient information for this data to be accurately collected.

MIPS 130- Documentation of Current Medications in the Medical Record

For all patients 18 and older, document clear language that states:

- Current medication correctly documented in the medical record
  - Include a check box or note that the patient’s medications have been reviewed and updated, obtained, or documented.
    - List ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements
    - Medication name, dosage, frequency and route of administration must be included on the medication list
- Date the medication list was reviewed with patient
- If medication list is not reviewed with patient, include if applicable:
  - Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status

Additional Tips:

- Collect for each denominator eligible visit during the performance period.
- See measures specifications for all applicable CPT or HCPCS codes of eligible or ineligible cases.
MIPS 131 - Pain Assessment and Follow-Up

For all patients 18 and older, document the following in your notes:

- Pain assessed using standardized tools – document the assessment scale name, date provided, and results/score
  - Brief Pain Inventory (BPI)
  - Faces Pain Scale (FPS)
  - McGill Pain Questionnaire (MPQ)
  - Multidimensional Pain Inventory (MPI)
  - Neuropathic Pain Scale (NPS)
  - Numeric Rating Scale (NRS)
  - Oswestry Disability Index (ODI)
  - Roland Morris Disability Questionnaire (RMDQ)
  - Verbal Descriptor Scale (VDS)
  - Verbal Numeric Rating Scale (VNRS)
  - Visual Analog Scale (VAS)
  - Patient-Reported Outcomes Measurement Information System (PROMIS)

- Follow-up plan documented for a positive pain assessment
  - Date of follow-up appointment
  - Referral to another provider
  - Notification to other care providers as applicable
  - Statement that initial treatment plan is still in effect
  - Statement that follow-up plan includes a pharmacologic, behavioral, physical medicine, and/or educational intervention

- Pain assessment using standardized tool did not occur, include if applicable:
  - Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others
  - 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

Additional Tips:

- Collect for each denominator eligible visit during the performance period.
- See measure specifications for all applicable CPT or HCPCS codes and telehealth modifiers that make cases eligible or ineligible.
- Go to the DataDerm dashboard “Resources” tab. Click “Tools” for resources on picking the best assessment tool for your workflow.

MIPS 137 - Melanoma: Continuity of Care – Recall System

For all patients, document the following in your notes:

- Current diagnosis of melanoma or a history of melanoma
  - ICD-10 code for diagnosis of melanoma
  - CPT code for patient encounter during reporting period

- Target/scheduled date for the next complete physical exam
  - Enter patient in the melanoma recall system with date of next appointment
Process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment
  - patient identifier,
  - patient contact information,
  - cancer diagnosis(es),
  - date(s) of initial diagnosis, and
  - target date for next exam

If not entering patient into recall system, include if applicable:
  - Patient’s melanoma is monitored by another physician provider

Additional Tips:
  - Collect *once per reporting period* for patients seen during the performance period.
  - See measure specifications for all applicable CPT and ICD-10 codes and telehealth modifiers that make cases eligible or ineligible.
  - Document the date of scheduled exam that patient missed.
  - Document follow-up note regarding communication with patients that missed their appointment or are unscheduled for a follow-up appointment.

**MIPS 138- Melanoma: Coordination of Care**

For all patients, document the following in your notes:
  - New melanoma diagnosis
    - ICD-10 code for diagnosis of melanoma,
    - CPT code for patient encounter for outpatient setting or excision of malignant melanoma
  - Treatment plan documented
    - diagnosis,
    - tumor thickness, and
    - plan for surgery or alternative care
  - Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis
    - date the communication with the provider(s) was completed; and
    - how communicated (verbally, by letter, copy of treatment plan sent)
  - If treatment plan is not communicated with the provider(s), include if applicable:
    - Patient does not have primary care/referring physician or if self-referred patient
    - Patient requests plan not be communicated to primary care/referring physician

Additional Tips:
  - Collect *every patient visit* when the patient is diagnosed with a new occurrence of melanoma during an excision of malignant lesion or evaluated in an outpatient setting during the performance period ending November 30th.
  - See measure specifications for all applicable CPT and ICD-10 codes and telehealth modifiers that make cases eligible or ineligible.
### MIPS 224- Melanoma: Overutilization of Imaging Studies in Melanoma

For all patients, document the following in your notes:

- **Current melanoma diagnosis stage 0 through IIC**
  - ICD-10 code for diagnosis of melanoma,
  - CPT code for patient encounter during performance period, and
  - Code G8944 - AJCC Melanoma Cancer Stage 0 through IIC Melanoma

- **History of melanoma of any stage**
  - ICD-10 code Z85.820 for history of melanoma and
  - CPT code for patient encounter during performance period

- **No signs or symptoms of spread**
  - Code G8749 for absence of signs of melanoma (cough, dyspnea, tenderness, localized neurologic signs such as weakness, jaundice, or any other sign suggesting systemic spread) or absence of symptoms of melanoma (pain, paresthesia, or any other symptom suggesting the possibility of systemic spread of melanoma)

- **No diagnostic imaging studies ordered**

Diagnostic imaging studies order, include if applicable:

- Patient has co-morbid condition that warrants imaging, other medical reasons
- Imaging is a requirement for clinical trial enrollment or ordered by another provider

**Additional Tips:**

- Collect **once per performance period** for patients seen for an office visit during the performance period.
- See measure specifications for all applicable CPT and ICD-10 codes, and telehealth modifiers that make cases eligible or ineligible.

### MIPS 265- Biopsy Follow-Up

For all patients, document clear language that states:

- Biopsy results were reviewed with the patient
- Biopsy results communicated to the primary care/referring physician
- All communication is in a biopsy tracking log and patient medical record
- Documented reason patient’s biopsy results were not reviewed, include if applicable:
  - Patient does not have primary care/referring physician or if self-referred patient
  - Patient requests biopsy results not be communicated to primary care/referring physician

**Additional Tips:**

- Collect **once per performance period** for patients seen for an office visit and have a biopsy performed during the performance period.
- Biopsying physician must track communication in a log. Components of a tracking log include:
  - initials of physician performing biopsy
  - patient name
MIPS 337- Tuberculosis (TB) Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier

For all patients, document the following in your notes:
- Current diagnosis of psoriasis, psoriatic arthritis, or rheumatoid arthritis
  - ICD-10 diagnosis codes; and
  - CPT or HCPCS codes for the patient encounter during measurement period
- Code G9506 - Biologic immune response modifier prescribed
  - List name of biologic (see medication list) and/or identify biologics prescribed for treatment of psoriasis, psoriatic arthritis, or rheumatoid arthritis
  - Provider name that ordered the biologic in notes or state that biologics were ordered by another provider
- Document proof of tuberculosis (TB) screening test
  - Record date of TB screening test results
  - Results of TB screening test (positive or negative)
    - If positive, document that provider has managed positive TB screen with further evidence/documentation that TB is not active, confirmed via radiographic imaging (i.e. chest x-ray, CT)

Additional Tips:
- Collect once per performance period for patients seen with psoriasis and/or psoriatic arthritis or rheumatoid arthritis during the performance period.
- The provider reporting or being evaluated for the measure must see patient with eligible diagnosis AND prescribe the biologic immune response modifier.
- See measures specifications for all applicable CPT and ICD-10 codes and telehealth modifiers that make cases eligible or ineligible.

MIPS 410- Psoriasis: Clinical Response to Oral Systemic or Biologic Medications

For all patients, document the following in your notes:
- Current diagnosis of psoriasis vulgaris
  - Include the ICD-10 code L40.0 and
  - CPT or HCPCS codes for the patient encounter during measurement period
- Code G9764 - Patient is treated with an oral systemic or biologic medication for psoriasis
  - List oral systemic or biologic medication on medication list and/or identify biologics prescribed for treatment of psoriasis vulgaris
Provider name that ordered the oral systemic or biologic medication in notes or identify biologics ordered by another provider

State date the biologic or oral systemic was prescribed
- Document dates of any gap in medication use
- Document if patient had a gap of 4 weeks or more during the course of treatment

Assessment scale name, date provided, and results/score
- Physician Global Assessment (PGA)
- Body Surface Area (BSA)
- Psoriasis Area and Severity Index (PASI)
- Dermatology Life Quality Index (DLQI)

Document if applicable:
- Patient declined therapy change
- Patient has documented contraindications
- Patient has not been treated with an oral systemic or biologic for at least 6 consecutive months

Additional Tips:
- Collect once per performance period for patients seen during the performance period.
- This measure ONLY applies to patients with a diagnosis of psoriasis vulgaris (L40.0).
- See measure specifications for all applicable CPT and ICD-10 codes and telehealth modifiers that make cases eligible or ineligible are included in the measures specifications.
- Go to the DataDerm dashboard Resources" tab to get the assessment tools for this measure. Click “Tools” for resources on picking the best assessment tool for your workflow.