



2026 Quality Payment Program (QPP) Measure Specification and Measure Flow Guide for Medicare Part B Claims Measures

Utilized by Merit-based Incentive Payment System (MIPS) Eligible Clinicians

December 2025

Introduction

This document contains general guidance for the 2026 Measure Specifications and Measure Flows for Medicare Part B claims collection type. The individual Measure Specifications are detailed descriptions of the quality measures and are intended to be used for the purposes of reporting the measures. In addition, each quality Measure Specification includes a Measure Flow and associated measure calculation algorithm as a resource. This information assists users with understanding quality measure logic related to data completeness and measure performance. The Measure Flow shouldn't be used as a substitute for the quality Measure Specification, but used as an additional visual resource.

Collection Types

Medicare Part B claims collection type utilizes unique specifications that are specific for collecting and submitting quality data via Medicare Part B claims. Measure data are reported on Medicare Part B claims when they're submitted for reimbursement. (Medicare Part B claims measures can only be reported by solo practitioners and small practices (15 or fewer clinicians)). Data are only reported for Medicare patients. The following are the other collection types available for meeting the reporting requirements for the quality performance category. These specifications are located on the QPP Resource Library. Other collection types will use different submission methods as outlined below.

- [MIPS Clinical Quality Measures \(CQMs\)](#): Utilize unique specifications that may be collected by individual MIPS eligible clinicians, groups, virtual groups, subgroups, or APM Entities in preparation for submission to CMS. MIPS CQM data may be gathered from paper, electronic charts, or collected with the assistance of a third party intermediary. Data are collected for all patients that qualify for the measure, not just Medicare patients.
- [Electronic Clinical Quality Measures \(eCQMs\)](#): Utilize unique specifications that are specific for collecting and submitting quality data via electronic health records (EHRs). Measure data are collected at the point of care in electronic health record technology that's been certified by the Office of the National Coordinator for Health Information Technology (ONC). Data are collected for all patients that qualify for the measure, not just Medicare patients.
- [Medicare Clinical Quality Measures \(Medicare CQMs\)](#): Utilize unique specifications that are specific for collecting quality data (only available for Medicare Shared Savings Program Accountable Care Organizations).
- [Qualified Clinical Data Registry \(QCDR\) Measures](#): QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures. Data are collected in a manner specified by the QCDR for all patients that qualify for the measure, not just Medicare patients.
- [Consumer Assessment of Healthcare Providers and Systems \(CAHPS\) for MIPS Survey Measure](#): Assess patients' experiences of care and must be administered by a CMS-approved survey vendor. Advance registration is required.
- [Administrative Claims Measures](#): Automatically assess performance (conducted by CMS) based on Medicare claims and automatically scored if measure requirements are met. Data are only collected for Medicare patients.

Medicare Part B Claims Quality Measure Specifications

Each quality measure is assigned a unique number. Measure numbers represent a continuation in numbering since the inception of MIPS (2017 through the 2026 performance period). Measure stewards provided revisions to the measures that were finalized in the Calendar Year (CY) 2026 Physician Fee Schedule (PFS) final rule. The measures use standard formatting across the inventory to support clarity and consistency.

Instructions

This component of the Measure Specification breaks down important characteristics of each measure into subcomponents that guide measure implementation and reporting. This ensures that important content is visible and clearly labeled supporting consistent reporting across submissions.

Reporting Frequency (Subcomponent)

This section identifies the reporting frequency for each measure indicating how often the measure should be reported for each denominator eligible instance. This may be, but is not limited to, 'once per performance period', 'each procedure', 'each episode', or 'once per [specified timeframe]'.

Intent and Clinician Applicability (Subcomponent)

Each measure outlines specific criteria that assesses a key aspect of health care. This intent will be included here to add clarity of measure purpose and better define applicability of the measure to MIPS eligible clinician specialties and/or scopes of care.

Measure Strata and Performance Rates (Subcomponent)

Measures that contain more than one stratum (i.e., subpopulation defined by submission criteria) may be reported with individual performance rates for each stratum or a single, combined rate. However, each Measure Specification has their own requirements; this section will outline the structure and submission requirements for the measure. Additionally, sample calculations within the Measure Flow detail how data completeness and performance are determined for measures with multiple submission criteria and/or performance rates.

Implementation Considerations (Subcomponent)

This subcomponent aggregates guidance for measure implementation. While certain aspects may be reiterated within the denominator and/or numerator sections of the Measure Specification, this location allows for visibility and cohesiveness of the information. Every Measure Specification will include the submission frequency tag here, as a standard, as well as within the Measure Flow.

MIPS Submission Frequency with Definitions

Each individual MIPS eligible clinician participating in MIPS should submit data for the 2026 performance period according to the submission frequency defined for the measure. The following are definitions for submitting frequencies that are used for the calculations of the individual measures:

- **Patient-Intermediate** measures are submitted a minimum of once per patient during the performance period. The most recent quality data code (QDC) will be used, if the measure is submitted more than once.
- **Patient-Process** measures are submitted a minimum of once per patient during the performance period. The most advantageous QDC will be used if the measure is submitted more than once.
- **Patient-Periodic** measures are submitted a minimum of once per patient per timeframe specified by the measure during the performance period. The most advantageous QDC will be used if the measure is submitted more than once. If more than one quality data code is submitted during the episode time period, performance rates shall be calculated by the most advantageous QDC.
- **Episode** measures are submitted once for each occurrence of a particular illness or condition during the performance period.
- **Procedure** measures are submitted each time a procedure is performed during the performance period.
- **Visit** measures are submitted each time a patient has a denominator eligible encounter during the performance period.

Telehealth (Subcomponent)

This subcomponent of the Measure Specification provides information on whether or not a measure is telehealth eligible and how to report telehealth visits. Decisions for the inclusion or exclusion of the telehealth setting are at the measure level, or by submission criteria for multi-strata measures, and as such are not further outlined at the encounter/procedure code level.

Measure Submission (Subcomponent)

This subcomponent contains standardized language to address measure submission based upon collection type.

Denominator and Numerator

Quality measures consist of a numerator and denominator that are used to calculate data completeness and performance for a defined patient population. These calculations indicate either achievement of a particular process of care being provided, or a clinical outcome being attained. The denominator is the lower part of a fraction used to calculate a rate, proportion, or ratio and represents the population defined for the measure. The numerator is the upper portion of a fraction used to calculate a rate, proportion, or ratio and represents a subset of the denominator population. The numerator represents the target quality actions defined within the measure. It may be a process, condition, event, or outcome. Numerator criteria are the measure defined quality actions expected for each patient, procedure, or other unit of measurement defined in the denominator.

Performance Period

Each Measure Specification includes information on the performance period and/or measurement period used to capture the intended numerator and denominator. In general, the performance period for the measure refers to the calendar year of January 1 to December 31. However, a measure may have a different timeframe for determining the measure's intended eligible population and/or the quality action as defined within the Measure Specification. For example, the Measure Specification for Quality #039: Screening for Osteoporosis for Women Aged 65-85 Years of Age allows the assessment for the numerator's quality action any time prior to the denominator eligible encounter.

Denominator (Eligible Cases)

The denominator population is specified in the measure and submitted by individual MIPS eligible clinicians. The denominator population may be defined by the following criteria, and their specifications may be found on the [QPP Resource Library](#).

- Demographic information.
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis.
- International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) procedure.
- Current Procedural Terminology (CPT) code.
- Healthcare Common Procedure Coding System (HCPCS) code.

These denominator criteria are specified in the Measure Specification and submitted by individual MIPS eligible clinicians as part of a claim for covered services under the Medicare Part B Physician Fee Schedule (PFS) for Medicare Part B claims collection type.

If the specified denominator criteria for a measure is not applicable to the patient's claim (for the same date of service) as submitted by the individual MIPS eligible clinician, then the patient does not fall into the measure's eligible denominator and the measure does not apply to the patient. With measure steward guidance, some Measure Specifications are revised annually for implementation in MIPS to ensure that the measures represent the most current clinical concepts and have analytical integrity. For example, CPT codes for non-covered services such as preventive visits may be included in the denominator but would not apply to the measure since only covered services can be analyzed via claims data.

Measure Specifications include instructions regarding CPT Category I modifiers, place of service codes (POS), and other detailed information. Each MIPS eligible clinician should carefully review the measure's denominator criteria to determine whether submitted data meets denominator inclusion criteria.

Denominator exclusions describe a circumstance where the patient should be removed from the denominator. Measure Specifications define denominator exclusion(s) in which a patient shouldn't be included in the intended population for the measure even if other denominator criteria are applicable. The QDCs, or equivalent codes using other coding systems (e.g., SNOMED, DRG, codes used by individual EHR systems), are available to describe denominator exclusions and are provided within the Measure Specifications. QDCs are HCPCS and

CPT Category II codes (or other equivalent codes) describing clinical concepts or outcomes that assist with determining the intended population for the measure. Patients that meet the intent of the denominator exclusion do not need to be included for data completeness or in the performance rate of the measure.

Numerator Quality Data Codes

If the patient falls into the denominator eligible population, the applicable QDCs defining the appropriate numerator option should be submitted for data completeness of quality data for Medicare Part B claims submissions. QDCs found in the Numerator section of the Measure Specification are HCPCS and CPT Category II codes that describe the quality action that assist with determining the the numerator outcome.

Performance Met:

If the intended quality action for the measure is performed for the patient, QDCs are available to describe that performance has been met and should be submitted on the claim.

Denominator Exception:

When a patient falls into the denominator eligible population, but the Measure Specification defines circumstances in which a patient may be deemed as not appropriate for the numerator's quality action, they will be reported as a denominator exception. QDCs such as CPT Category II codes with modifiers such as 1P, 2P, and 3P, are referenced in the Measure Specification to describe medical, patient, or system reasons for denominator exceptions and must be submitted on the claim. A denominator exception removes a patient from the performance denominator only if the numerator compliant option isn't met and the criteria defined by the exception are met. This allows for the exercise of clinical judgment by the MIPS eligible clinician or consideration of system limitations.

Performance Not Met:

When the denominator exception doesn't apply, measure-specific QDCs, such as CPT Category II codes with or without modifier 8P, are reference in the Measure Specification to indicate that the quality action wasn't provided for a reason not otherwise specified and must be submitted on the Medicare Part B claim.

Inverse Measure

A lower calculated performance rate for this type of measure would indicate better clinical care or control. The "Performance Not Met" numerator option for an inverse measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.

Please note that for an inverse measure, the denominator exception would be considered if the data doesn't support the "Performance Not Met" numerator option(s). This is reflected in the ordering of the numerator options with the Measure Specification and Measure Flow.

Each Measure Specification provides detailed numerator options for submitting data for the quality action described by the measure. The numerator clinical concepts described for each measure are to be followed when submitting data to CMS.

Individual Measure Submission

For MIPS eligible clinicians submitting individually, measures (including patient-level measure[s]) may be submitted for the same patient by multiple MIPS eligible clinicians practicing under the same Tax Identification Number (TIN). If a patient sees multiple providers during the performance period, that patient can be counted for each individual National Provider Identifier (NPI) submitting if the patient meets denominator inclusion criteria. The following is an example of two NPIs billing under the same TIN who are intending to submit Quality #317: *Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented*. Clinician A sees a patient on February

2, 2026 and documents in the medical record a normal blood pressure reading with follow-up not required and submits the appropriate QDC, G8783, for Quality #317. Clinician B sees the same patient at an encounter on July 16, 2026 and documents in the medical record a normal blood pressure reading with follow-up not required. Clinician B should also submit the appropriate QDC(s), for the patient at the July encounter to meet data completeness for submission of Quality #317.

Need Assistance

If you have any questions, please contact the Quality Payment Program (QPP) Service Center by emailing QPP@cms.hhs.gov, by creating a [QPP Service Center ticket](#), or by calling 1-866-288-8292 (Monday – Friday, 8 a.m. – 8 p.m. ET).

Example Medicare Part B Claims Specification

Medicare Part B Claims Measure Specification format: Each Medicare Part B Claims conforms to a standard format. The measure format includes the following fields:

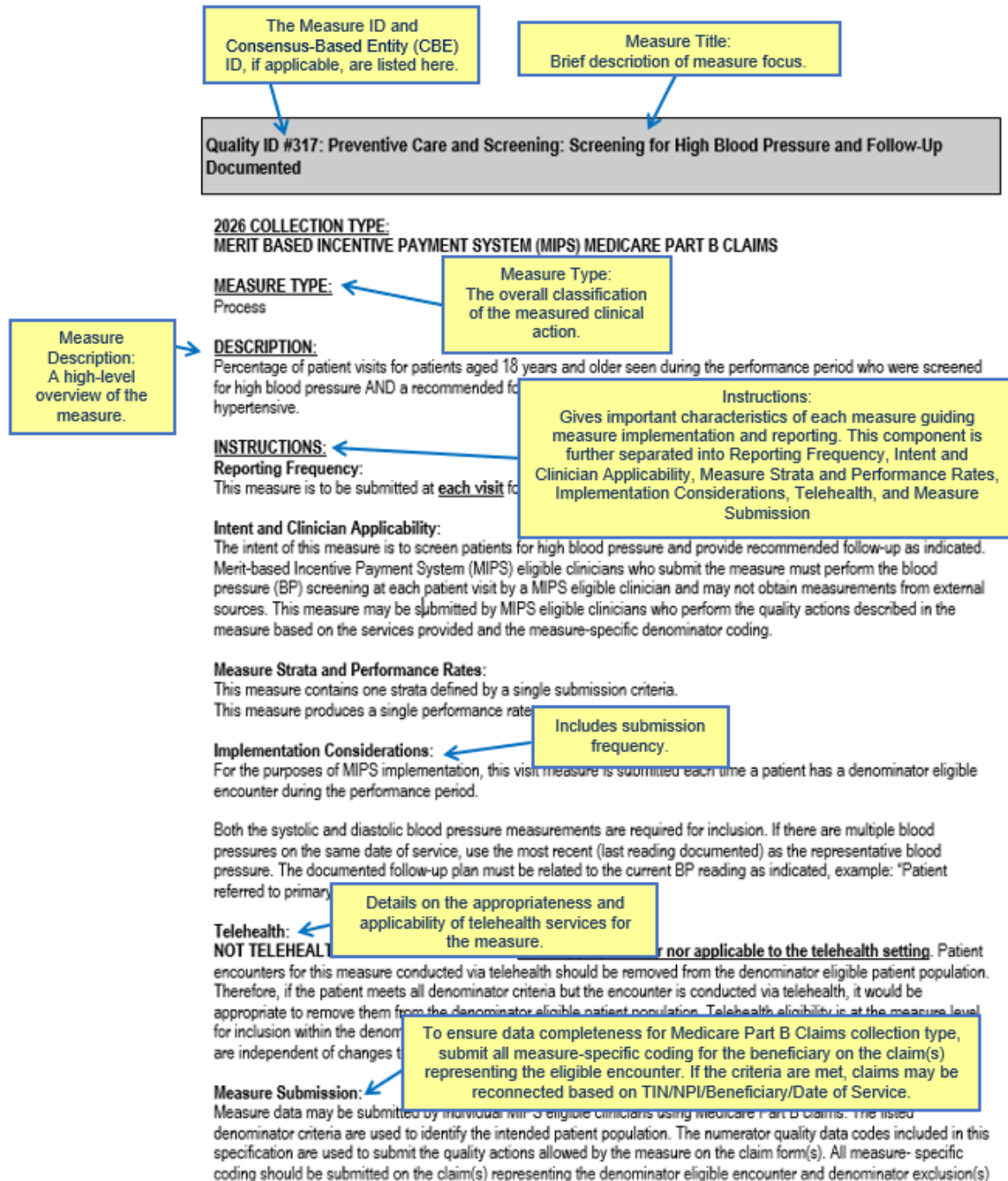
The measure header includes: Quality ID, Consensus-Based Entity (CBE) ID (if applicable), and Measure Title.

The body of the document includes the following sections:

- Collection Type
- Measure Type
- Measure Description
- Instructions which are further separated to guide reporting for the purposes of MIPS including Reporting Frequency, Intent and Clinical Applicability, Measure Strata and Performance Rates, Implementation Considerations, Telehealth, and Measure Submission
- Denominator Statement, Criteria, Exclusion(s), Exception(s), Instructions, Notes, and Definition(s) of terms where applicable
- Numerator Statement, Options (Performance Met, Denominator Exception, Performance Not Met); Instructions, Notes, and Definition(s) of terms where applicable
- Rationale
- Clinical Recommendations Statement(s)

The Rationale and Clinical Recommendation Statement sections provide limited clinical guidelines and references supporting the quality actions described in the measure. Please contact the Measure Steward for section references and further information regarding the clinical rationale and recommendations for the described quality action. Measure Steward contact information is located on the “Measure Steward Contacts” tab of the 2026 MIPS Quality Measures List, which can be found on [MIPS Explore Measures](#) webpage (select Performance Year 2026).

Example Medicare Part B Claims Measure Specification:



- Dietary Sodium Restriction
- Increased Physical Activity
- Moderation in alcohol consumption

Recommended Blood Pressure Follow-Up Table

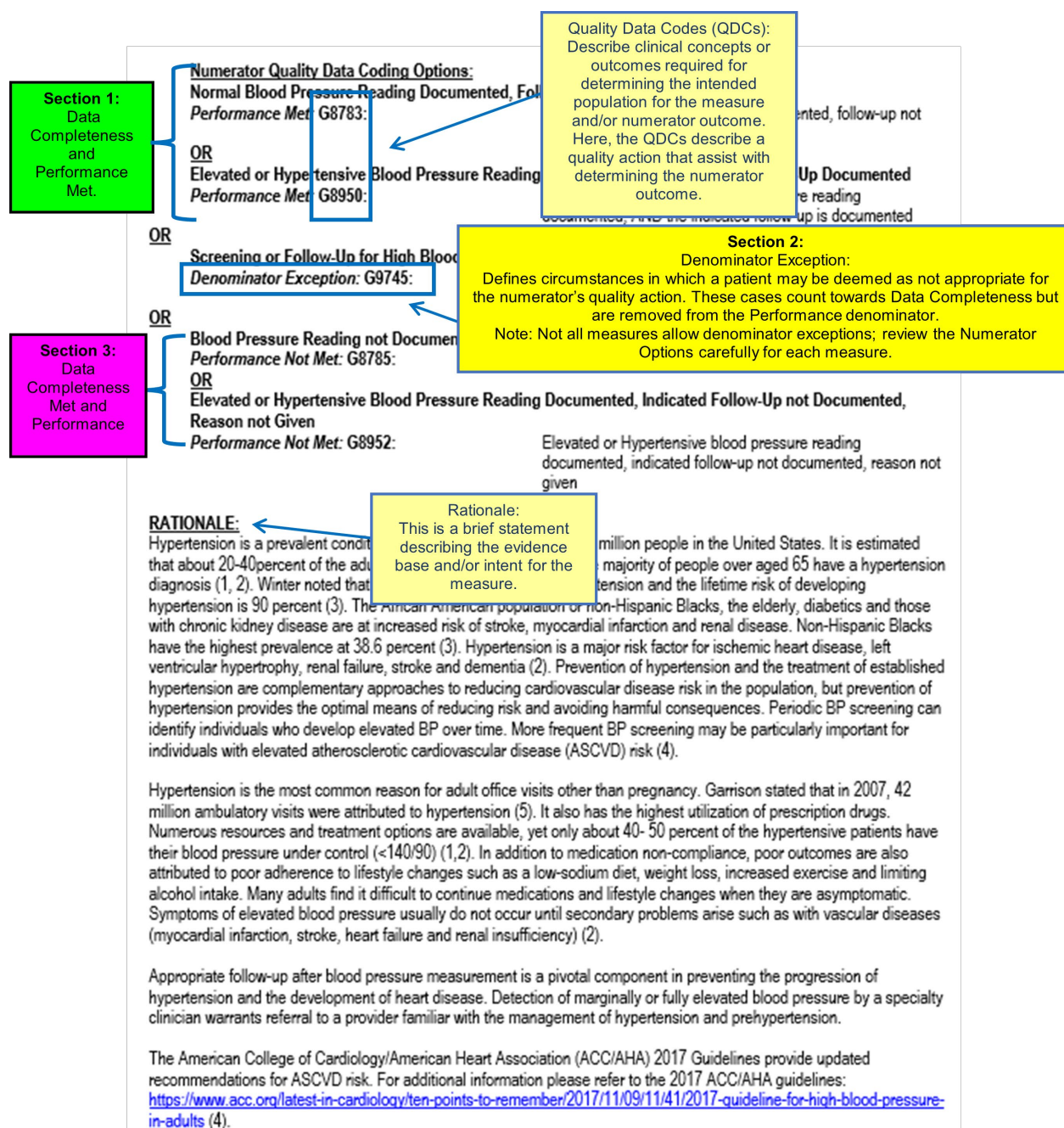
BP Classification	Systolic Blood Pressure (mmHg)	Diastolic Blood Pressure (mmHg)	Recommended Follow-Up Actions for each BP
Normal BP Reading	< 120		
Elevated BP Reading	120 - 129	AND < 80	Rescreen BP within 6 months AND recommended nonpharmacologic interventions OR Referral to Alternate/Primary Care Provider
First Hypertensive BP Reading	> = 130	OR > = 80	Rescreen BP within 4 weeks AND recommended nonpharmacologic interventions OR Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	130-139 and NOT > = 140	OR 80-89 and NOT > = 90	Recommended nonpharmacologic intervention AND reassessment within 6 months AND an order for laboratory test or ECG for hypertension OR Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	> = 140	OR > = 90	Recommended nonpharmacologic intervention AND BP-lowering medication AND reassessment within 4 weeks AND an order for laboratory test or ECG for hypertension OR Referral to Alternate/Primary Care Provider

Patients with a Documented Reason for not Screening or no Follow-Up Plan for High Blood Pressure (Denominator Exception) –

- Documentation of medical reason(s) for not screening for high blood pressure (e.g., 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).
- Documentation of patient reason(s) for not screening for blood pressure measurements or for not ordering an appropriate follow-up intervention if patient BP is elevated or hypertensive (e.g., patient refuses).

NUMERATOR NOTE:

Although the recommended screening interval for a normal BP reading is every year, to meet the intent of this measure, BP screening and follow-up must be performed at every patient visit. For patients with Normal blood pressure, a follow-up plan is not required (G8783). Denominator Exception(s) are determined on the date of the denominator eligible encounter.



Lifestyle modifications have demonstrated effectiveness in lowering blood pressure (6). The synergistic effect of several lifestyle modifications results in greater benefits than a single modification alone. Baseline diagnostic/laboratory testing establishes if a co-existing underlying condition is the etiology of hypertension and evaluates if end organ damage from hypertension has already occurred. Landmark trials such as the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) have repeatedly proven the efficacy of pharmacologic therapy to control blood pressure and reduce the complications of hypertension. A review of 35 studies found that the pharmacist-led interventions involved medication counseling and patient education. Twenty-nine of these studies showed a statistically significant improvement in BP levels of the intervention groups at follow-up (7). Follow-up studies have been established by the 2017 ACC/AHA guideline and the United States Preventive Services Task Force (USPSTF).

Clinical Recommendation Statements:
This is a summary of the clinical recommendations based on best practices, guidelines, etc.

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults aged 18 years and older. This is a Class A recommendation.

Reference:

These are sources cited in the Rationale and Clinical Recommendation Statements.

REFERENCE:

1. Appleton, S. L., Neo, S. H., & Hoo, C. (2012). Untreated hypertension: prevalence and patient factors and beliefs associated with under-treatment in a population sample. *Journal of Human Hypertension*, 27, 453-462. doi:10.1038/jhh.2012.62
2. Luehr, D., Woolley, T., Burke, R., Dohmen, F., Hayes, R., Johnson, M., Schoenleber, M. (2012). Hypertension diagnosis and treatment; Institute for Clinical Systems Improvement health care guideline. Updated November, 2012
3. Winter, K. H., Tuttle, L. A. & Viera, A.J. (2013). Hypertension. *Primary Care Clinics in Office Practice*, 40, 179-194. doi:10.1016/j.pop.2012.11.008
4. Whelton, P.K., Carey, R.M., Aronow, W.S., Casey, D.E., Collins, K., Dennison Himmelfarb, C., Depalma, S.M., Gidding, S., Jamerson, K.A., Jones, D.W., MacLaughlin, E.J., Muntener, P., Ovbhaggele, B., Smith, S.C., Spencer, C.C., Stafford, R.S., Taler, S.J., Thomas, R.J., Williams, K. A., Williamson, J.D., Wright, J.T., (2018). 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Hypertension*, 71(6), e13-e115. doi.org/10.1161/HYP.0000000000000065
5. Garrison, G. M. & Oberhelman, S. (2013). Screening for hypertension annually compared with current practice. *Annals of Family Medicine*, 11 (2), 116-121. doi:10.1370/afm.1467
6. U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute & National High Blood Pressure Education Program (2003). The Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-7). NIH Publication No. 03-5233
7. Reeves, L., Robinson, K., McClelland, T., Adedoyin, C., Broeseker, A., and Adunlin, G. (2020). "Pharmacist Interventions in the Management of Blood Pressure Control and Adherence to Antihypertensive Medications: A Systematic Review of Randomized Controlled Trials." *Journal of Pharmacy Practice*. Available at <https://doi.org/10.1177/0897190020903573>. Accessed October 5, 2020
8. U.S. Preventive Services Task Force (2021). Screening for hypertension in adults. *US Preventive Services Task Force reaffirmation recommendation statement*. *Journal of the American Medical Association*, 325(16): 1650-1656.

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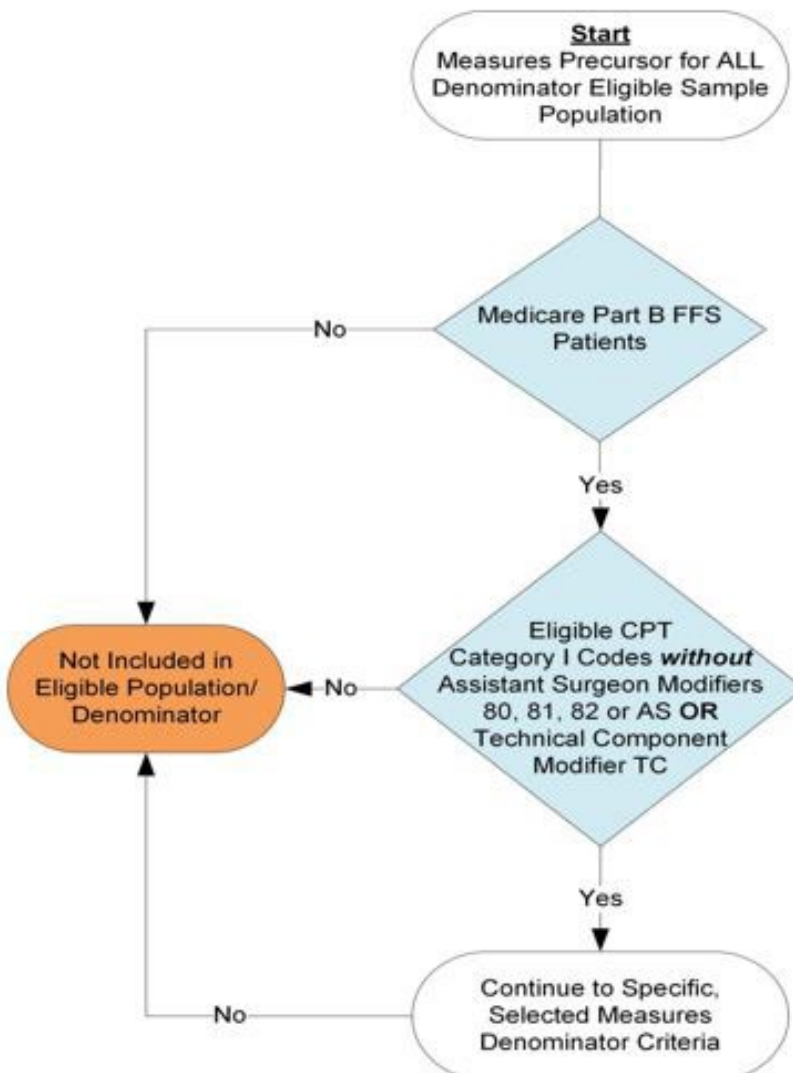
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Interpretation of Medicare Part B Claims Measure Flows

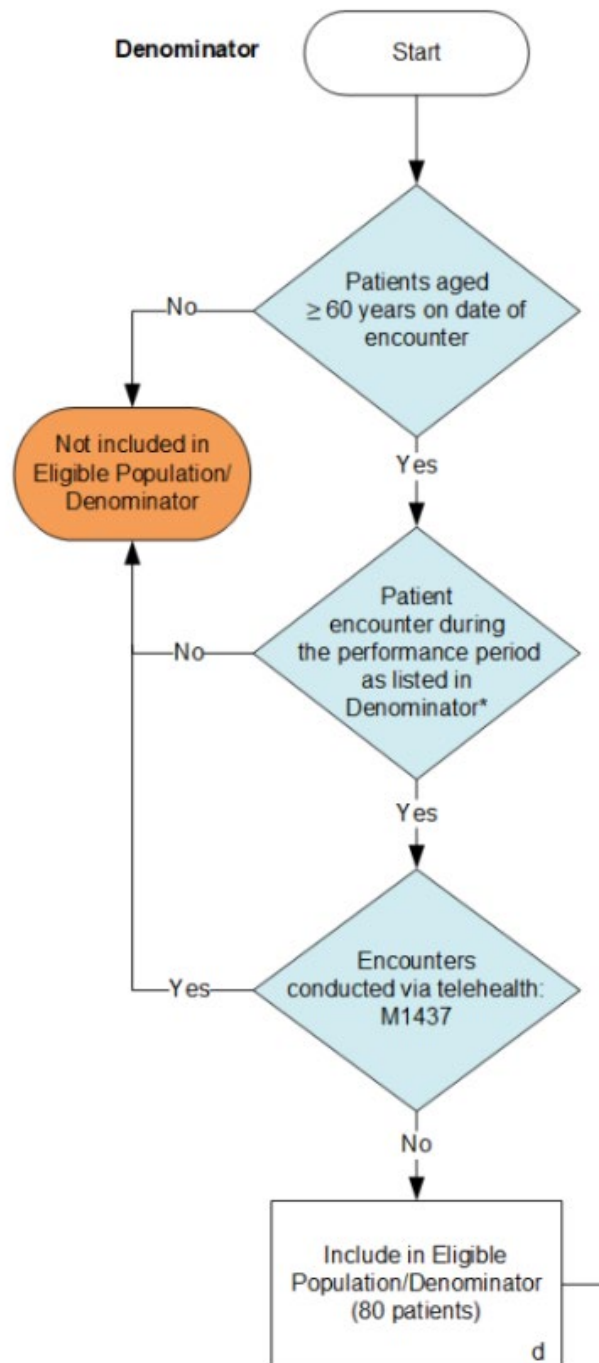
Denominator

The Medicare Part B Claims Measure Flow is designed to provide interpretation of the measure logic and calculation methodology for data completeness and performance rates. The measure flow starts with the identification of the patient population (denominator) for the applicable measure's quality action (numerator). When determining the denominator for all measures, please remember to include only Medicare Part B FFS (Fee for Service) patients and CPT I Categories **without** modifiers 80, 81, 82, AS or TC.

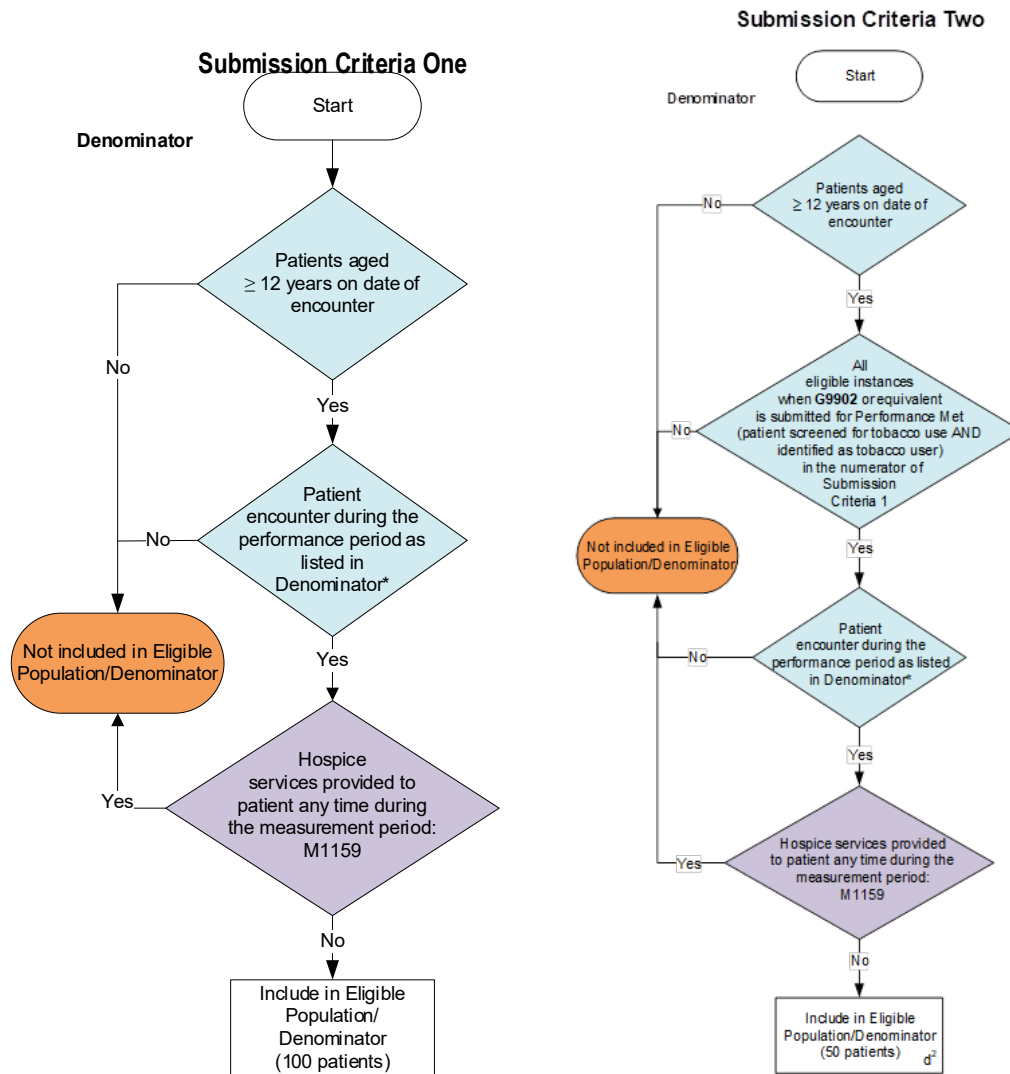
Below is an illustration of the above prerequisite denominator criteria to obtain the patient sample for all 2026 Medicare Part B Claims Measures:



The Medicare Part B Claims Measure Flow in each Measure Specification begins with the appropriate age group and denominator population for the measure. The Eligible Population box equates to the letter “d” (as shown at the bottom right corner of the last box of the denominator diagram) by the patient population that meets the measure’s inclusion requirements. Below is an example of the denominator criteria used to determine the eligible population for Quality #181: *Elder Maltreatment Screen and Follow-Up Plan*:



Some Medicare Part B Claims measures, such as Quality #226: *Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*, have multiple submission criteria to determine the measure denominator. In the example below, the Submission Criteria also represents multiple performance rates. Patients meeting the submission criteria for either denominator option are included as part of the eligible population. In some cases, denominator exclusions will be found within the denominator. Quality #226 is also an example of a measure that exhibits a denominator exclusion that is labeled and is represented by a purple diamond. Review the Instructions section of the Medicare Part B Claims Specification to determine if it contains multiple submission criteria, each of which will be fully detailed within the Denominator section.

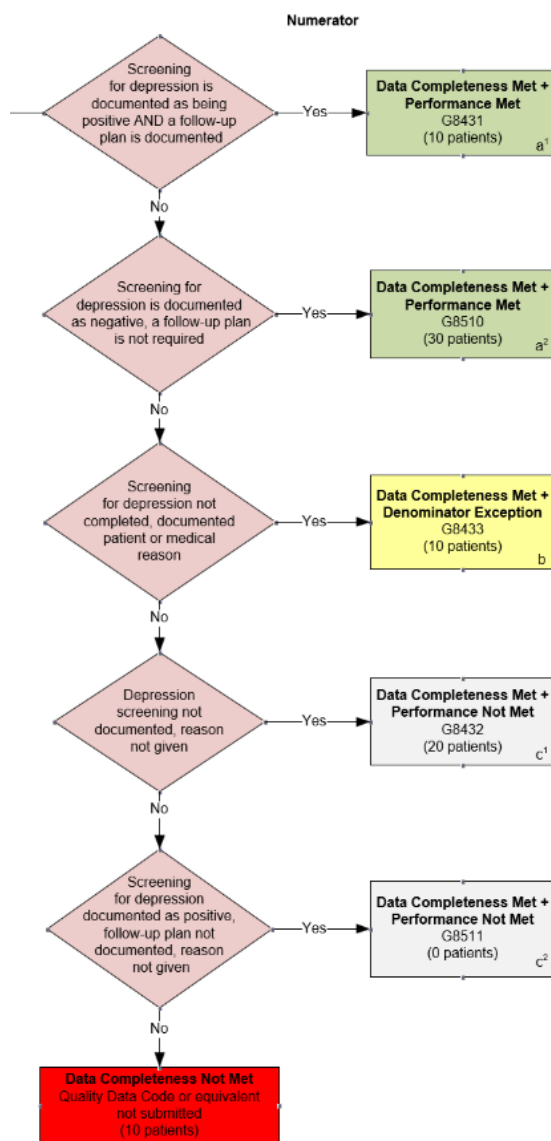


Numerator

Once the denominator is identified, the Medicare Part B Claims Measure Flow illustrates and stratifies the quality action (numerator) to assist with calculation of data completeness and performance. Depending on the measure, there are several outcomes that may be applicable for the measure's calculation. Each measure outcome is represented by a variable that is included in an algorithm. The number of patients within an outcome category will be used to populate the algorithm:

- Top two right boxes below - Performance Met = "a" and shaded green;
- Middle right box - Denominator Exception = "b" and shaded yellow;
- Bottom right boxes below - Performance Not Met = "c" and shaded gray, and
- Bottom left box - Data Completeness Not Met = red shaded box.

On the flow, these outcomes are color-coded and labeled as described to identify the particular outcome of the measure represented. This is illustrated below for Quality #134: *Preventive Care and Screening: Screening for Depression and Follow-Up Plan*:



Algorithms

Please note that a Measure Specification includes a data completeness and performance algorithm for each submission criteria and/or performance rate. Information regarding submission requirements for each measure will be found within the Measure Narrative section (separate from the Flow Narrative section) of the Measure Specification.

Data Completeness Algorithm

The Data Completeness Algorithm calculation is based on the eligible population and the volume of performance data reported as described in the Measure Flow. The Data Completeness Algorithm provides the calculation logic for patients who have been submitted in the MIPS eligible clinicians' appropriate denominator. Data completeness for a measure may include the following categories provided in the numerator: Performance Met, Denominator Exception, and Performance Not Met. Below is a sample Data Completeness Algorithm for Quality #134: *Preventive Care and Screening: Screening for Depression and Follow-Up Plan*. In the example, 80 patients met the denominator criteria for eligibility, 40 patients had the quality action performed (Performance Met), 10 patients didn't receive the quality action for a documented reason (Denominator Exception), and 20 patients were reported as not receiving the quality action (Performance Not Met).

Data Completeness =

$$\frac{\text{Performance Met (a1+a2=40)} + \text{Denominator Exception (b=10)} + \text{Performance Not Met (c1+c2=20)}}{\text{Eligible Population/Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Algorithm

The Performance Algorithm calculation is based on only those patients where data completeness was met and submitted for the measure. For those patients submitted, the numerator is then determined based on completion of the quality action as indicated by Performance Met. Patients submitting with Denominator Exclusions or Denominator Exceptions are subtracted from the performance denominator when calculating the performance rate percentage. Below is a sample Performance Algorithm that represents this calculation for Quality #134. In this scenario, the patient sample equals 70 patients where 40 of these patients had the quality action performed (Performance Met), and 10 patients were reported as meeting the Denominator Exception.

Performance Rate =

$$\frac{\text{Performance Met (a1+a2=40 patients)}}{\text{Data Completeness Numerator (70 Patients) – Denominator Exception (b=10 patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

Multiple Performance Rates

MIPS measures may contain multiple performance rates. The Instructions section of the Medicare Part B Claims measure will provide guidance if the measure is indeed a multiple performance rate measure. The Medicare Part B Claims Measure Flow for these measures includes algorithm examples to understand the different data completeness and performance rates for each statum and/or performance rate for the measure in addition to including the overall measure data completeness and performance rate used for accountability reporting in the CMS MIPS Program. The system will calculate the data completeness and performance rates for the measure based on the submission of claims data by the MIPS eligible clinician.