

Quality ID #113: Colorectal Cancer Screening

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) MEDICARE PART B CLAIMS--MIPS VALUE PATHWAY (MVP) REPORTING ONLY

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients 45-75 years of age who had appropriate screening for colorectal cancer

INSTRUCTIONS:

Reporting Frequency:

This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients 45-75 years of age who had appropriate screening for colorectal cancer. There is no diagnosis associated with this measure. Performance for this measure is not limited to the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

The intent of the exclusion for individuals age 66 and older residing in long-term care facilities, including nursing homes, is to exclude individuals who may have limited life expectancy and increased frailty where the benefit of the process may not exceed the risks. This exclusion is not intended as a clinical recommendation regarding whether the measures process is inappropriate for specific populations, instead the exclusion allows clinicians to engage in shared decision making with patients about the benefits and risks of screening when an individual has limited life expectancy.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient during the performance period. The most advantageous quality data code (QDC) will be used if the measure is submitted more than once.

This measure specification is only available for MIPS Value Pathway (MVP) reporting and is not available for traditional MIPS reporting.

Telehealth:

TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

Measure data may be submitted by individual MIPS eligible clinicians using Medicare Part B claims. The listed denominator criteria are used to identify the intended patient population. The numerator quality data codes included in this specification are used to submit the quality actions allowed by the measure on the claim form(s). All measure-specific coding should be submitted on the claim(s) representing the denominator eligible encounter and denominator exclusion(s) (as applicable) or selected numerator option. Denominator exclusions describe a circumstance where the patient should be removed from the denominator. Within Medicare Part B claims submissions, denominator exclusions identify circumstances where the patient should be removed from the performance rate calculation prior to determining which numerator outcome is appropriate. QDCs are available to describe the denominator exclusion within the Measure Specification and should be submitted on the claim.

DENOMINATOR:

Patients 45-75 years of age with a visit during the measurement period.

DENOMINATOR NOTE:

**Signifies that this CPT Category I code is a non-covered service under the Physician Fee Schedule (PFS). These non-covered services will not be counted in the denominator population for Medicare Part B claims measures.*

To assess the age for exclusions, the patient's age on the date of the encounter should be used.

Denominator Criteria (Eligible Cases):

Patients 45 to 75 years of age on date of encounter

AND

Patient encounter during the performance period (CPT or HCPCS): 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98979, 98980, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99386*, 99387*, 99421, 99422, 99423, 99457, 99396*, 99397*, 99470, G0402, G0438, G0439, G2250, G2251, G2252

AND NOT**DENOMINATOR EXCLUSIONS:**

Patient receiving Hospice Services, Patient Not Eligible

Patient was provided hospice services any time during the measurement period: G9710

OR

Patient receiving Palliative Care Services, Patient Not Eligible

Patient was provided palliative care services any time during the measurement period: G9993

OR

Colorectal Cancer Screening Not Performed for Medical Reasons

Patients with a diagnosis or past history of total colectomy or colorectal cancer: G9711

OR

Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care facility, Patient Not Eligible

Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period: G9901

OR

Patient with Frailty AND Medication for Dementia, Patient Not Eligible

Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period: G2100

OR

Patient with Frailty AND Advanced Illness, Patient Not Eligible

Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND an advanced illness diagnosis during the measurement period or the year prior to the

measurement period: G2101

Reference Coding/Medication:

Table 1: Denominator Exclusion for a **dispensed medication for dementia [G2100]** is defined by the following Dementia Medications **only**:

Description	Prescription
Cholinesterase inhibitors	Donepezil Galantamine Rivastigimine
Miscellaneous central nervous system agents	Memantine
Dementia combinations	Donepezil-memantine

Denominator Exclusion for **Frailty [G2100 and G2101]** is defined by the following coding **only**:

99504, 99509, E0100, E0105, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0163, E0165, E0167, E0168, E0170, E0171, E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290, E0291, E0292, E0293, E0294, E0295, E0296, E0297, E0301, E0302, E0303, E0304, E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0462, E0465, E0466, E0470, E0471, E0472, E0561, E0562, E1130, E1140, E1150, E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, E1296, E1297, E1298, G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000, T1001, T1002, T1003, T1004, T1005, T1019, T1020, T1021, T1022, T1030, T1031, L89.000, L89.001, L89.002, L89.003, L89.004, L89.006, L89.009, L89.010, L89.011, L89.012, L89.013, L89.014, L89.016, L89.019, L89.020, L89.021, L89.022, L89.023, L89.024, L89.026, L89.029, L89.100, L89.101, L89.102, L89.103, L89.104, L89.106, L89.109, L89.110, L89.111, L89.112, L89.113, L89.114, L89.116, L89.119, L89.120, L89.121, L89.122, L89.123, L89.124, L89.126, L89.129, L89.130, L89.131, L89.132, L89.133, L89.134, L89.136, L89.139, L89.140, L89.141, L89.142, L89.143, L89.144, L89.146, L89.149, L89.150, L89.151, L89.152, L89.153, L89.154, L89.156, L89.159, L89.200, L89.201, L89.202, L89.203, L89.204, L89.206, L89.209, L89.210, L89.211, L89.212, L89.213, L89.214, L89.216, L89.219, L89.220, L89.221, L89.222, L89.223, L89.224, L89.226, L89.229, L89.300, L89.301, L89.302, L89.303, L89.304, L89.306, L89.309, L89.310, L89.311, L89.312, L89.313, L89.314, L89.316, L89.319, L89.320, L89.321, L89.322, L89.323, L89.324, L89.326, L89.329, L89.40, L89.41, L89.42, L89.43, L89.44, L89.45, L89.46, L89.500, L89.501, L89.502, L89.503, L89.504, L89.506, L89.509, L89.510, L89.511, L89.512, L89.513, L89.514, L89.516, L89.519, L89.520, L89.521, L89.522, L89.523, L89.524, L89.526, L89.529, L89.600, L89.601, L89.602, L89.603, L89.604, L89.606, L89.609, L89.610, L89.611, L89.612, L89.613, L89.614, L89.616, L89.619, L89.620, L89.621, L89.622, L89.623, L89.624, L89.626, L89.629, L89.810, L89.811, L89.812, L89.813, L89.814, L89.816, L89.819, L89.890, L89.891, L89.892, L89.893, L89.894, L89.896, L89.899, L89.90, L89.91, L89.92, L89.93, L89.94, L89.95, L89.96, M62.50, M62.81, M62.84, R26.2, R26.89, R26.9, R29.6, R53.1, R53.81, R54, R62.7, R63.4, R63.6, R64, W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS, Y92.199, Z59.3, Z73.6, Z74.01, Z74.09, Z74.1, Z74.2, Z74.3, Z74.8, Z74.9, Z91.81, Z99.11, Z99.3, Z99.81, Z99.89

Denominator Exclusion for **Advanced Illness [G2101]** is defined by the following coding **only**:

A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02,

C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C91.00, C91.02, C92.00, C92.02, C93.00, C93.02, C93.90, C93.92, C93.Z0, C93.Z2, C94.30, C94.32, F01.50, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01.C18, F01.C2, F01.C3, F01.C4, F02.80, F02.811, F02.818, F02.82, F02.83, F02.84, F02.A0, F02.A11, F02.A18, F02.A2, F02.A3, F02.A4, F02.B0, F02.B11, F02.B18, F02.B2, F02.B3, F02.B4, F02.C0, F02.C11, F02.C18, F02.C2, F02.C3, F02.C4, F03.90, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A0, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, F04, F10.27, F10.96, F10.97, G10, G12.21, G20.A1, G20.A2, G20.B1, G20.B2, G20.C, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G35.A, G35.B0, G35.B1, G35.B2, G35.C0, G35.C1, G35.C2, G35.D, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.170, J84.178, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6

NUMERATOR:

Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period
- Computed tomography (CT) colonography during the measurement period or the four years prior to the measurement period
- Stool DNA (sDNA) with FIT test during the measurement period or the two years prior to the measurement period

Definition:

Reviewed – to meet the quality action, there must be documentation in the medical record that the clinician reviewed the colorectal screening report. The colorectal screening report may also be provided by the patient for the clinician's review during the visit and should be documented in the medical record.

Numerator Instructions:

Do not count digital rectal exam (DRE)-acquired fecal occult blood tests (FOBTs) performed in an office setting or performed on a sample collected via DRE.

Please note the measure may include screenings performed outside the age range of patients referenced in the initial population. Screenings that occur prior to the measurement period are valid to meet measure criteria.

NUMERATOR NOTE:

Patient reported procedures and diagnostic studies, when recorded in the medical record, are acceptable for meeting the numerator. While reviewing the results with the patient is not required for the purposes of reporting this measure, it is nonetheless best practice.

Numerator Quality Data Coding Options:

Colorectal Cancer Screening Performed

Performance Met: 3017F:

Colorectal cancer screening results documented and reviewed

OR

Colorectal Cancer Screening not Performed, Reason not Otherwise Specified

Append a submission modifier (8P) to CPT Category II code 3017F to submit circumstances when the action

described in the numerator is not performed and the reason is not otherwise specified.

Performance Not Met: 3017F with 8P:

Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified

RATIONALE:

Colorectal cancer represents eight percent of all new cancer cases in the United States. In 2020, there are an estimated 147,950 new cases of colorectal cancer and an estimated 53,200 deaths attributed to it. According to the National Cancer Institute, about 4.2 percent of men and women will be diagnosed with colorectal cancer at some point during their lifetimes. For most adults, older age is the most important risk factor for colorectal cancer, although being male and black are also associated with higher incidence and mortality. Colorectal cancer is most frequently diagnosed among people 65 to 74 years old (Howlader et al., 2020).

Screening can be effective for finding precancerous lesions (polyps) that could later become malignant, and for detecting early cancers that can be more easily and effectively treated. Precancerous polyps usually take about 10 to 15 years to develop into colorectal cancer, and most can be found and removed before turning into cancer. The five-year relative survival rate for people whose colorectal cancer is found in the early stage before it has spread is about 90 percent (SEER, 2022).

CLINICAL RECOMMENDATION STATEMENTS:

The U. S. Preventive Services Task Force (2021) recommends screening for colorectal cancer in adults aged 45 to 49 years. This is a Grade B recommendation (U.S. Preventive Services Task Force 2021).

The U.S. Preventive Services Task Force (2021) recommends screening for colorectal cancer in adults aged 50 to 75 years. This is a Grade A recommendation (U.S. Preventive Services Task Force, 2021).

Appropriate screenings are defined by any one of the following:

- Colonoscopy (every 10 years)
- Flexible sigmoidoscopy (every 5 years)
- Fecal occult blood test (annually)
- Stool DNA (sDNA) with FIT test (every 3 years)
- Computed tomographic colonography (every 5 years)

REFERENCES:

Howlader N, Noone AM, Krapcho M, Miller D, Brest A, Yu M, Ruhl J, Tatalovich Z, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (2020). SEER Cancer Statistics Review, 195-2017. Retrieved September 22, 2020, https://seer.cancer.gov/csr/1975_2017/

SEER. (n.d.). Cancer of the Colon and Rectum. <https://seer.cancer.gov/statfacts/html/colorect.html>

US Preventive Services Task Force, Davidson, K. W., Barry, M. J., Mangione, C. M., Cabana, M., Caughey, A. B., Davis, E. M., Donahue, K. E., Doubeni, C. A., Krist, A. H., Kubik, M., Li, L., Ogedegbe, G., Owens, D. K., Pbert, L.,

Silverstein, M., Stevermer, J., Tseng, C. W., & Wong, J. B. (2021). Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement. JAMA, 325(19), 1965–1977. <https://doi.org/10.1001/jama.2021.6238>

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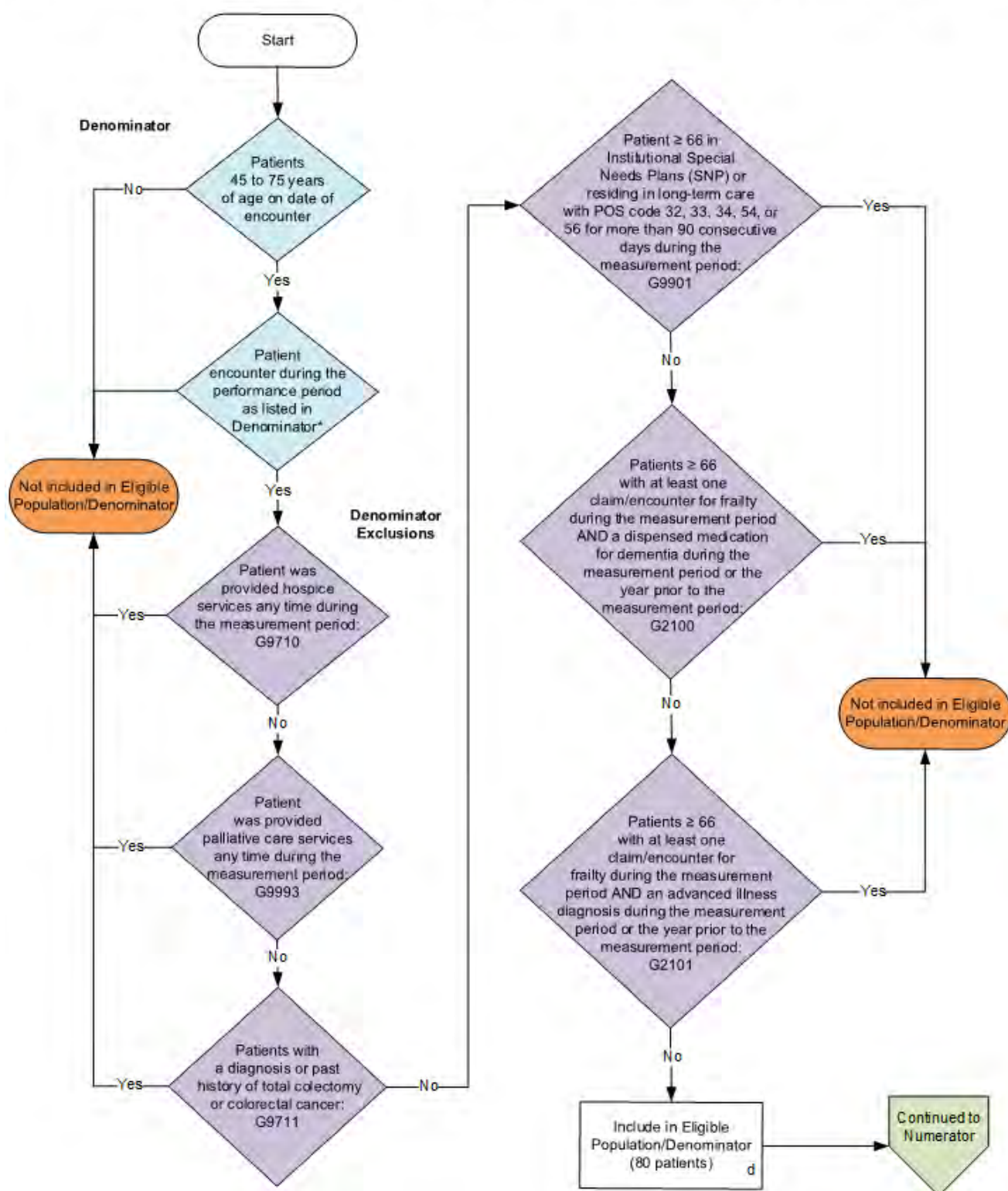
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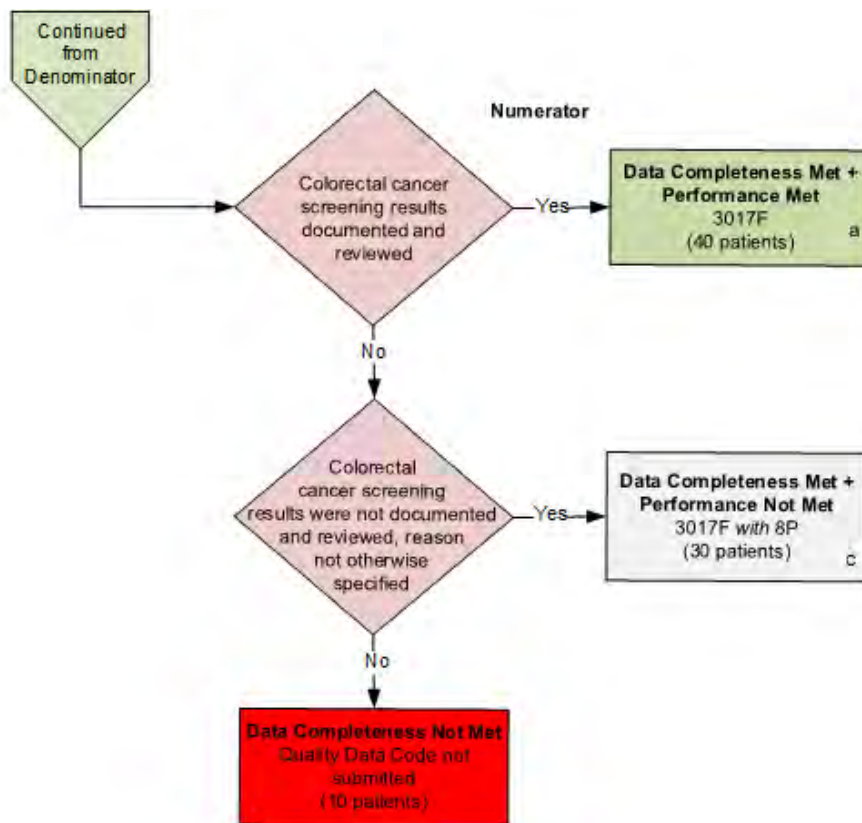
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2026 Medicare Part B Claims Measure Flow for Quality ID #113: Colorectal Cancer Screening

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.





SAMPLE CALCULATIONS

Data Completeness=

$$\frac{\text{Performance Met (a=40 patients)} + \text{Performance Not Met (c=30 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a=40 patients)}}{\text{Data Completeness Numerator (70 patients)}} = \frac{40 \text{ patients}}{70 \text{ patients}} = 57.14\%$$

* See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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v10

2026 Medicare Part B Claims Flow Narrative for Quality ID #113: Colorectal Cancer Screening

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

1. Start with Denominator
2. Check *Patients 45 to 75 years of age on date of encounter*:
 - a. If *Patients 45 to 75 years of age on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients 45 to 75 years of age on date of encounter* equals Yes during the measurement period, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
 - a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, check *Patient was provided hospice services any time during the measurement period*.
4. Check *Patient was provided hospice services any time during the measurement period*:
 - a. If *Patient was provided hospice services any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient was provided hospice services any time during the measurement period* equals No, proceed to check *Patient was provided palliative care services any time during the measurement period*.
5. Check *Patient was provided palliative care services any time during the measurement period*:
 - a. If *Patient was provided palliative care services any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient was provided palliative care services any time during the measurement period* equals No, proceed to check *Patients with a diagnosis or past history of total colectomy or colorectal cancer*.
6. Check *Patients with a diagnosis or past history of total colectomy or colorectal cancer*:
 - a. If *Patients with a diagnosis or past history of total colectomy or colorectal cancer* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients with a diagnosis or past history of total colectomy or colorectal cancer* equals No, check *Patients greater than or equal to 66 in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period*.
7. Check *Patients greater than or equal to 66 in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period*:
 - a. If *Patients greater than or equal to 66 in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days*

during the measurement period equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

- b. If Patients greater than or equal to 66 in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period equals No, proceed to check Patients greater than or equal to 66 with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.
8. Check Patients greater than or equal to 66 with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period
 - a. If Patients greater than or equal to 66 with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period equals Yes, do not include in Eligible Population/Denominator. Stop processing.
 - b. If Patients greater than or equal to 66 with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period equals No, proceed to check Patients greater than or equal to 66 with at least one claim/encounter for frailty during the measurement period AND an advanced illness diagnosis during the measurement period or the year prior to the measurement period.
9. Check Patients greater than or equal to 66 with at least one claim/encounter for frailty during the measurement period AND an advanced illness diagnosis during the measurement period or the year prior to the measurement period:
 - a. If Patients greater than or equal to 66 with at least one claim/encounter for frailty during the measurement period AND an advanced illness diagnosis during the measurement period or the year prior to the measurement period equals Yes, do not include in Eligible Population/Denominator. Stop processing.
 - b. If Patients greater than or equal to 66 with at least one claim/encounter for frailty during the measurement period AND an advanced illness diagnosis during the measurement period or the year prior to the measurement period equals No, include in Eligible Population/Denominator.
10. Denominator Population:
 - a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
11. Start Numerator
12. Check Colorectal cancer screening results documented and reviewed:
 - a. If Colorectal cancer screening results documented and reviewed equals Yes, include in Data Completeness Met and Performance Met.
 - Data Completeness Met and Performance Met letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in the Sample Calculation.

- b. If *Colorectal cancer screening results documented and reviewed* equals No, proceed to check *Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified*.
13. Check *Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified*:
- a. If *Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified* equals Yes, include in the *Data Completeness Met and Performance Not Met*.
 - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.
 - b. If *Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.
14. Check *Data Completeness Not Met*:
- a. If *Data Completeness Not Met*, the Quality Data Code was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

* See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.