



2023 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

November 2022

Introduction

This document contains general guidance for the 2023 Quality Payment Program (QPP) Individual Measure Specifications and Measure Flows for Medicare Part B claims submissions. The individual measure specifications are detailed descriptions of the quality measures and are intended to be used by individual MIPS eligible clinicians submitting individual measures via Medicare Part B claims for the 2023 QPP. In addition, each measure specification document includes a measure flow and associated algorithm as a resource for the application of logic for data completeness and performance. Please note that the measure flows were created by CMS and may or may not have been reviewed by the Measure Steward. These diagrams should not be used in place of the measure specification but may be used as an additional resource.

Collection Types

Other collection types will use different submission methods as outlined below.

- There are separate documents for the MIPS Clinical Quality Measures (CQMs) collection type.
- Measure specifications for electronic health record (EHR) based submission should be used for electronic clinical quality measures (eCQMs).
- Performance year 2022 was the final year that Web Interface (WI) measures were available for traditional MIPS reporting. However, Shared Savings Program Accountable Care Organizations reporting through the APM Performance Pathway (APP) may still report measures through WI.
- Information regarding Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician & Group Survey (CG-CAHPS) may be found at: <https://www.ahrq.gov/cahps/about-cahps/index.html>
- Beginning with performance year 2023, MIPS Value Pathways (MVP) reporting is available. Each MVP contains traditional MIPS measures. Groups electing to report via MVP should use the relevant MVP tool kits.

Medicare Part B claims Measure Specifications

Each measure is assigned a unique number. Measure numbers for 2023 QPP represent a continuation in numbering from the 2022 QPP measures. Measure stewards have provided revisions for the measures that are finalized for use in 2023 QPP.

Frequency with Definitions

Frequency labels are provided in each measure instruction as well as the measure flow. The analytical submitting frequency defines the time period or event for which the measure should be submitted. Each individual MIPS eligible clinician participating in 2023 QPP should submit during the performance period according to the frequency defined for the measure. Below are definitions of the analytical submitting frequencies that are used for 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 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 quality data code 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 quality data code 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 quality data code.
- **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 is seen by the individual MIPS eligible clinician during the performance period.

Performance Period

There are several sections (Instruction, Description, or Numerator Statement) within the measure specification that may include information on the performance period. Performance period for the measure refers to the calendar year of January 1st to December 31st. However, measures may have a different timeframe for determining if the quality action indicated within the measure was performed. This may be referenced as the measurement period.

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.

Denominator Codes (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:

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

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 codes for a measure are not included on 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 population, and the measure does not apply to the patient. Some measure specifications are adapted as needed for implementation in agreement with the measure steward. 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 specific 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 coding to determine whether codes submitted on a given claim meet denominator inclusion criteria.

Numerator Quality Data Codes

If the patient does fall into the denominator population, the applicable Quality Data Codes (QDCs) that define the numerator should be submitted for data completeness of quality data for a measure for Medicare Part B claims submissions. QDCs are HCPCS and CPT-II codes found in the measure numerator that describe clinical outcomes or quality actions (i.e., Performance Met, Performance Not Met) or assist with determining the intended population of the numerator outcome (i.e., Denominator Inclusion, Denominator Exclusion, Denominator Exception).

Denominator Exclusion:

Typically, a denominator exclusion describes 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. For Medicare Part B claims submission, these patients should be included within the data completeness calculation, but removed from the denominator of the performance rate. Please refer to the algorithm portion of this document below.

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, but the measure specifications define circumstances in which a patient may be appropriately deemed as a denominator exception. CPT Category II codes with modifiers such as 1P, 2P, and 3P, or HCPCS QDCs are available 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 criteria are not met as defined by the exception. This allows for the exercise of clinical judgment by the MIPS eligible clinician.

Performance Not Met:

When the denominator exception does not apply, a measure-specific CPT Category II code with or without modifier 8P or HCPCS QDC is used to indicate that the quality action was not 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.

Medicare Part B claims Measure Collection Type

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 encounter(s) meet denominator inclusion. The following is an example of two provider NPIs billing under the same TIN who are intending to submit Quality ID # 317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented. Provider A sees a patient on February 2, 2023 and documents in the medical record a normal blood pressure reading with follow-up not required and submits the appropriate QDC, G8783, for Quality ID # 317. Provider B sees the same patient at an encounter on July 16, 2023 and documents in the medical record a normal blood pressure reading with follow-up not required. Provider B should also submit the appropriate QDC, G8783, for the patient at the July encounter to meet data completeness for submission of Quality ID # 317.

CMS recommends review of any measures that an individual MIPS eligible clinician intends to submit. Below is an example measure specification that will assist with demonstrating data completeness for a measure. For additional assistance, please contact the Quality Payment Program Service Now help desk at **1-866-288-8292 (TRS: 711)** (Monday – Friday 8:00AM – 8:00PM Eastern Time) or email via gpp@cms.hhs.gov.

Medicare Part B claims Measure Specification Format (Refer to the Example Measure Specification Below)

Each Medicare Part B claims measure conforms to a standard format. The measure format includes the following fields.

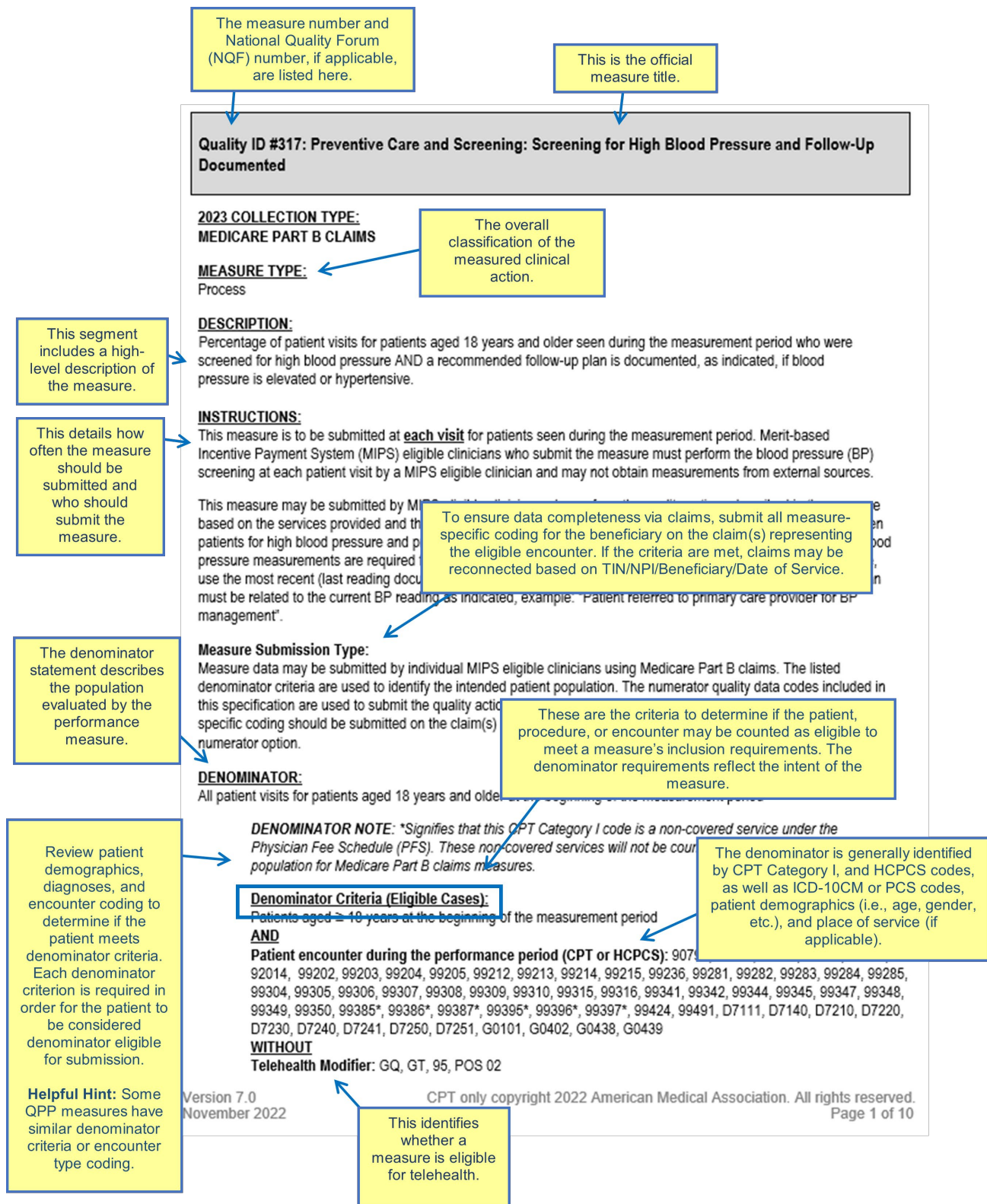
The measure header includes: Quality ID number, National Quality Forum (NQF) number (if applicable), and measure title.

The body of the document includes the following sections:

- Collection type
- Measure type
- Measure description
- Instructions on submitting including frequency, timeframes, and applicability
- Denominator statement, denominator criteria and coding
- Numerator statement and coding options (denominator exclusion, performance met, denominator exception, performance not met); definition(s) of terms where applicable
- Rationale
- Clinical recommendations statement or clinical evidence supporting the measure intent

The Rationale and Clinical recommendation statement sections provide limited clinical guidelines and supporting clinical references regarding 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 2023 MIPS Quality Measures List, which can be found on the performance year 2023 MIPS Explore Measures page:
<https://qpp.cms.gov/mips/explore-measures>.

Example Medicare Part B claims Measure Specification:



This is a clinical action counted as meeting the measure's requirements (i.e., a patient who received a particular clinical service or obtained a particular outcome that is being measured).

NUMERATOR:

Patient visits where patients were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is elevated or hypertensive

Definitions provide further information on the intent of key concepts to assist with measure submission.

Definitions:

Blood Pressure (BP) Classification – BP is defined by four (4) BP reading classifications: Normal, Elevated, First Hypertensive, and Second Hypertensive Readings

- Normal BP: Systolic BP (SBP) < 120 mmHg AND Diastolic BP (DBP) < 80 mmHg
- Elevated BP: SBP of 120-129 mmHg AND DBP < 80 mmHg

- This is an example of a complex Numerator. Review the Numerator section carefully to submit the quality-data codes (QDC's) necessary to meet data completeness and performance.

- the current encounter AND a most recent BP reading within the last 12 months SBP >= 130 mmHg OR DBP >= 80 mmHg

Recommended BP Follow-Up – The 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults from the American College of Cardiology and American Heart Association (2017 Guideline) recommends BP screening and thresholds as defined under Blood Pressure Classifications and recommends interventions based on the current BP reading as listed in the "Recommended Blood Pressure Follow-Up" Table below

Recommended Nonpharmacologic Interventions (Lifestyle Modifications) – The 2017 Guideline outlines nonpharmacologic interventions which must include one or more of the following as indicated:

- Weight Reduction
- Dietary Approaches to Stop Hypertension (DASH) Eating Plan
- Dietary Sodium Restriction
- Increased Physical Activity
- Moderation in alcohol (ETOH) Consumption

Recommended Blood Pressure Follow-Up Table

BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up (must include all indicated actions for each BP Classification)
Normal BP Reading	< 120	AND < 80	No Follow-Up required
Elevated BP Reading	120 - 129	AND < 80	Rescreen BP in 2 to 6 months AND recommended nonpharmacologic interventions OR Referral to Alternate/Primary Care Provider
First Hypertensive BP Reading	> = 130	OR >= 80	Rescreen BP > 1 day and < 4 weeks AND recommended nonpharmacologic interventions OR Referral to Alternate/Primary Care Provider

BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up (must include all indicated actions for each BP Classification)
Second Hypertensive BP Reading	130-139 and NOT >= 140	OR 80-89 and NOT >= 90	Recommended nonpharmacologic intervention AND reassessment in 2 to 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

Section 1:

Medicare Part B Claims measures may contain denominator exclusions within the Numerator. Denominator exclusions are applied before determining if the quality action is met.

Helpful Hint: For Medicare Part B claims collection type, even though a denominator exclusion is applied before determining the quality actions, this encoded concept needs to be submitted to CMS so the claims data will be accurately calculated.

Section 2:

Data Completeness and Performance Met.

*Not Eligible for High Blood Pressure Screening (Denominator Exclusion) –

- Patient has an active diagnosis of hypertension prior to the current encounter

**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.

Numerator Quality Data Coding Options:

*Screening for High Blood Pressure not Documented
Denominator Exclusion: G9744:

Normal Blood Pressure Reading Documented, Follow-up not required
Performance Met G8783:

OR
Elevated or Hypertensive Blood Pressure Reading Documented, AND Indicated Follow-Up
Documented
Performance Met G8950:

These codes are examples of QDC's or Quality Data Codes. These codes may be used to identify numerator options.

**Screening or Follow-Up for High Blood Pressure not Completed, Documented Reason
Denominator Exception: G9745:

Documented reason for not screening or no follow-up for high blood pressure

Section 3:

Measures may have denominator exceptions represented with HCPCS or CPTII Codes. CPT II codes may represent a medical (1P), patient (2P), or system (3P) reason for not performing the quality action. Some measures within the Quality Payment Program allow no denominator exceptions.

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Section 4:

Data
Completeness
Met and
Performance Not
Met.

Performance Not Met:

Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given (G8952)

RATIONALE:

Hypertension is a prevalent condition that about 20-40% of the adult population has a diagnosis (1,2). Winter notes that hypertension is 90% (3). The prevalence of chronic kidney disease are the highest prevalence of hypertension, renal failure, stroke and dementia (4). Prevention of hypertension and the treatment of established hypertension are complementary approaches to reducing CVD risk in the population, but prevention of hypertension provides the optimal means of reducing risk and avoiding harmful consequences. Periodic BP screening can identify individuals who develop elevated BP over time. More frequent BP screening may be particularly important for individuals with elevated ASCVD risk (4).

This is a brief statement describing the evidence base and/or intent for the measure.

Approximately 66.9 million people in the United States. It is estimated that about 20-40% of the adult population has a diagnosis; the majority of people over age 65 have a hypertension diagnosis. Adults have hypertension and the lifetime risk of developing hypertension or non-Hispanic Blacks, the elderly, diabetics and those with chronic kidney disease are the highest prevalence of hypertension, myocardial infarction and renal disease. Non-Hispanic Blacks have the highest prevalence of hypertension. Hypertension is a major risk factor for ischemic heart disease, left ventricular hypertrophy, renal failure, stroke and dementia (4).

Hypertension is the most common reason for adult office visits other than pregnancy. Garrison stated that in 2007, 42 million ambulatory visits were attributed to hypertension (5). It also has the highest utilization of prescription drugs. Numerous resources and treatment options are available, yet only about 40- 50% of the hypertensive patients have their blood pressure under control (<140/90) (1,2). In addition to medication non-compliance, poor outcomes are also attributed to poor adherence to lifestyle changes such as a low-sodium diet, weight loss, increased exercise and limiting alcohol intake. Many adults find it difficult to continue medications and lifestyle changes when they are asymptomatic. Symptoms of elevated blood pressure usually do not occur until secondary problems arise such as with vascular diseases (myocardial infarction, stroke, heart failure and renal insufficiency) (2).

Appropriate follow-up after blood pressure measurement is a pivotal component in preventing the progression of hypertension and the development of heart disease. Detection of marginally or fully elevated blood pressure by a specialty clinician warrants referral to a provider familiar with the management of hypertension and prehypertension. The 2010 ACCF/AHA Guideline for the Assessment of Cardiovascular Risk in Asymptomatic Adults continues to support using a global risk score such as the Framingham Risk Score, to assess risk of coronary heart disease (CHD) in all asymptomatic adults (6). Lifestyle modifications have demonstrated effectiveness in lowering blood pressure (7). 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 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 the 35 studies showed statistically significant improvement in BP levels of the intervention groups at follow-up (8). Follow-up intervals based on blood pressure control have been established by the 2017 ACC/AHA guideline and the USPSTF.

References

1. Appleton, S. L., Neo, C., Hill, C. L., Douglas, K. A., & Adams, R. J. (2013). 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.2012.62ID
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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., Ovbiagge, 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,

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This is a summary of the clinical recommendations based on best practices.

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation. (1)

References

- U.S. Preventive Services Task Force (USPSTF) (2007). Screening for high blood pressure: U.S. Preventive Services Task Force recommendation statement. Annals of Internal Medicine; 147(11):783-6

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These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.

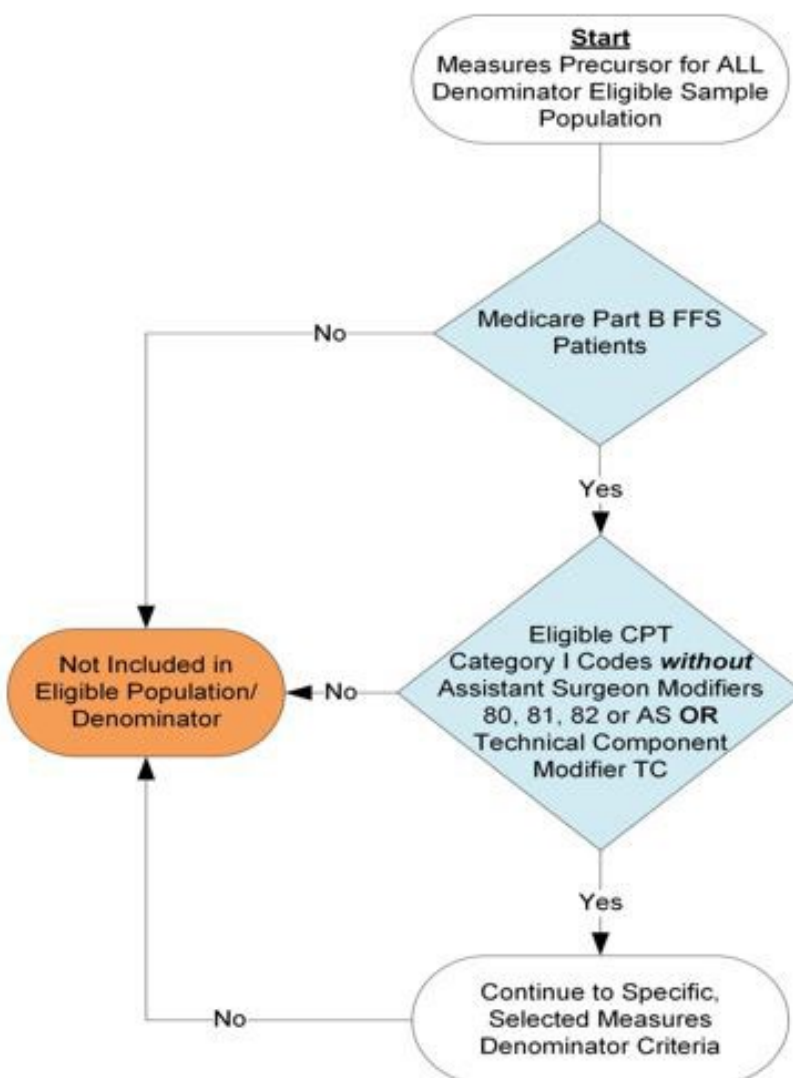
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Interpretation of Medicare Part B claims Measure Flow

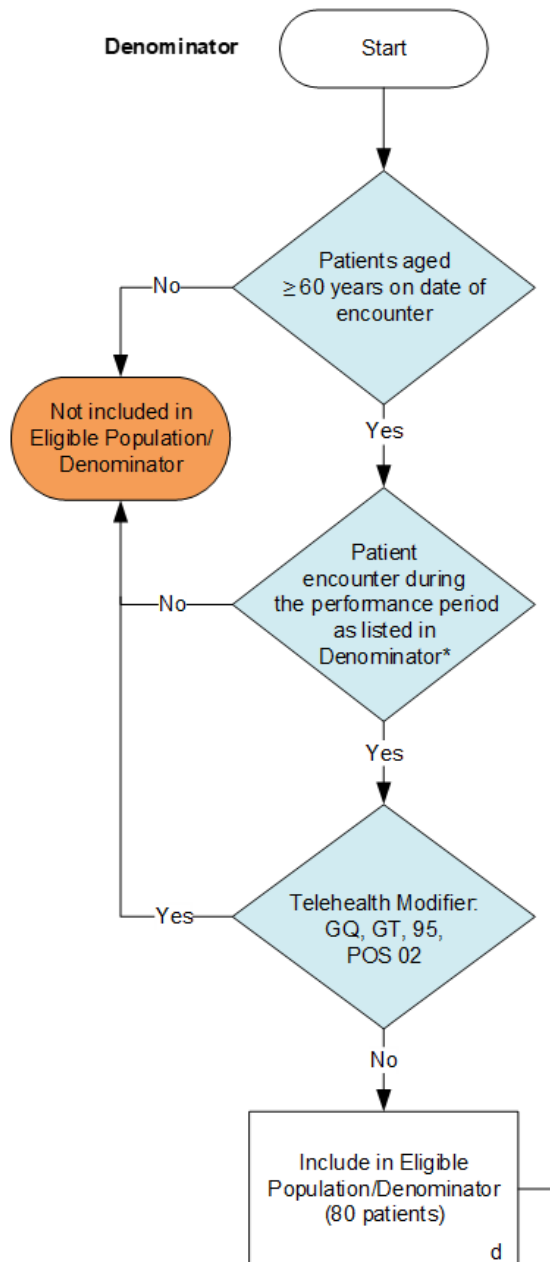
Denominator

The Medicare Part B claims Measure Flows are designed to provide interpretation of the measure logic and calculation methodology for data completeness and performance rates. The flows start 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.

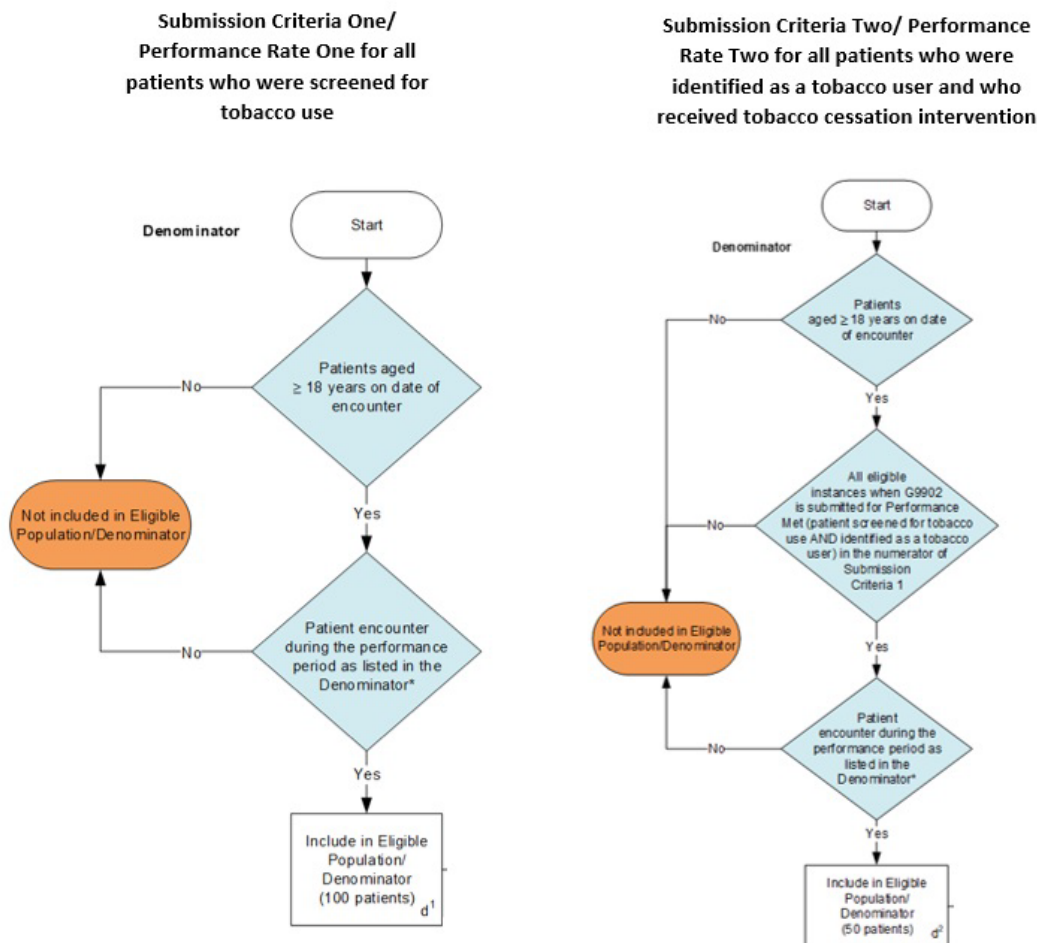
Below is an illustration of the above prerequisite denominator criteria to obtain the patient sample for all 2023 Medicare Part B claims Measures:



The Medicare Part B claims Measure Flows in each specification document begin with the appropriate age group and denominator population for the measure. The Eligible Population box equates to the letter “d” by the patient population that meets the measures inclusion requirements. Below is an example of the denominator criteria used to determine the eligible population for Quality ID # 181: Elder Maltreatment Screen and Follow-Up Plan:

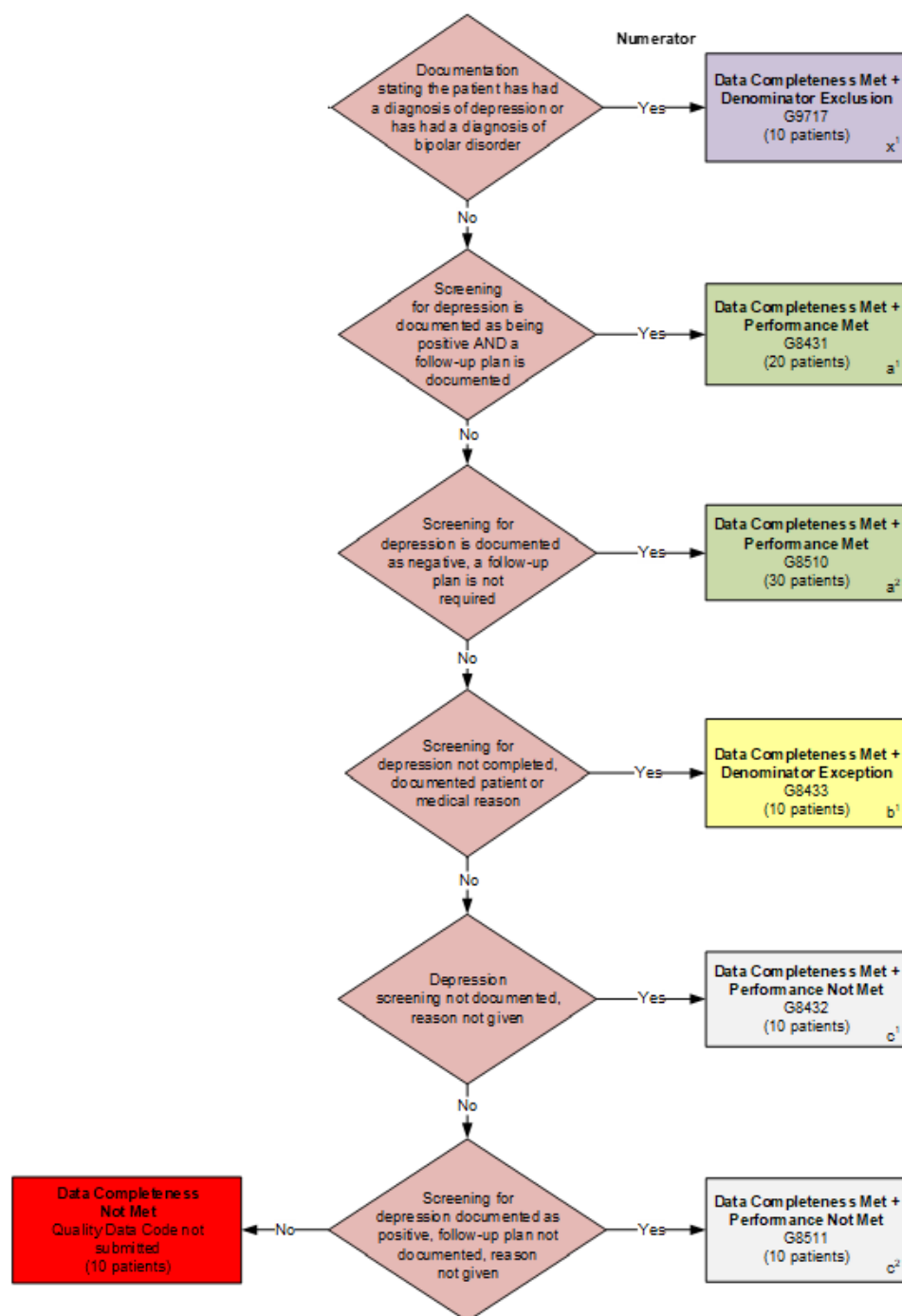


Some Medicare Part B claims measures, such as Quality ID # 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, have multiple submission criteria to determine the measure denominator. In the example below, the denominator also represents multiple performance rates. Patients meeting the submission criteria for either denominator option are included as part of the eligible population. Review the Medicare Part B claims measures specification to determine if multiple performance rates are required for each submission criteria. The example below shows two of three submission criteria.



Numerator

Once the denominator is identified, the flow illustrates and stratifies the quality action (numerator) for data completeness. Depending on the measure, there are several outcomes that may be applicable for submission. 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 right box - Denominator Exclusion = “x” and shaded purple; next two boxes below - Performance Met = “a” and shaded green; next box below - Denominator Exception = “b” and shaded yellow; next two 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 to identify the particular outcome of the measure represented. This is illustrated below for Quality ID # 134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan:



Denominator/Numerator Variation of Medicare Part B claims vs. CQM Collection Types

For measures submitted via Medicare Part B claims or CQM, there are separate Measure Specifications, Flows, and Narratives. The denominator for the CQM measure may differ slightly from the denominator as outlined in the Medicare Part B claims measure specification. In the Medicare Part B claims measure specifications the denominator exclusions appear in the numerator section of the specification. For example, Quality ID # 134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan, includes a clarifying code G-code G9717 in the numerator to identify patients that meet the denominator exclusion when no CPT or ICD-10 diagnosis code exists. In Quality ID # 134, MIPS Clinical Quality Measure collection type, the denominator includes the code G9717 used to identify patients who meet the denominator exclusion. To comply with the Measure Steward's intent of the measures and since Qualified Registries or QCDRs may not necessarily be reliant on Medicare Part B claims data; the CQM collection type measure specification and flow show these QDCs or clinical concepts in the denominator. Therefore, the numerator quality data code options for CQM specifications and flow may vary from the Medicare Part B claims measure specification and flow.

Algorithms

Data Completeness Algorithm

The Data Completeness Algorithm calculation is based on the eligible population and sample outcomes of the possible quality actions as described in the flow of the measure. 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: Denominator Exclusion, Performance Met, Denominator Exception, and Performance Not Met. Below is a sample Data Completeness Algorithm for Quality ID # 134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan. In the example, 90 patients met the denominator criteria for eligibility, where 10 patients were considered a denominator exclusion, 50 patients had the quality action performed (Performance Met), 10 patients did not receive the quality action for a documented reason (Denominator Exception), and 20 patients were reported as not receiving the quality action (Performance Not Met). **Note:** In the example, 10 patients were eligible for the measure but were not reported and are not represented in the algorithm (Data Completeness Not Met).

Data Completeness =

$$\frac{\text{Denominator Exclusion (x=10)} + \text{Performance Met (a1+a2=50)} + \text{Denominator Exception (b=10)} + \text{Performance Not Met (c1+c2=20)}}{\text{Eligible Population/Denominator (d=100 patients)}} = \frac{90 \text{ patients}}{100 \text{ patients}} = 90.00\%$$

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 ID # 134. In this scenario, the patient sample equals 90 patients where 50 of these patients had the quality action performed (Performance Met), 10 patients were submitted as a Denominator Exclusion, and 10 patients were submitted as having a Denominator Exception.

Performance Rate =

$$\frac{\text{Performance Met (a1+a2=50 patients)}}{\text{Data Completeness Numerator (90 Patients) - Denominator Exclusion (x=10 patients) - Denominator Exception (b=10 patients)}} = \frac{50 \text{ patients}}{70 \text{ patients}} = 71.43\%$$

For measures with inverse performance rates, such as Quality ID # 1: Hemoglobin A1c (HbA1c) Poor Control

(>9%), a lower rate indicates better performance. Submitting the Performance Not Met quality action is actually the clinically recommended outcome.

Multiple Performance Rates

QPP 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 type. The Medicare Part B claims measure flow for these measures includes algorithm examples to understand the different data completeness and performance rates required for the measure. The system will calculate the performance rates for the measure based on the submission of claims data by the MIPS eligible clinician.