



2018 Quality Payment Program (QPP) Measure Specification and Measure Flow Guide for Claims Submission of Individual Measures

Utilized by Individual Eligible Clinicians for Claims Submissions

12/11/2017

Introduction

This document contains general guidance for the 2018 Quality Payment Program (QPP) Individual Measure Specifications and Measure Flows for claims submissions. The individual measure specifications are detailed descriptions of the quality measures and are intended to be utilized by individual eligible clinicians reporting individual measures via claims for the 2018 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.

Submission Methods

The individual measure specifications for claims submissions may be utilized for claims, registry, and Qualified Clinical Data Registries (QCDRs) data submission methods. Below outlines which measure specifications can be utilized for the other data submission methods.

- Measure specifications for individual measure reporting via registry also have separate measure documents.
- Group practices electing to submit via the Web Interface should utilize the Web Interface Measure documents.
- Measure specifications for electronic health record (EHR) based reporting should utilize the electronic clinical quality measures (eCQMs).
- Information regarding CG-CAHPS may be found at: <http://acocahps.cms.gov/Content/Default.aspx#aboutSurvey>
Please note that this link is directed to the Accredited Care Organization webpage.

Individual Measure Specifications

Each measure is assigned a unique number. Measure numbers for 2017 QPP represents a continuation in numbering from the 2016 Physician Quality Reporting System (PQRS) measures. Measure stewards have provided revisions for the 2016 PQRS measures that are continuing forward in the 2017 QPP.

Frequency with Definitions

Frequency labels are provided for each measure and included in each measures instruction as well as the measure flow. The analytical submitting frequency defines the time period or event in which the measure should be submitted. Each individual eligible clinician participating in 2018 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 utilized 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 eligible clinician during the performance period.

Performance Period

Performance period for the measure may refer to the overall period of January 1st to December 31st. Although, there may be measures where the clinical action of the measure may have a different timeframe to determine if the quality action indicated within the measure was performed to meet performance. There are several sections (Instruction, Description, or Numerator Statement) within the measure specification that could include information on the performance period.

Denominator and Numerator

Quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome. The denominator is the lower part of a fraction used to calculate a rate, proportion, or ratio. The numerator is the upper portion of a fraction used to calculate a rate, proportion, or ratio. Also called the measure focus, it is the target process, condition, event, or outcome. Numerator criteria are the processes or outcomes expected for each patient, procedure, or other unit of measurement defined in the denominator.

Denominator Codes (Eligible Cases)

The denominator population may be defined by demographic information, certain International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis, International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in the measure that are submitted **by individual eligible clinician** as part of a claim for **covered services** under the Medicare Part B Physician Fee Schedule (PFS) for claims-based submissions.

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 eligible clinician, then the patient does not fall into the 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, and other detailed information. Each **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 or QDCs (CPT Category II codes or G-codes) that define the numerator should be submitted for data completeness of quality data for a measure for claims-based submission.

Denominator Exclusion:

Typically, a denominator exclusion describes a circumstance where the patient should be removed from the denominator. Within claims submission, denominator exclusions identify circumstances where the patient should be removed from the performance prior to determining which numerator outcome is appropriate. Quality-data codes are available to describe the denominator exclusion within the measure specification and should be submitted on the claim. For claims submission, these patients should be

included within the data completeness, but removed from the denominator of the performance rate for the measure. Please refer to the algorithm portion of this document below.

Performance Met:

If the intended clinical action for the measure is performed for the patient, quality-data code(s) 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 code modifiers such as 1P, 2P and 3P or quality-data codes are available to describe medical, patient, or system reasons for denominator exceptions and should be submitted on the claim. A denominator exception would remove a patient from the performance denominator only if the numerator criteria are not met. This allows for the exercise of clinical judgment.

Performance Not Met:

When the denominator exception does not apply, a measure-specific CPT Category II reporting modifier 8P or quality-data code may be used to indicate that the quality action was not provided for a reason not otherwise specified and should be submitted on the 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.

HCPCS coding may include G-codes, D-codes, or S-codes. These HCPCS codes may be found within the denominator and would be associated with billable charges. QDC’s may be found in the denominator or numerator and may utilize HCPCS coding. These QDC’s describe clinical outcomes or quality actions that assist with determining the intended population or numerator outcome.

Individual Measure Submission

For eligible clinicians reporting individually, measures (including patient-level measure[s]) may be submitted for the same patient by multiple 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 NPI reporting if the patient encounter(s) meet denominator inclusion. The following is an example of two provider NPIs (National Provider Identifiers), billing under the same TIN who are intending to submit Quality ID #134 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan. Provider A sees a patient on February 2, 2018 and documents the patient’s current medications in the medical chart and submits the appropriate quality-data code (QDC) for Quality ID #134. Provider B sees the same patient at an encounter on July 16, 2018 and also verifies that the patient has documented the patient’s current medications in the medical chart. Provider B should also submit the appropriate QDC’s for the patient at the July encounter to meet data completeness for submission of Quality ID #134.

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

Measure Specification Format (Refer to the Example Measure Specification Below)

Measure number, NQF number (if applicable), Measure title and domain

Submission method option

Measure type

Measure description

Instructions on reporting 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)

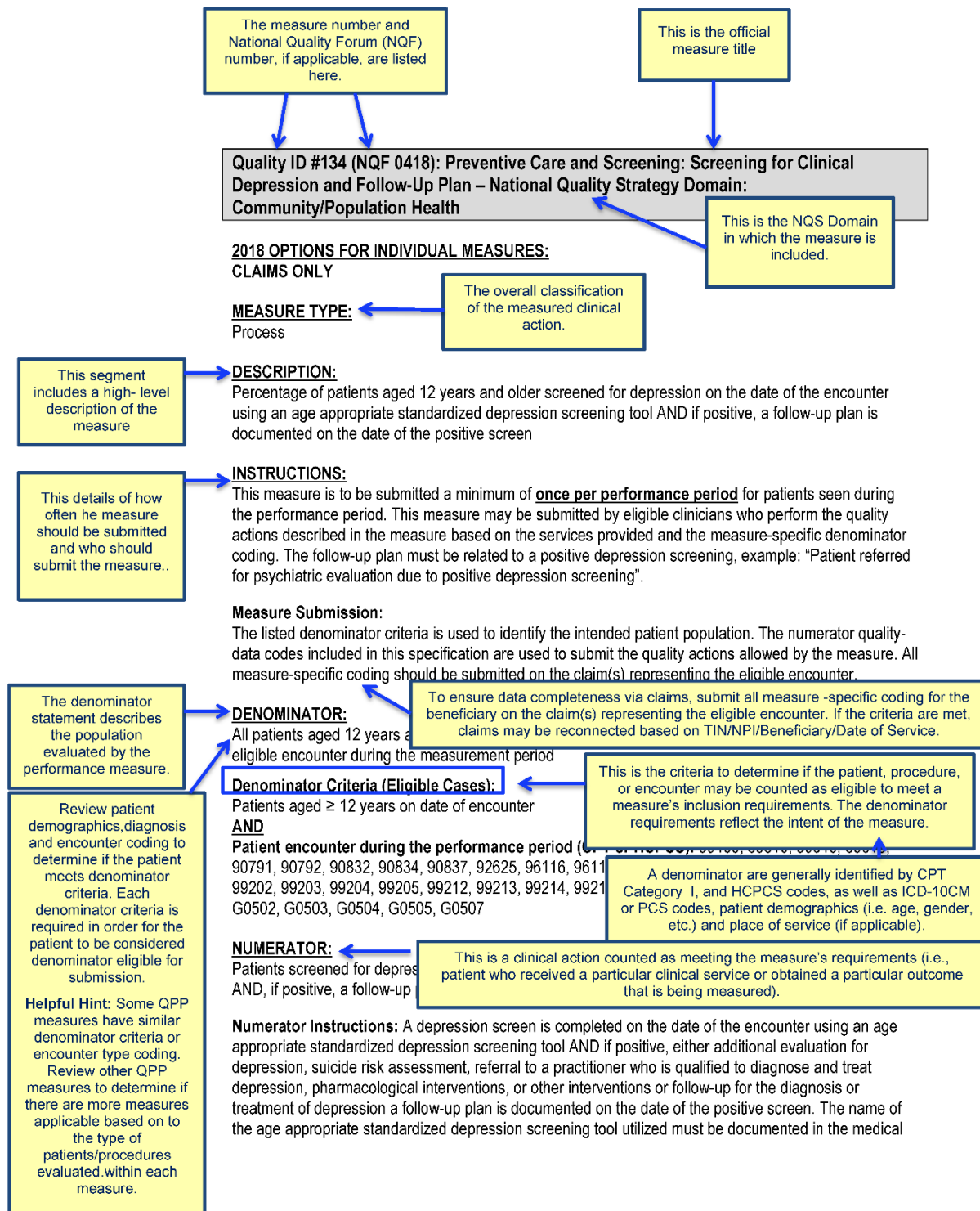
Definition(s) of terms where applicable

Rationale

Clinical recommendations statement or clinical evidence supporting the measure intent

The Rationale and Clinical Recommendation Statements sections provide limited supporting information 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 last page of the Measures List document, which can be accessed at: <https://qpp.cms.gov/measures/quality>.

Example Individual Claims Measure Specification:



record. The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter and the screening should occur during a qualified encounter.

Definitions provide further information on the intent of key concepts to assist with measure submission. Measures may or may not contain definitions.

Definitions:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

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

Examples of depression screening tools include but are not limited to:

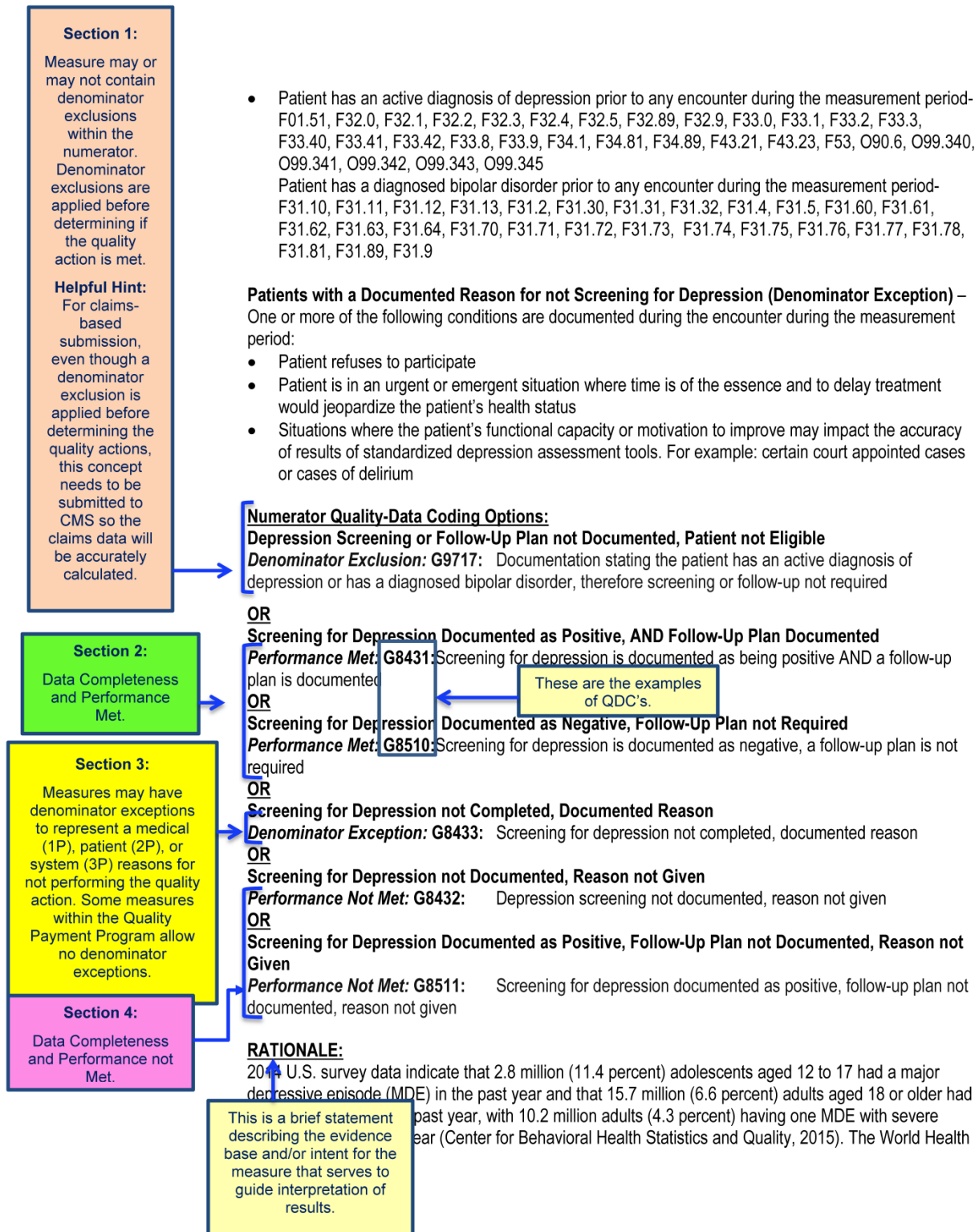
- **Adolescent Screening Tools (12-17 years)**
Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older)**
Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ2, Hamilton Rating Scale for Depression (HAM-D), and Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
- **Perinatal Screening Tools**
Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory-II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale

Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

* Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion) –



Organization (WHO), as cited by Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Data indicate that approximately 80% of people diagnosed with depression report some level of difficulty in functioning because of their depressive symptoms. For example, 35% of males and 22% of females with depression reported that their depressive symptoms make it extremely difficult for them to work, get things done at home, or get along with other people. Additionally, more than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their depressive symptoms (Pratt & Brody, 2008). In young adulthood, major depressive disorder (MDD) has been found to be associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning (Williams et al., 2009, p. e716). In the perinatal period, depression and other mood disorders, such as bipolar disorder and anxiety disorders, can have devastating effects on women, infants, and families. Maternal suicide rates rise over hemorrhage and hypertensive disorders as a cause of maternal mortality (American College of Obstetricians and Gynecologists, 2015).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Borner, 2010, p. 948). "Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated" (Borner, 2010, p. 948). "In nationally representative U.S. surveys, about 8% of adolescents reported having major depression in the past year. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated" (Sui, A. and USPSTF, 2016). Evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women.

If preventing negative patient outcomes is not enough, the substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. Depression imposes economic burden through direct and indirect costs. "In the United States, an estimated \$22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated \$23 billion in 2011" (Sui, A. and USPSTF, 2016).

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014) and makes an important contribution to the quality domain of community and population health.

CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years):

"The USPSTF recommends screening for MDD in adolescents implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui, A. and USPSTF, 2016, p. 360).

This is the summary of the Clinical recommendations based on best practices.

“Clinicians and health care systems should try to consistently screen adolescents ages 12-18 for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up” (ICSI, 2013, p.16).

Adult Recommendation (18 years and older):

“The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)” (Sui, A. and USPSTF, 2016, p. 380).

The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations:

1. “Clinicians should routinely screen all adults for depression using a standardized instrument.”
2. “Clinicians should establish and maintain follow-up with patients.”
3. “Clinicians should screen and monitor depression in pregnant and post-partum women.” (Trangle, 2016 p.p. 9 – 10)

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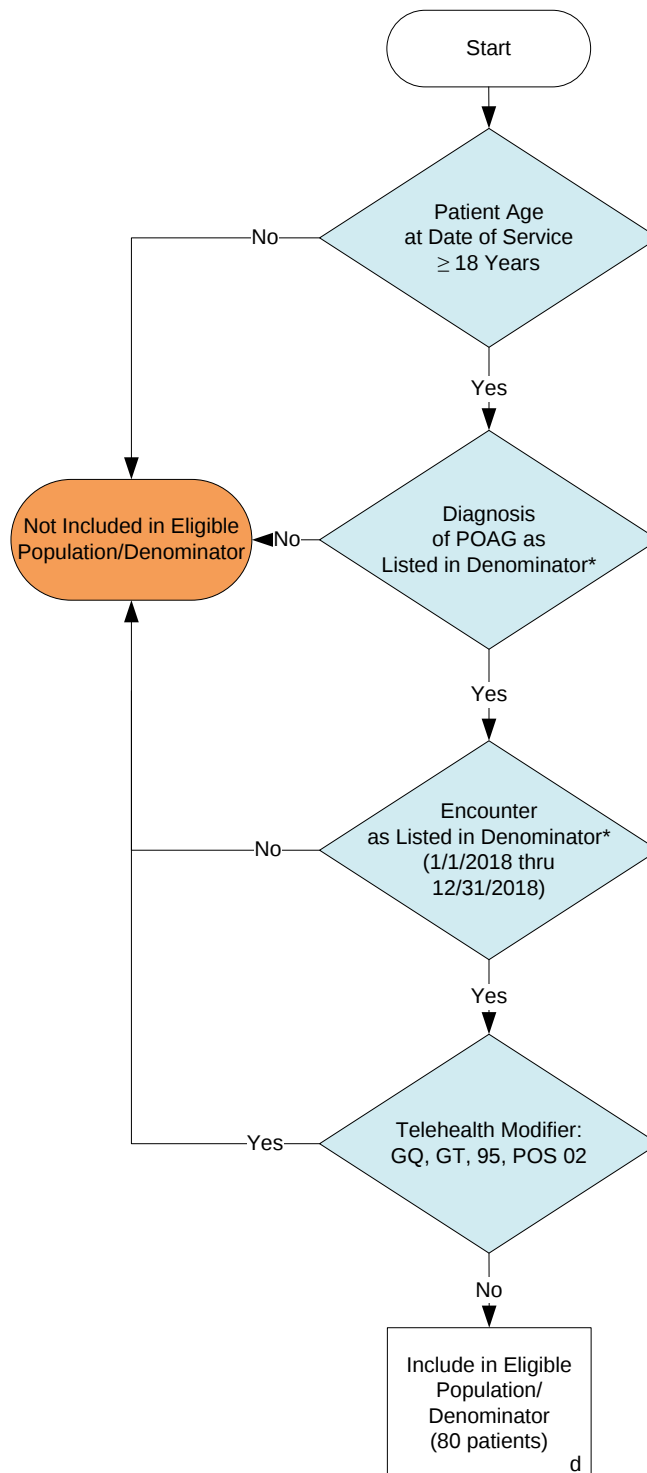
Interpretation of Individual Claims Measure Flows

Denominator

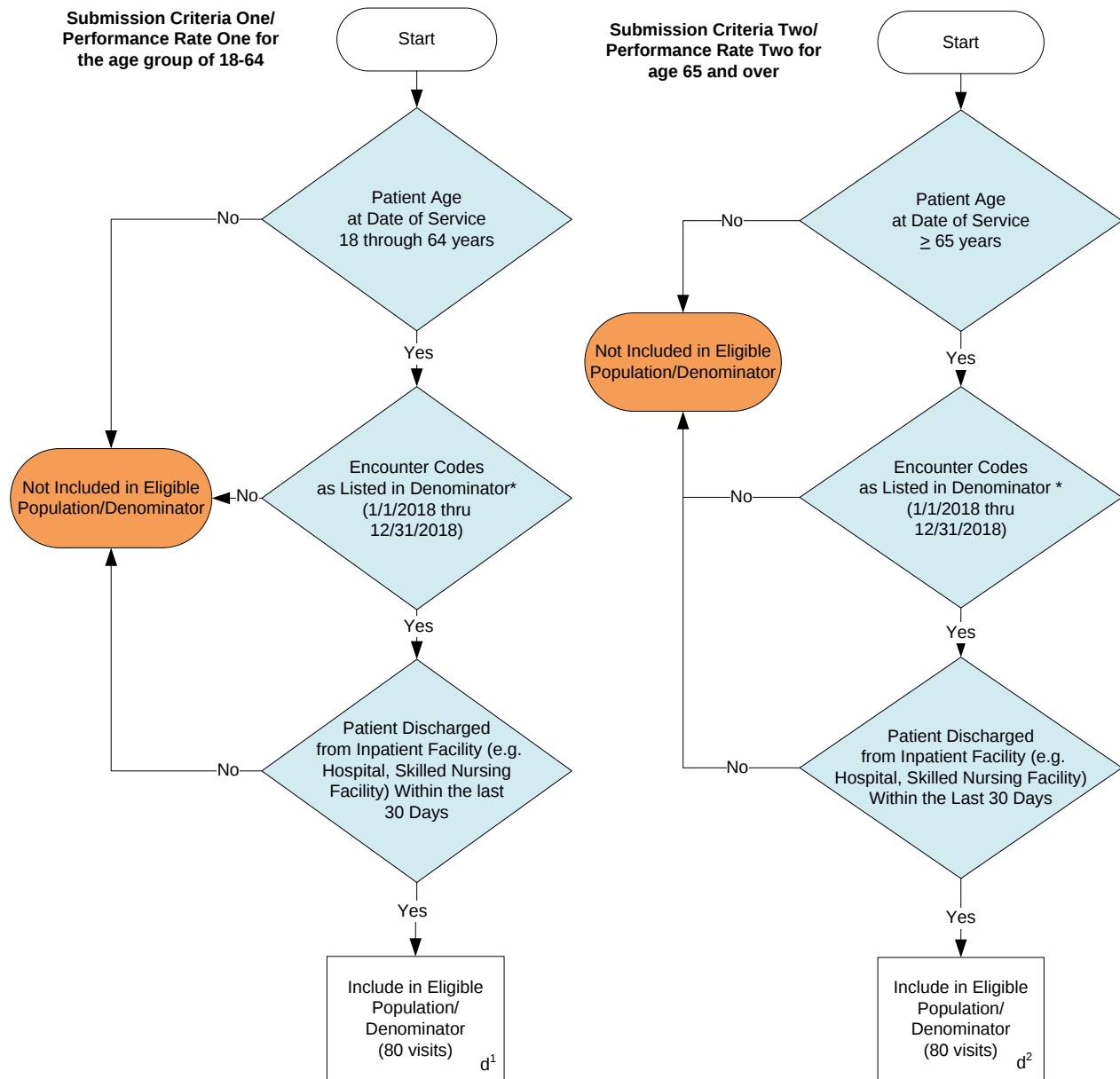
The Individual Measure Flows are designed to provide interpretation of the measure logic and calculation methodology for data completeness and performance rates. The flows start with the identification of the patient population (denominator) for the applicable measure's quality action (numerator). When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

Below is an illustration of additional prerequisite denominator criteria to obtain the patient sample for all 2018 Individual Measures:

The Individual Measure Flows continue 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 #12 NQF # 0086: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation:

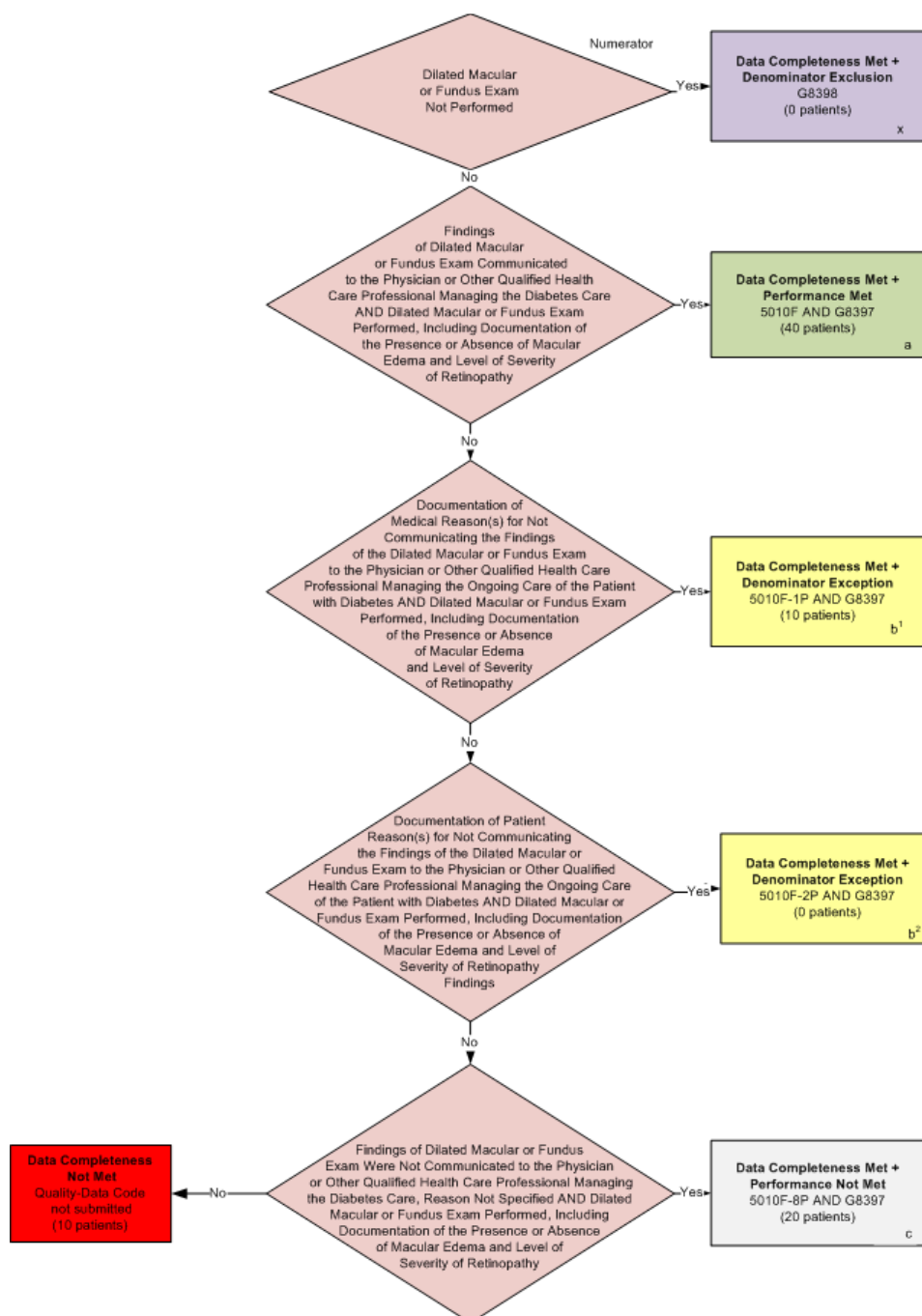


Some measures, such as Quality ID #46 Medication Reconciliation Post-Discharge have multiple submission criteria to determine the measure denominator. In the example below, the denominator also represents multiple performance rates. Patients meeting the criteria for either denominator option are included as part of the eligible population. Review the measures specification to determine if multiple performance rates are required for each reporting 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 submitting the measures outcome: Denominator Exclusion = "x"/purple, Performance Met = "a"/green, Denominator Exception = "b"/yellow, Performance Not Met = "c"/gray, and Data Completeness Not Met = red 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 #19 NQF # 0089: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care:



Algorithms

Data Completeness Algorithm

The Data Completeness Algorithm 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 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 #19. In the example, 80 patients met the denominator criteria for eligibility, where 0 patients were considered a denominator exclusion, 40 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 (Data Completeness Not Met).

Data Completeness =

$$\frac{\text{Denominator Exclusion (x=0 pts)} + \text{Performance Met (a=40 pts)} + \text{Denominator Exception (b1+b2=10 pts)} + \text{Performance Not Met (c=20 pts)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ pts}}{80 \text{ pts}} = 87.50\%$$

Performance Algorithm

The Performance Algorithm calculation is based on only those patients where data completeness was met for the measure. For those patients, the numerator is determined by completing the quality action as indicated by Performance Met. Meeting the quality action for a patient, as indicated in the Claims Individual Measure Specification, would add one patient to the denominator and one to the numerator. Patients reporting with Denominator Exclusions or Denominator Exceptions are subtracted from the performance denominator when calculating the performance rate percentage. Below is a sample performance rate algorithm that represents this calculation for Quality ID #19. In this scenario, the patient sample equals 70 patients where 40 of these patients had the quality action performed (Performance Met), zero patients was submitted as a Denominator Exclusion, and 10 patients were submitted as having a Denominator Exception.

Performance Rate=

$$\frac{\text{Performance Met (a=40 patients)}}{\text{Data Completeness Numerator (70 patients) - Denominator Exclusion (x=0 patients) - Denominator Exception (b1+b2=10 patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

For measures with inverse performance rates, such as Quality ID #1 (NQF 0059) Diabetes: Hemoglobin A1c Poor Control, a lower rate indicates better performance. Submitting the Performance Not Met is actually the clinically recommended outcome or quality action.

Multiple Performance Rates

QPP measures may contain multiple performance rates. The Instructions section of the individual measure will provide guidance if the measure is indeed a multiple performance. The Individual 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-based data by the eligible clinician.