**Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report**
**– National Quality Strategy Domain: Communication and Care Coordination**
**– Meaningful Measure Area: Transfer of Health Information and Interoperability**

**2020 COLLECTION TYPE:**
**MIPS CLINICAL QUALITY MEASURES (CQMS)**

**MEASURE TYPE:**
Process – High Priority

**DESCRIPTION:**
Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred

**INSTRUCTIONS:**
This measure is to be submitted a minimum of **once per performance period** for all patients with a referral during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure for the patients for whom a referral was made during the performance period based on the services provided and the measure-specific denominator coding. The provider who refers the patient to another provider is the provider who should be held accountable for the performance of this measure. All Merit-based Incentive Payment System (MIPS) eligible professionals or eligible clinicians reporting on this measure should note that all data for the reporting year is to be submitted by the deadline established by CMS. Therefore, all Merit-based Incentive Payment System (MIPS) eligible professionals or eligible clinicians who refer patients towards the end of the reporting period (i.e., November - December), should request that providers to whom they referred their patients share their consult reports as soon as possible in order for those patients to be counted in the measure numerator during the measurement period. When providers to whom patients are referred communicate the consult report as soon as possible with the referring providers, it ensures that the communication loop is closed in a timely manner and that the data is included in the submission to CMS.

**Measure Submission Type:**
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

**DENOMINATOR:**
Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period

> ***DENOMINATOR NOTE*:** *If there are multiple referrals for a patient during the performance period, use the first referral.*
>
> **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients regardless of age on the date of the encounter
> **AND**


CPT only copyright 2019 American Medical Association. All rights reserved.

**Patient encounter during the performance period (CPT or HCPCS):** 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99381*, 99382*, 99383*, 99384*, 99385*, 99386*, 99387*, 99391*, 99392*, 99393*, 99394*, 99395*, 99396*, 99397*
**WITHOUT**
**Telehealth Modifier:** GQ, GT, 95, POS 02
**AND**
**Patient was referred to another provider or specialist during the performance period:** G9968

**NUMERATOR:**
Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred

**Definitions:**
**Referral:** A request from one physician or other eligible provider to another practitioner for evaluation, treatment, or co-management of a patient's condition. This term encompasses referral and consultation as defined by Centers for Medicare and Medicaid Services.

**Report:** A written document prepared by the eligible clinician (and staff) to whom the patient was referred and that accounts for his or her findings, provides summary of care information about findings, diagnostics, assessments and/or plans of care, and is provided to the referring eligible clinician.

***NUMERATOR NOTE:*** *The consultant report that will fulfill the referral should be completed after the referral, and should be related to the referral for which it is attributed. If there are multiple consultant reports received by the referring provider which pertain to a particular referral, use the first consultant report to satisfy the measure.*

*The provider to whom the patient was referred should be the same provider that sends the report.*

**Numerator Options:**

| | |
|---|---|
| ***Performance Met:*** | Provider who referred the patient to another provider received a report from the provider to whom the patient was referred **(G9969)** |
| **OR** | |
| ***Performance Not Met:*** | Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred **(G9970)** |

**RATIONALE:**
Problems in the outpatient referral and consultation process have been documented, including lack of timeliness of information and inadequate provision of information between the specialist and the requesting physician (Gandhi et al., 2000; Forrest, 2000; Stille, 2005). In a study of physician satisfaction with the outpatient referral process, Gandhi et al. (2000) found that 68% of specialists reported receiving no information from the primary care provider prior to referral visits, and 25% of primary care providers had still not received any information from specialists 4 weeks after referral visits. In another study of 963 referrals (Forrest, 2000), pediatricians scheduled appointments with specialists for only 39% and sent patient information to the specialists in only 51% of the time.

In a 2006 report to Congress, the Medicare Payment Advisory Commission (MedPAC) found that care coordination programs improved quality of care for patients, reduced hospitalizations, and improved adherence to evidence-based care guidelines, especially among patients with diabetes and CHD. Associations with cost-savings were less clear; this was attributed to how well the intervention group was chosen and defined, as well as the intervention put in place. Additionally, cost-savings were usually calculated in the short-term, while some argue that the greatest cost-savings accrue over time (MedPAC, 2006).


CPT only copyright 2019 American Medical Association. All rights reserved.

Improved mechanisms for information exchange could facilitate communication between providers, whether for time-limited referrals or consultations, on-going co-management, or during care transitions. For example, a study by Braner et al. (1999) found that an electronic communication network that linked the computer-based patient records of physicians who had shared care of patients with diabetes significantly increased frequency of communications between physicians and availability of important clinical data. There was a 3-fold increase in the likelihood that the specialist provided written communication of results if the primary care physician scheduled appointments and sent patient information to the specialist (Forrest et al., 2000).

Care coordination is a focal point in the current health care reform and our nation's ambulatory health information technology (HIT) framework. The National Priorities Partnership (2008) recently highlighted care coordination as one of the most critical areas for development of quality measurement and improvement.

**CLINICAL RECOMMENDATION STATEMENTS:**

None

**COPYRIGHT:**

This performance Measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications.

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

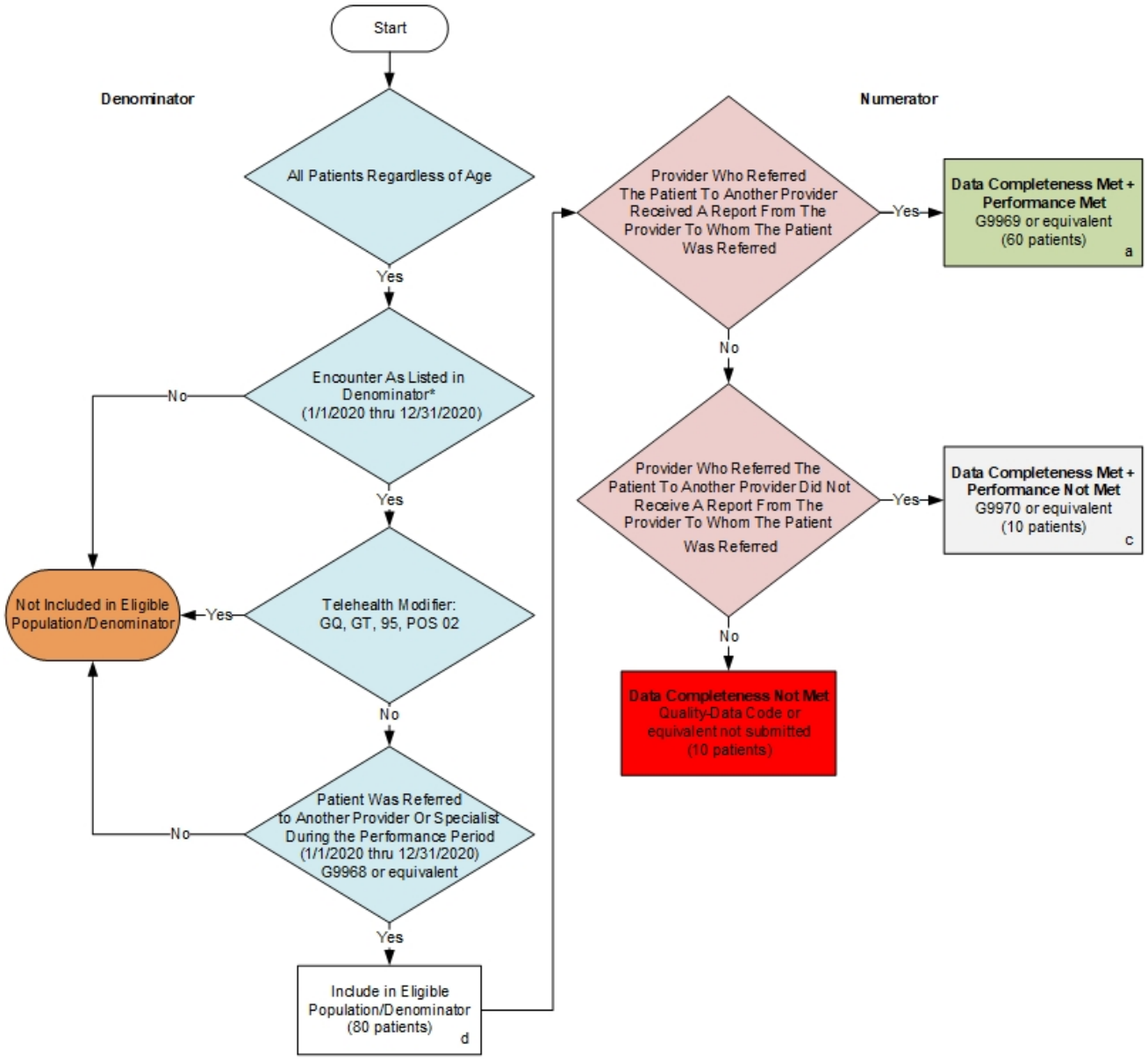
Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. PCPI disclaims all liability for use or accuracy of any CPT or other codes contained in the specifications.

CPT® contained in the Measure specifications is copyright 2004-2019 American Medical Association. LOINC® is copyright 2004-2019 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2019 International Health Terminology Standards Development Organisation. All Rights Reserved.


CPT only copyright 2019 American Medical Association. All rights reserved.

## 2020 Clinical Quality Measure Flow for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

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




**SAMPLE CALCULATIONS:**

**Data Completeness=**
Performance Met (a=60 patients) + Performance Not Met (c=10 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

**Performance Rate=**
Performance Met (a=60 patients) = 60 patients = **85.71%**
Data Completeness Numerator (70 patients) = 70 patients

* See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

CPT only copyright 2019 American Medical Association. All rights reserved.
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.
v4


CPT only copyright 2019 American Medical Association. All rights reserved.

## 2020 Clinical Quality Measure Flow Narrative for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

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

1. Start with Denominator
2. Check Patient Age
    a. All Patients Regardless of Age, proceed to check Encounter Performed.
3. Check Encounter Performed:
    a. If Encounter as Listed in Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If Encounter as Listed in Denominator equals Yes, proceed to check Telehealth Modifier.
4. Check Telehealth Modifier:
    a. If Telehealth Modifier equals Yes, do not include in Eligible Population. Stop Processing.
    b. If Telehealth Modifier equals No, proceed to check Patient Was Referred to Another Provider Or Specialist During the Performance Period.
5. Check Patient Was Referred to Another Provider Or Specialist During the Performance Period.
    a. If Patient Was Referred to Another Provider Or Specialist During the Performance Period equals No, do not include in Eligible Population. Stop Processing.
    b. If Patient Was Referred to Another Provider Or Specialist During the Performance Period equals Yes, include in Eligible Population.
6. 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.
7. Start Numerator
8. Check Provider Who Referred The Patient To Another Provider Received A Report From The Provider To Whom The Patient Was Referred:
    a. If Provider Who Referred The Patient To Another Provider Received A Report From The Provider To Whom The Patient Was Referred equals Yes, include in Data Completeness Met and Performance Met.
    b. 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 60 patients in the Sample Calculation.
    c. If Provider Who Referred The Patient To Another Provider Received A Report From The Provider To Whom The Patient Was Referred equals No, proceed to check Provider Who Referred The Patient To Another Provider Did Not Receive A Report From The Provider To Whom The Patient Was Referred.


CPT only copyright 2019 American Medical Association. All rights reserved.

9. Check Provider Who Referred The Patient To Another Provider Did Not Receive A Report From The Provider To Whom The Patient Was Referred:

    a. If Provider Who Referred The Patient To Another Provider Did Not Receive A Report From The Provider To Whom The Patient Was Referred equals Yes, include in Data Completeness Met and Performance Not Met.

    b. Data Completeness Met and Performance Not Met letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 10 patients in the Sample Calculation.

    c. If Provider Who Referred The Patient To Another Provider Did Not Receive A Report From The Provider To Whom The Patient Was Referred equals No, proceed to Data Completeness Not Met.

10. Check Data Completeness Not Met:

    a. If Data Completeness Not Met, the Quality-Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

**SAMPLE CALCULATIONS:**

**Data Completeness=**

Performance Met (a=60 patients) + Performance Not Met (c=10 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

**Performance Rate=**

Performance Met (a=60 patients) = 60 patients = **85.71%**

Data Completeness Numerator (70 patients) = 70 patients


CPT only copyright 2019 American Medical Association. All rights reserved.