Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

2026 COLLECTION TYPE:
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:
Process – High Priority

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

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 all patients. 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.

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 for the performance period. The most advantageous quality data code will be used if the measure is submitted more than once.

The clinician who refers the patient to another clinician is the clinician who should be held accountable for the performance of this measure. All MIPS 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, however, only first referrals made between January 1 - October 31 (the measurement period) will count towards the denominator to allow adequate time for the referring clinician to collect the consult report by the end of the performance period. When clinicians to whom patients are referred communicate the consult report as soon as possible with the referring clinicians, it ensures that the communication loop is closed in a timely manner and that the data is included in the submission to CMS.

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:
The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria:

Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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 had an encounter during the performance period and were referred by one clinician to another clinician on or before October 31.

DENOMINATOR NOTE:
If there are multiple referrals for a patient during the measurement 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
Patient encounter during the performance period (CPT or HCPCS): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 90791, 90792, 90839, 96112, 96116, 96136, 96138, 96156, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 99381*, 99382*, 99383*, 99384*, 99385*, 99386*, 99387*, 99391*, 99392*, 99393*, 99394*, 99395*, 99396*, 99397*
AND
Patient was referred to another clinician or specialist during the measurement period: G9968

NUMERATOR:
Number of patients with a referral on or before October 31, for which the referring clinician received a report from the clinician to whom the patient was referred.

Definitions:
Referral – A request from one clinician to another clinician for evaluation, treatment, or co-management of a patient's condition. This term encompasses "referral" and consultation as defined by Centers for Medicare & Medicaid Services.
Report – A written document prepared by the eligible clinician (and staff) to whom the patient was referred and that accounts for their findings, provides summary of care information about findings, diagnostics, assessments and/or plans of care, or states the patient did not attend the appointment, and is provided to the referring eligible clinician.

NUMERATOR NOTE:
The consultant report that will successfully close the referral loop should be related to the first referral for a patient during the measurement period. If there are multiple consultant reports received by the referring clinician which pertain to a particular referral, use the first consultant report to satisfy the measure.

The clinician to whom the patient was referred is responsible for sending the consultant report that will fulfill the communication. Note: this is not the same clinician who would report on the measure.

Numerator Options:

Performance Met:	Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred (G9969)

OR

Performance Not Met:	Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred (G9970)

RATIONALE:
Problems in the outpatient referral and consultation process have been documented, including inadequate care pathways between specialty and primary care. Studies suggest that both specialists and primary care providers (PCPs) are not satisfied with current processes [1,2]. Breakdowns in referral communication lead to worse health outcomes, increased cost, and appointment delays [3,4]. A 2018 analysis of primary care referrals to specialists found that of the 103,737 referral scheduling attempts analyzed, only 36,072 (34.8%) resulted in documented complete appointments, defined by the specialty clinician providing report to the PCP after the referral visit [3].
Technological and process-based updates can improve the referral loop process and increase rates of closing the referral loop. Ramelson et. al (2018) enhanced an EHR's Referral Manager module to meet the Controlled Risk Insurance Company's best practice steps and the requirements of both the CMS EHR Incentive Program and the National Committee for Quality Assurance Patient-Centered Medical Home program. Following the updates, 76.8% of referrals were completed and all defined referral process steps were easier to accomplish [5]. Odisho et. al (2020) developed a referrals automation software to simplify the fax to referral process. Feedback from key stakeholder interviews noted that the software enhanced the referrals process by further streamlining and organizing the patient referral process [4].The Institute for Healthcare Improvement and the National Patient Safety Foundation (2017) reviewed the referrals process in the ambulatory care setting and found that organizational leaders, EHR vendors, regulatory agencies, clinicians, and patients all all play a role in creating a referrals system that is effective, safe, convenient, and patient-centered [1].

CLINICAL RECOMMENDATION STATEMENTS:
None

REFERENCES:

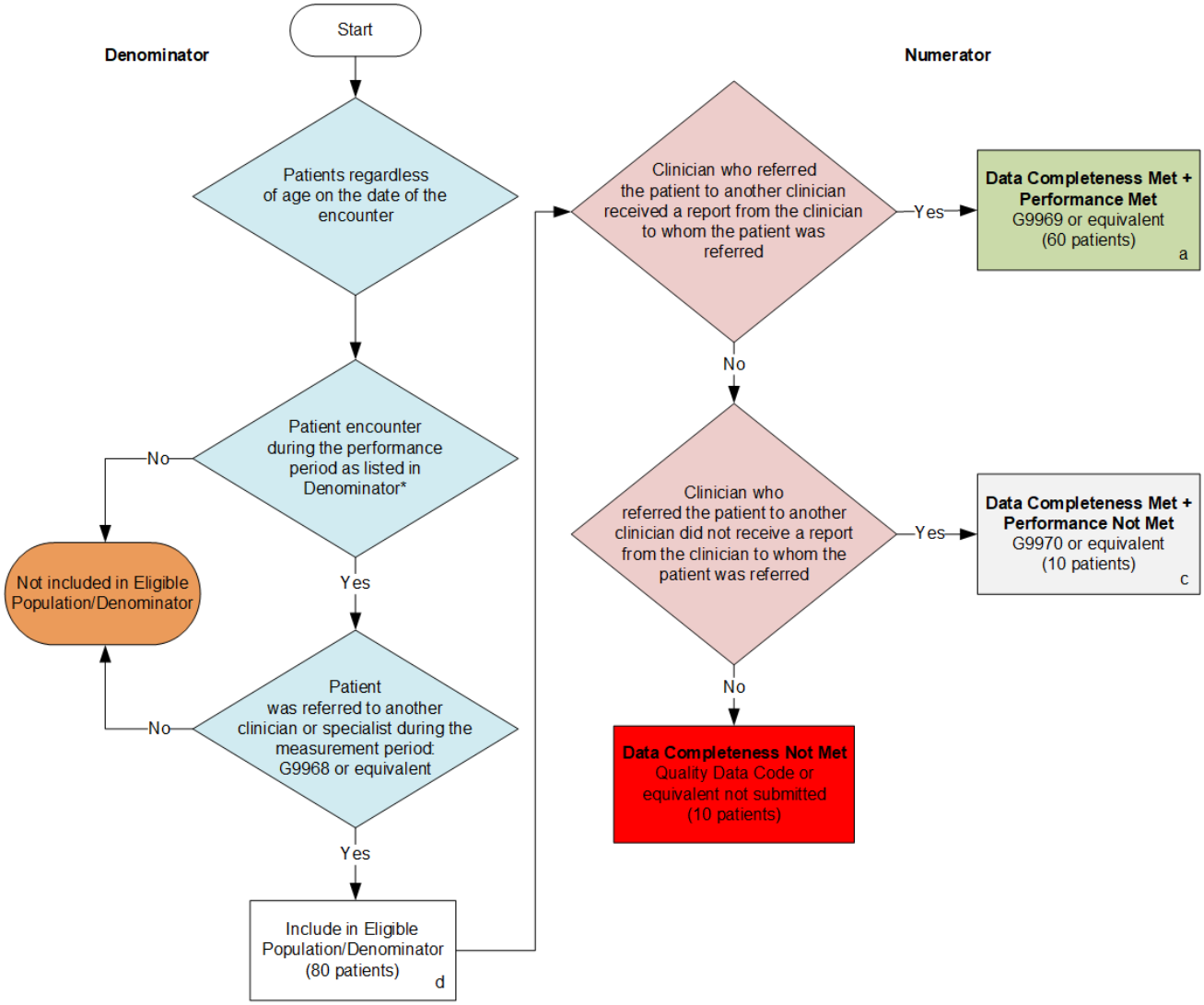
1. Institute for Healthcare Improvement / National Patient Safety Foundation. (2017). Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era. Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era | IHI - Institute for Healthcare Improvement
2. Greenwood-Lee, J., Jewett, L., Woodhouse, L., & Marshall, D. A. (2018). A categorisation of problems and solutions to improve patient referrals from primary to specialty care. BMC health services research, 18(1), 986. https://doi.org/10.1186/s12913-018-3745-y
3. Patel, M. P., Schettini, P., O'Leary, C. P., Bosworth, H. B., Anderson, J. B., & Shah, K. P. (2018). Closing the Referral Loop: an Analysis of Primary Care Referrals to Specialists in a Large Health System. Journal of general internal medicine, 33(5), 715–721. https://doi.org/10.1007/s11606-018-4392-z
4. Odisho, A. Y., Lui, H., Yerramsetty, R., Bautista, F., Gleason, N., Martin, E., Young, J. J., Blum, M., & Neinstein, A. B. (2020). Design and development of referrals automation, a SMART on FHIR solution to improve patient access to specialty care. JAMIA open, 3(3), 405–412. https://doi.org/10.1093/jamiaopen/ooaa036
5. Ramelson, H., Nederlof, A., Karmiy, S., Neri, P., Kiernan, D., Krishnamurthy, R., Allen, A., & Bates, D. W. (2018). Closing the loop with an enhanced referral management system. Journal of the American Medical Informatics Association: JAMIA, 25(6), 715–721. https://doi.org/10.1093/jamia/ocy004

no liability to anyone who relies on such measures or specifications. This measure is in the public domain.
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. AIR disclaims all liability for use or accuracy of any third party codes contained in the specifications.

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.

2026 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

2026 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 *Patients regardless of age on the date of the encounter*
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, proceed to check *Patient was referred to another clinician or specialist during the measurement period.*
4. Check *Patient was referred to another clinician or specialist during the measurement period*:
    a. If *Patient was referred to another clinician or specialist during the measurement period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient was referred to another clinician or specialist during the measurement period* equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population
    - 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.
6. Start Numerator
7. Check *Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred*:
    a. If *Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented in the 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.
    b. If *Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred* equals No, proceed to check *Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred.*
8. Check *Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred:*
    a. If *Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred* equals Yes, include in *Data Completeness Met and Performance Not Met.*
        - *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.

b. If *Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred* equals No, proceed to *Data Completeness Not Met.*

9. Check *Data Completeness Not Met:*

- 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 equals Performance Met (a equals 60 patients) plus Performance Not Met (c equals 10 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 60 patients) divided by Data Completeness Numerator (70 patients). All equals 60 patients divided by 70 patients. All equals 85.71 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.