2020 Quality Payment Program (QPP) Measure Specification and Measure Flow Guide for MIPS Clinical Quality Measures (CQMs)

Utilized by Merit-based Incentive Payment System (MIPS) Eligible Clinicians, Groups, or Third-Party Intermediaries

November 2019

Introduction

This document contains general guidance for the 2020 Quality Payment Program (QPP) Individual Measure Specifications and Measure Flows for MIPS clinical quality measures (CQMs) submissions. The individual measure specifications are detailed descriptions of the quality measures and are intended to be utilized by individual MIPS eligible clinicians submitting CQMs via Quality Clinical Data Registry (QCDR) or Qualified Registries and by groups submitting via Qualified Registry for the 2020 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

Data submission from individual CQMs may be collected by individual MIPS eligible clinicians or groups. Other collection types will utilize different submission types as outlined below.

- There are separate documents for Medicare Part B claims measures collection type.
- Groups electing to submit via the Web Interface (WI) should utilize the Web Interface Measure documents.
- Measure specifications for electronic health record (EHR) based submission should be utilized for the electronic clinical quality measures (eCQMs).
- Information regarding CG-CAHPS may be found at: https://www.ahrq.gov/cahps/about-cahps/index.html

Clinical Quality Measures Specifications

Each measure is assigned a unique number. Measure numbers for 2020 QPP represent a continuation in numbering from the 2019 QPP measures. Measure stewards have provided revisions for the measures that are finalized for use in 2020 QPP.

Frequency with Definitions

Frequency labels are provided in each measures 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 2020 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 MIPS eligible clinician during the performance period.

Performance Period

Performance period for the measure may refer 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. There are several sections (Instruction, Description, or Numerator Statement) within the measure specification that may include information on the performance period. For example, in Quality ID # 19 (NQF 0089): Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care the submitting MIPS eligible clinician would be allowed to 'look back' from the date of the denominator eligible encounter and 'forward' to the end of the current program year to confirm if the most advantageous numerator option was met.

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 as an indication of achievement for a particular process of care being provided or clinical outcome being attained. 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. The numerator focuses 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 may be defined by demographic information, certain International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis, Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) diagnosis, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in the measure that are submitted by individual MIPS eligible clinicians, groups, or third-party intermediaries. CQM collection type may include patients from all payers not just Medicare Part B Physician Fee Schedule (PFS) covered services.

If the specified denominator codes for a measure are not applicable to the patient (for the same date of service) as submitted by the individual MIPS eligible clinician, group, or third-party intermediary, then the patient does not fall into the measure's eligible denominator. Some measure specifications are adapted as needed for implementation in agreement with the measure steward.

Measure specifications include specific instructions regarding CPT Category I modifiers, place of service codes (POS), and other detailed information. Each MIPS eligible clinician, group, or third-party intermediary should carefully review the measure's denominator coding to determine whether codes submitted to a Qualified Registry or QCDR meet denominator inclusion criteria.

Denominator exclusions describe a circumstance where the patient should be removed from the denominator. Measure specifications define denominator exclusion(s) in which a patient should not be included in the intended population for the measure even if other denominator criteria are applicable. Quality-data codes (QDCs) or equivalent codes are available to describe the denominator exclusion and are provided within the measure specification. Patients that meet the intent of the denominator exclusion do not need to be included for data completeness or in the performance rate of the measure.

Numerator Quality-Data Codes

If the patient does fall into the denominator population and no denominator exclusions apply, the applicable QDCs or equivalent as indicated by the registry that define the numerator options should be submitted for data completeness of quality data for CQM submissions.

Performance Met

If the intended quality action for the measure is performed for the patient, QDCs or equivalent from the CQM are available to describe that performance has been met and should be submitted to the Qualified Registry or QCDR.

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, QDCs, or equivalents referenced in the CQM are available to describe medical, patient or system reasons for denominator exceptions and can be submitted to the Qualified Registry or QCDR. 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 judgement by the MIPS eligible clinician.

Performance Not Met
When the denominator exception does not apply, a measure-specific CPT Category II submitting modifier 8P, QDC, or equivalent in the CQM may be used to indicate that the quality action was not provided for a reason not otherwise specified and should be submitted to the Qualified Registry or QCDR.

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.

Each measure specification provides detailed Numerator Options for submitting on the quality action described by the measure. A Qualified Registry or QCDR may or may not utilize these same QDCs. The numerator clinical concepts described for each measure are to be followed when submitting data to a Qualified Registry or QCDR.

HCPCS coding may include G-codes, D-codes, S-codes, or M-codes. These HCPCS codes may be found in 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.

Clinical Quality 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 NPI submitting if the patient meets 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 # 130 (NQF 0419): Documentation of Current Medications in the Medical Record. Provider A sees a patient on February 2, 2020 and documents in the medical record that they obtained, updated, or reviewed the patient's current medications and submits the appropriate QDC, G8427, for Quality ID #130. Provider B sees the same patient at an encounter on July 16, 2020 and documents in the medical record that they obtained, updated, or reviewed the patient's current medications. 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 # 130.

Group Submission
MIPS eligible clinicians submitting under a group practice selecting to participate in the group submission under the same Tax Identification Number (TIN), should be submitting on the same patient, when instructed within the chosen measure. For example, if submitting Quality ID # 130 (NQF 0419): Documentation of Current Medications in the Medical Record all MIPS eligible clinicians under the same TIN would submit each denominator eligible instance as instructed by this measure.

If the group choses a measure that is required to be submitted once per performance period, then this measure should be submitted at least once during the measure period by at least one MIPS eligible clinician under the TIN.

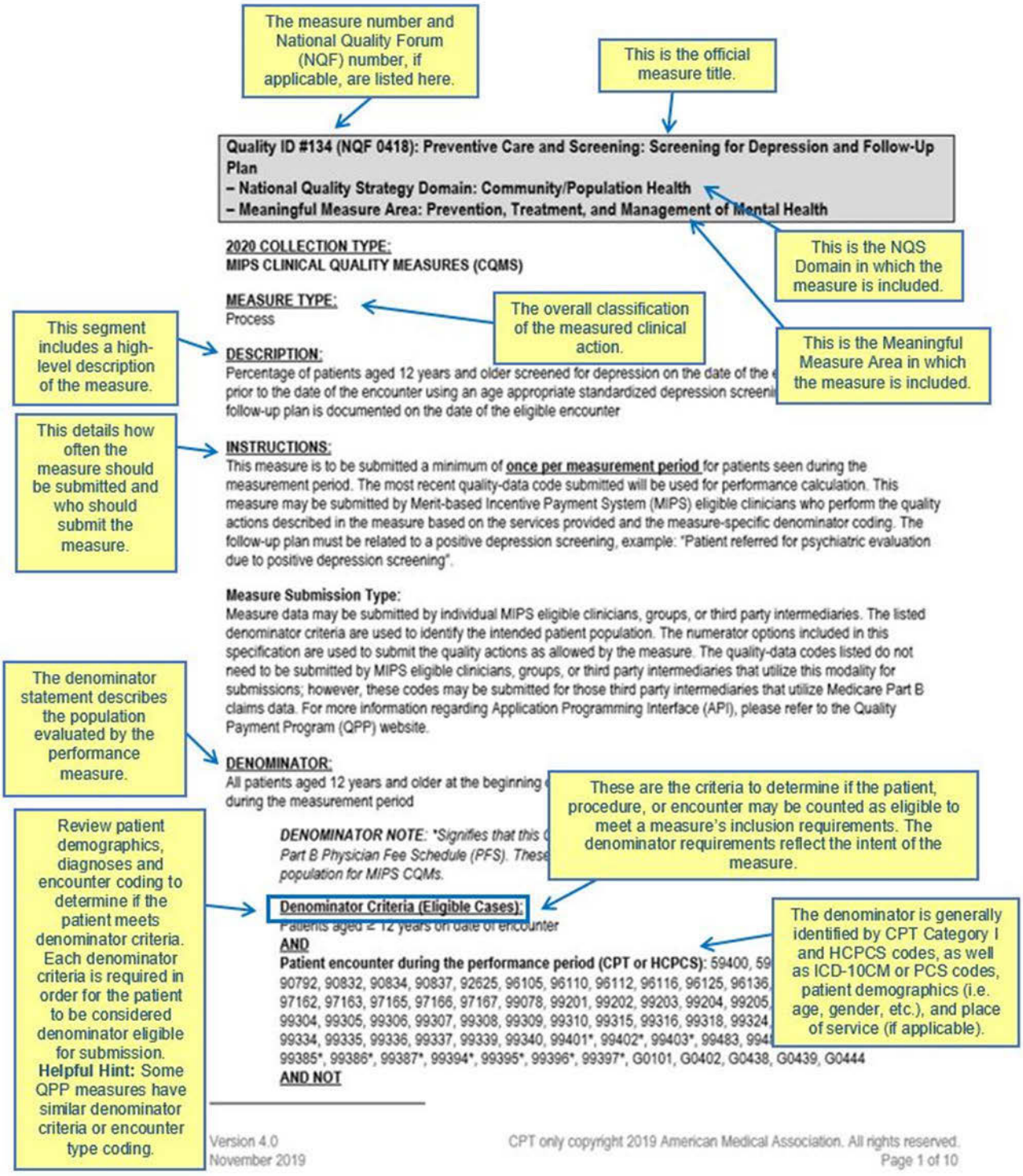
Quality ID # 6 (NQF 0067): Coronary Artery Disease (CAD): Antiplatelet Therapy is an example of a measure that would be submitted once per performance period under the TIN.

CMS recommends review of any measures that an individual MIPS eligible clinician or group 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- 866-288-8912 (Monday – Friday 8:00AM – 8:00PM Eastern Time) or email via qnetsupport@hcqis.org.

Clinical Quality Measure Specification Format (Refer to the Example CQM Specification Below)
Quality ID number, National Quality Forum (NQF) number (if applicable), measure title, National Quality Strategy Domain, and Meaningful Measure Area
Collection Type
Measure type
Measure description
Instructions on submitting including frequency, timeframes, and applicability
Denominator statement, denominator criteria, coding, and denominator exclusion
Numerator statement and coding options (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 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 last tab of the Measures List document, which can be accessed at:
https://qpp-cm-prod-content.s3.amazonaws.com/uploads/763/2020%20MIPS%20Quality%20Measures%20List.xlsx.

Example Clinical Quality Measure (CQM) Specification:



Measures may contain denominator exclusions within the denominator. Denominator exclusions are used to narrow the measure population before determining if the quality action is met.

DENOMINATOR EXCLUSION:

Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or f

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:

Patients screened for depression on the date
using an age appropriate standardized tool A
eligible encounter

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

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.

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-PHQ-2
- **Adult Screening Tools (18 years and older)**
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression S… Duke Anxiety-Depression Scale (DADS), Geriatric …r Depression in Dementia (CSDD), PRIME MD-PHQ… (HAM-D), Quick Inventory of Depressive Symptomat… d Adaptive Testing Depression Inventory (CAT-DI), and …ener (CAD-MDD)
- **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

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

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

- Additional evaluation or assessment 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

Examples of a follow-up plan include but are not limited to:

* Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder
* Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale
* Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression
* Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options
* 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) –

- Patient has an active diagnosis of depression prior to any encounter during the measurement period - F01.51, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345
- Patient has a diagnosed bipolar disorder prior to any encounter during the measurement period - F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9

Patients with a Documented Reason for not Screening for Depression (Denominator Exception) –

One or more of the following conditions are documented during the encounter during the measurement period:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

Numerator Instructions:

A depression screen is completed on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the eligible encounter. Depression screening is required once per measurement period, not at all encounters; this is patient based and not an encounter based measure. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice. The screening should occur during a qualified encounter or 14 days prior to the date of the qualifying encounter.

Section 1: Data Completeness and Performance met

Numerator Options:

Performance Met: Screening for depression is documente… AND a follow-up plan is documented (G…

OR

Performance Met: Screening for depression is documente… follow-up plan is not required **(G8510)**

OR

Denominator Exception: Screening for depression not completed, documented reason **(G8433)**

OR

Performance Not Met: Depression screening not documented, reason not given **(G8432)**

OR

Performance Not Met: Screening for depression documented as positive, follow-up plan not documented, reason not given **(G8511)**

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

Section 2: Measures may have denominator exceptions to represent a medical (1P), patient (2P), or system (3P) reasons for not performing the quality action. Some measures within Quality Payment Program allow no denominator exceptions.

RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease increased health care utilization, and impaired functioning (Pratt& Brody, 2014). 2016 U.S. survey data indicate that 12.8 percent of adolescents (2.2

Section 3: Data Completeness and Performance not Met

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

million adolescents) had a major depressive episode (MDE) in the past year, with nine percent of adolescents (2.2 million adolescents) having one MDE with severe impairment; 6.7 percent of adults aged 18 or older (16.2 million adults) had at least one MDE in the past year, with 4.3 percent of adults (10.3 million adults) having one MDE with severe impairment in the past year (Substance Abuse and Mental Health Services Administration, 2017). Data indicate that severity of depressive symptoms factor into having difficulty with work, home, or social activities. For example, as the severity of depressive symptoms increased, rates of having difficulty with work, home, or social activities related to depressive symptoms increased. For those twelve and older with mild depressive symptoms, 45.7% reported difficulty with activities and those with severe depressive symptoms, 88.0% reported difficulty (Pratt & Brody, 2014). Children and teens with, major depressive disorder (MDD) has been found to have difficulty carrying out their daily activities, relating to others, and growing up healthy with an increased risk of suicide (Siu & the U.S. Preventive Services Task Force [USPSTF], 2016). Additionally, perinatal depression (considered here as depression arising in the period from conception to the end of the first postnatal year) affects up to 15% of women. Depression and other mood disorders, such as bipolar disorder and anxiety disorders, especially during the perinatal period, can have devastating effects on women, infants, and families (Molenaar et al., 2018). 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: "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 et al., 2010, p. 948). "In nationally representative U.S. surveys, about eight percent 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 on behalf of USPSTF, 2016, p. 360 & p. 364). 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 &,USPSTF, 2016, p. 383-384).

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:

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

Adolescent Recommendation (12-18 years):

"The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui on behalf of USPSTF, 2016, p. 360).

"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" (Wilkinson et al., 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 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 et al., 2016 p.p. 8 – 10).

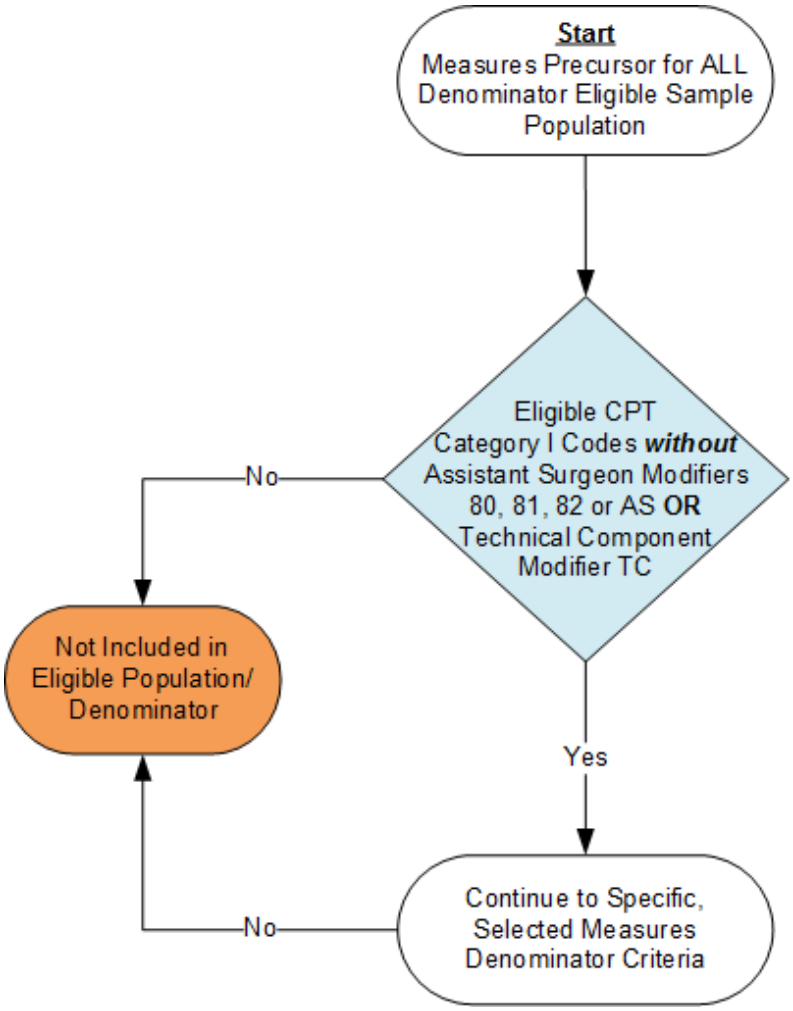
This is the copyright for the measure as indicated by the measure steward.

Interpretation of Clinical Quality Measure Flows

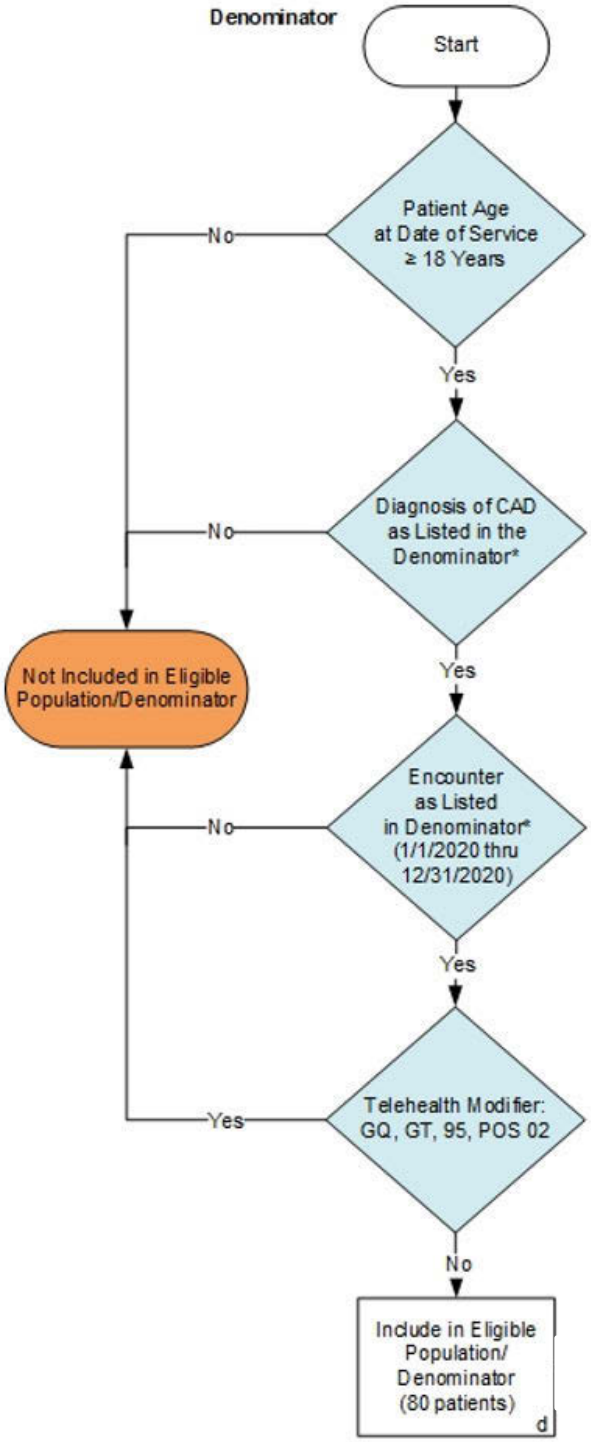
Denominator

The CQM 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 patients from all payers and CPT Categories **without** modifiers 80, 81, 82, AS or TC.

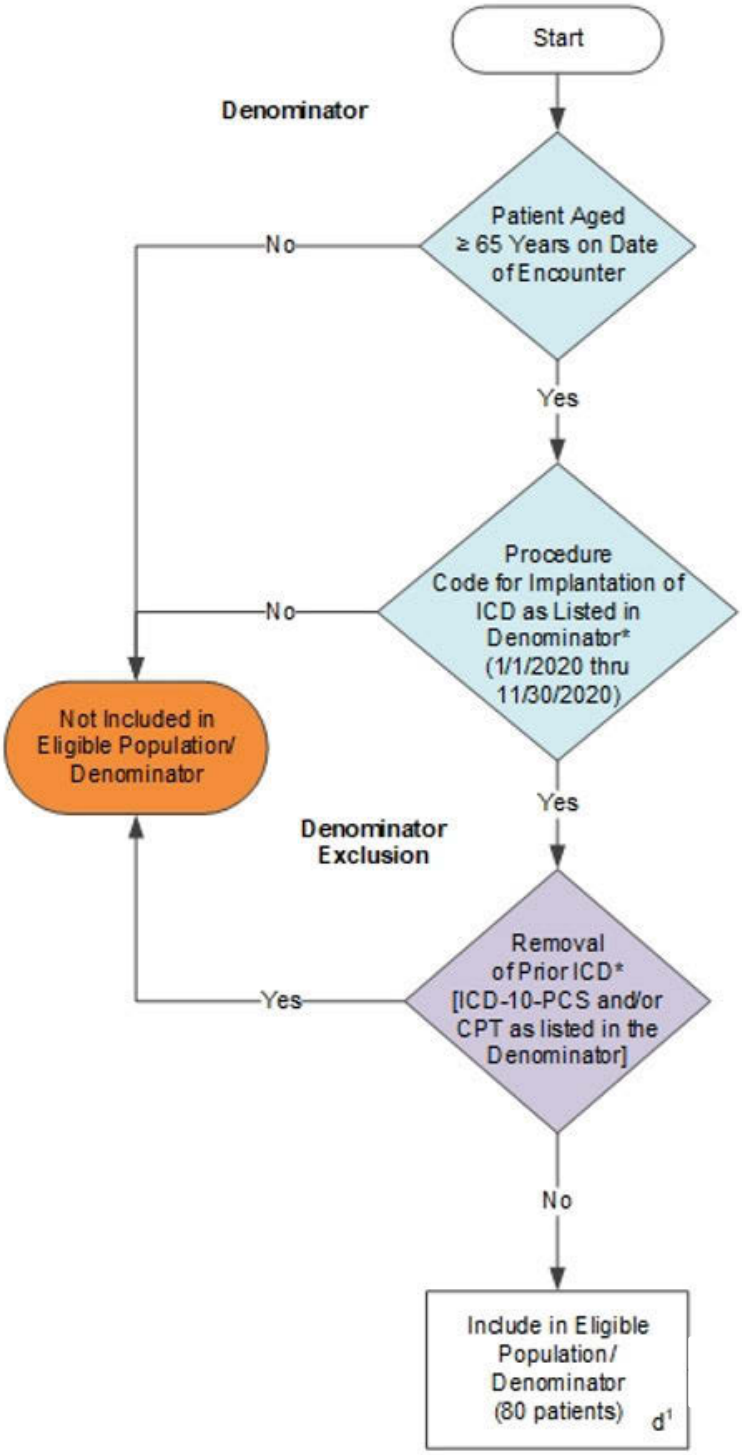
Below is an illustration of additional prerequisite denominator criteria to obtain the patient sample for all 2020 CQMs:



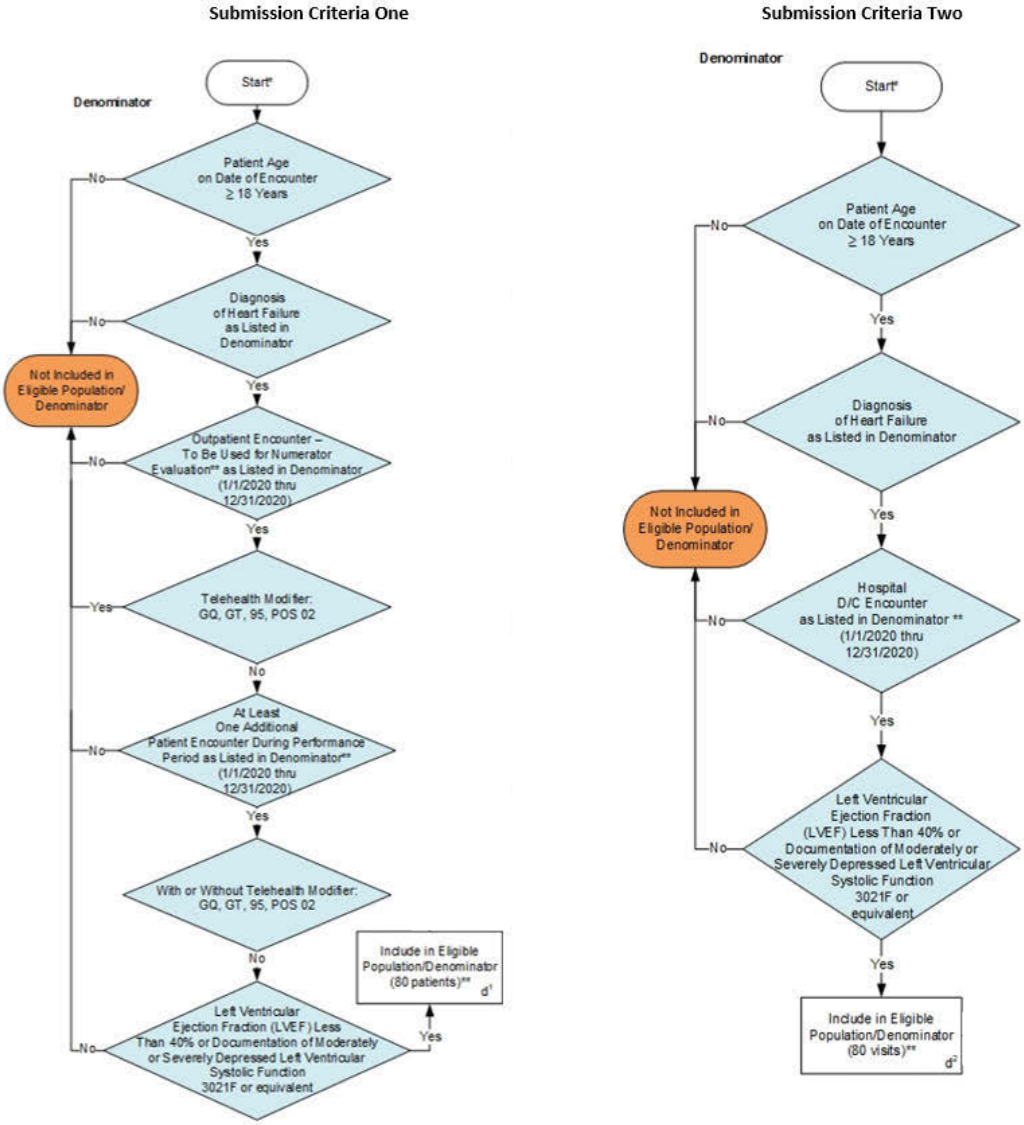
The CQM Flows continue with the appropriate age group and denominator population for the measure. The Eligible Population box equates to the letter “d” by the patient population that meets the measures inclusion requirements. Below is an example of the denominator criteria used to determine the eligible population for Quality ID # 6 (NQF 0067): Coronary Artery Disease (CAD): Antiplatelet Therapy:



In some instances denominator exclusions will be found within the denominator. Quality ID #348: Implantable Cardioverter-Defibrillator (ICD) Complications Rate below is an example of a measure that exhibits a denominator exclusion that is labeled and is represented by a purple diamond.

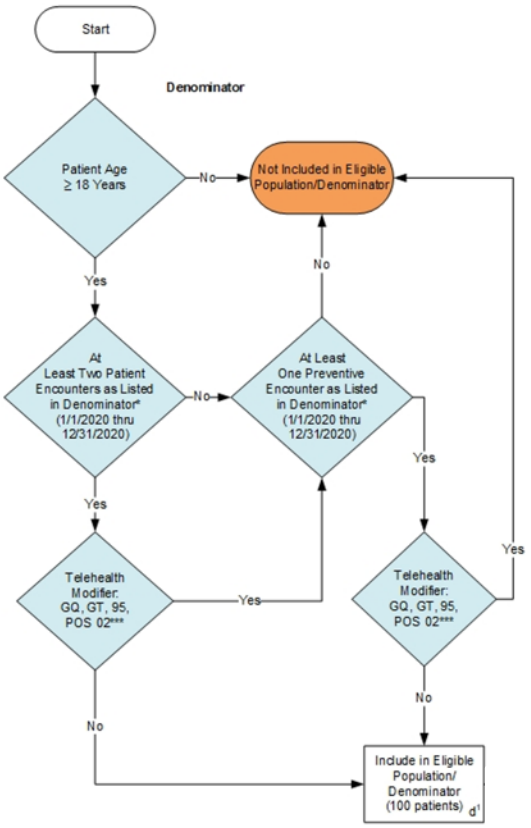


Some measures, such as Quality ID # 5 (NQF 0081): Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD), have multiple options to determine the measure's denominator. Patients meeting the submission criteria for either denominator option are included as part of the eligible population. Review the CQM to determine if multiple performance rates are required for each submission criteria.

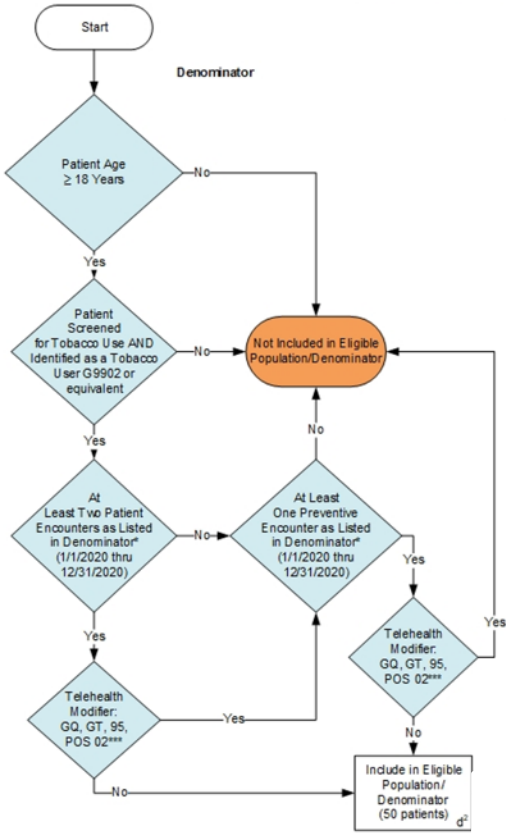


Some CQMs, such as Quality ID # 226 (NQF 0028) Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention have multiple submission criteria and multiple performance rates. Patients meeting the criteria for either denominator option are included as part of the eligible population. Review the CQM to determine if multiple performance rates are required for each submission criteria.

Submission Criteria One/ All patients who were screened for tobacco use

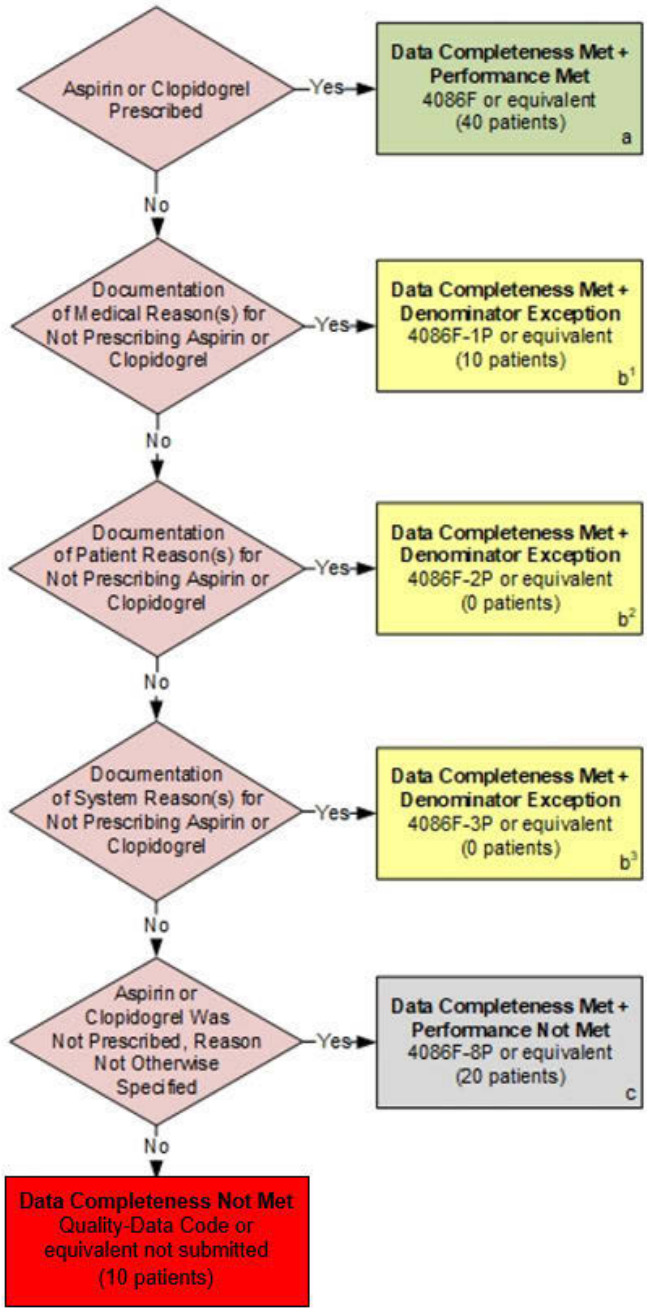


Submission Criteria Two/ All patients who were identified as a tobacco user and who received tobacco cessation intervention



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: Top right box - Performance Met = "a" and shaded green; Middle right boxes - Denominator Exception = "b" and shaded yellow; bottom box - Performance Not Met = "c" and shaded gray; and bottom left box - Data Completeness Not Met = shaded red. 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 # 6 (NQF 0067): Coronary Artery Disease (CAD): Antiplatelet Therapy:



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. Some measures, such as Quality ID #19 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, have a clarifying code and/or language (e.g. G-code G8397 for Quality ID #19) in the numerator to identify eligible patients when no CPT or ICD-10 diagnosis code exists. In the case of Quality ID #19, an applicable CPT code does not exist for dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy. In Medicare Part B claims collection type, a MIPS eligible clinician would submit the numerator code G8397 to identify patients who had a dilated macular or fundus exam with documentation of the results. 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 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 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: Performance Met, Denominator Exception, and Performance Not Met. Below is a sample data completeness algorithm for Quality ID #6. In the example, 80 patients met the denominator criteria for eligibility, where 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 submitted (Data Completeness Not Met). Additionally, depending on the Qualified Registry's or QCDR's data source and abstraction method, the data completeness may not reflect missing numerator data.

Data Completeness =

$$\frac{\text{Performance Met}\,(a=40\,\text{patients}) + \text{Denominator Exception}\,(b1+b2+b3=10\,\text{patients}) + \text{Performance Not Met}\,(c=20\,\text{patients})}{\text{Eligible Population / Denominator}\,(d=80\,\text{patients})} = \frac{70\,\text{patients}}{80\,\text{patients}} = 87.50\%$$

Performance Algorithm

The Performance Algorithm calculation is based on only those patients where data completeness was met for the measure. For those patients reported, 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 CQM measure specification, would add one patient to the denominator and one to the numerator. Patients reporting with 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 #6. In this scenario, the patient sample equals 70 patients where 40 of these patients had the quality action performed (Performance Met) and 10 patients were reported as having a Denominator Exception.

Performance Rate=

$$\frac{\text{Performance Met}\,(a=40\,\text{patients})}{\text{Data Completeness Numerator}\,(70\,\text{patients}) - \text{Denominator Exception}\left(b^1+b^2+b^3=10\,\text{patients}\right)} = \frac{40\,\text{patients}}{60\,\text{patients}} = 66.67\%$$

For measures with inverse performance rates, such as Quality ID #331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse), 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 CQM will provide guidance if the measure is indeed a multiple performance. The CQM flow for these measures includes algorithm examples to understand the different data completeness and performance rates required for the measure. Please note, only the performance rates outlined in the measure specification are to be submitted for CQM submissions. CMS, with Measure Steward feedback, will calculate an overall performance rate for the measure if none is specified within the measure.