2025 Quality Payment Program (QPP) Measure Specification and Measure Flow Guide for Merit-based Incentive Payment System (MIPS) Clinical Quality Measures (CQMs)

Utilized by MIPS Eligible Clinicians, Groups, Virtual Groups, Subgroups, and APM Entities, or Third-Party Intermediaries

December 2024

Introduction

This document offers general guidance for the 2025 Measure Specifications and Measure Flows for the Merit-based Incentive Payment System (MIPS) clinical quality measure (CQM) collection type. The individual Measure Specifications are detailed descriptions of the quality measures and are intended to be used for the purposes of reporting the measures. In addition, each quality Measure Specification includes a Measure Flow with the associated measure calculation algorithm as a resource. This information assists users with understanding quality measure logic related to data completeness and measure performance. The Measure Flow shouldn't be used as a substitute for the quality Measure Specification, but used as an additional visual resource.

Collection Types

MIPS CQM data may be collected by individual MIPS eligible clinicians, groups, virtual groups, subgroups, or APM Entities in preparation for submission to CMS. MIPS CQM data may be gathered from paper, electronic charts, or collected with the assistance of a third party intermediary. Data are collected for all patients that qualify for the measure, not just Medicare patients. The following are the other collection types available for meeting the reporting requirements for the quality performance category. These specifications are located on the QPP Resource Library.

- Medicare Part B Claims Measures: Utilize unique specifications that are specific for collecting and submitting quality data via Medicare Part B claims. Measure data are reported on Medicare Part B claims when they're submitted for reimbursement. (Medicare Part B claims measures can only be reported by solo practitioners and small practices (15 or fewer clinicians).) Data are only reported for Medicare patients.
- Electronic Clinical Quality Measures (eCQMs): Utilize unique specifications that are specific for collecting and submitting quality data via electronic health records (EHRs). Measure data are collected at the point of care in electronic health record technology that's been certified by the Office of the National Coordinator for Health Information Technology (ONC). Data are collected for all patients that qualify for the measure, not just Medicare patients.
- Medicare Clinical Quality Measures (Medicare CQMs): Utilize unique specifications that are specific for collecting quality data (only available for Medicare Shared Savings Program Accountable Care Organizations).
- Qualified Clinical Data Registry (QCDR) Measures: QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures. Data are collected in a manner specified by the QCDR for all patients that qualify for the measure, not just Medicare patients.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey Measure: Assess patients' experiences of care and must be administered by a CMS-approved survey vendor. Advance registration is required.
- Administrative Claims Measures: Automatically assess performance (conducted by CMS) based on Medicare claims and automatically scored if measure requirements are met. Data are only collected for Medicare patients.

Submission Types

MIPS CQMs are often collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians, groups, virtual groups, subgroups, and APM Entities. If you choose the MIPS CQM collection type, you may choose to work with a Qualified Clinical Data Registry (QCDR), Qualified Registry Health IT vendor to submit quality data on your behalf, or you can submit quality data yourself. Individual MIPS eligible clinicians, groups, subgroups, and APM Entities electing to report via MIPS Value Pathways (MVPs) should use the relevant MVP tool kits.

MIPS Clinical Quality Measure Specifications

Each quality measure is assigned a unique measure number for all available collection types. Measure

numbers represent a continuation in numbering since the inception of MIPS (2017 through the 2025 performance period). Measure stewards provided revisions to the measures that were finalized in Calendar Year (CY) 2025 Physician Fee Schedule (PFS) final rule.

MIPS Submission Frequency with Definitions

Submission frequency labels are provided in the instructions of the Measure Specification and Measure Flow for each measure. Each individual MIPS eligible clinician, group, virtual group, subgroup, or APM Entity participating in MIPS should submit data for the 2025 performance period according to the frequency defined for the measure. The following are definitions for submitting frequencies that are used for the calculations of the individual measures.

- **Patient-Intermediate** measures are submitted a minimum of once per patient for the performance period. The most recent numerator option/quality data code (QDC) will be used, if the measure is submitted more than once.
- **Patient-Process** measures are submitted a minimum of once per patient for the performance period. The most advantageous QDC 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 for the performance period. The most advantageous QDC will be used if the measure is submitted more than once for the specified timeframe. If more than one QDC is submitted during the episode time period, performance rates shall be calculated by using the most advantageous QDC.
- **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 has a denominator eligible encounter during the performance period.

Performance Period

Each Measure Specification includes information on the performance period and/or measurement period used to capture the intended numerator and denominator. In general, the performance period for the measure refers to the calendar year of January 1 to December 31. However, a measure may have a different timeframe for determining the measure's intended eligible population or the quality action as defined within the Measure Specification. For example, in the Measure Specification for Quality #019: *Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care*, the measure includes a measurement period that extends prior to the start of the 2025 performance period, which is from the date of the denominator eligible encounter to the end of the 2025 performance period 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. These calculations indicate either achievement of a particular process of care being provided, or a clinical outcome being attained. The denominator is the lower part of a fraction used to calculate a rate, proportion, or ratio and represents the population defined for the measure. The numerator is the upper portion of a fraction used to calculate a rate, proportion, or ratio and represents a subset of the denominator population. The numerator represents the target quality actions defined within the measure. It may be a process, condition, event, or outcome. Numerator criteria are the measure defined quality actions expected for each patient, procedure, or other unit of measurement defined in the denominator.

Denominator (Eligible Cases)

The denominator population is specified in the measure and submitted by individual MIPS eligible clinicians, groups, virtual groups, subgroups, APM Entity, or third-party intermediaries. The denominator population may be defined by the following criteria, and their specifications may be found on the QPP Resource Library.
:

- Demographic information.

- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis.
- International Classification of Diseases, Tenth Revision Procedure Coding System (ICD-10-PCS) procedure.
- Current Procedural Terminology (CPT) code.
- Healthcare Common Procedure Coding System (HCPCS) code.

The MIPS CQM collection type includes patients from all payers, not just Medicare Part B PFS covered services.

If the specified denominator criteria for a measure is not applicable to the patient (in accordance with the posted Measure Specification) as submitted by the individual MIPS eligible clinician, group, virtual group, subgroup,* APM Entity, or third-party intermediary, then the patient does not fall into the measure's eligible denominator and should not be reported. With measure steward guidance, some Measure Specifications are revised annually for implementation in MIPS to ensure that the measures represent the most current clinical concepts and have analytical integrity.

Measure Specifications include instructions regarding CPT Category I modifiers, place of service codes (POS), and other detailed information. Each MIPS eligible clinician, group, virtual group, subgroup, APM Entity, or third party intermediary should carefully review the measure's denominator criteria to determine whether submitted data meets 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 shouldn't be included in the intended population for the measure even if other denominator criteria are applicable. The QDCs, or equivalent codes using other coding systems (e.g., SNOMED, DRG, codes used by individual EHR systems), are available to describe denominator exclusions and are provided within the Measure Specifications. QDCs are HCPCS and CPT Category II codes (or other equivalent codes) describing clinical concepts or outcomes that assist with determining the intended population for the measure. 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 Action of a Measure)

If the patient falls into the denominator eligible population and there are not any denominator exclusions that apply, the applicable QDCs defining the appropriate numerator options should be submitted for data completeness of quality data for MIPS CQM submissions. QDCs found in the Numerator section of the Measure Specification may include CPT Category II, HCPCS, or other coding. QDCs describe the quality action that assist with determining the numerator outcome. For the MIPS CQM collection type, QDCs listed may be substituted with other code languages or equivalent coding that are in alignment with the QDC's intent as described within the Measure Specification.

Performance Met

If the intended quality action for the measure is performed for the patient, QDCs from the MIPS CQM are available to describe that performance has been met. Note, equivalent coding may be utilized in place of QDCs.

Denominator Exception

When a patient falls into the denominator eligible population, but the Measure Specification defines circumstances in which a patient may be deemed as not appropriate for the numerator's quality action, they will be reported as a denominator exception. QDCs, such as CPT Category II codes with modifiers such as 1P, 2P, and 3P, are referenced in the Measure Specification to describe medical, patient, or system reasons and can be submitted as denominator exceptions. Note, equivalent coding may be utilized in place of QDCs. A denominator exception removes a patient from the performance denominator only if the numerator compliant option isn't met and the criteria defined by the exception are met. This allows for the exercise of clinical judgement by the MIPS eligible clinician or consideration of system

limitations.

Performance Not Met
When the denominator exception doesn't apply, measure-specific QDCs, such as CPT Category II codes with or without modifier 8P, are referenced in the Measure Specification to indicate that the quality action wasn't provided for a reason not otherwise specified. Note, equivalent coding may be utilized in place of QDCs.

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.

Please note that for an inverse measure, the denominator exception would be considered if the data doesn't support the "Performance Not Met" numerator option(s).

Each Measure Specification provides detailed numerator options for submitting data for the quality action described by the measure. The numerator clinical concepts described for each measure are to be followed when submitting data to CMS.

Individual Measure Submission
For MIPS eligible clinicians submitting individually, measures (including patient-level measure[s]) may be submitted for the same patient by multiple MIPS eligible clinicians practicing under the same Tax Identification Number (TIN). If a patient sees multiple providers during the performance period, that patient can be counted for each individual National Provider Identifier (NPI) submitting if the patient meets denominator inclusion criteria. The following is an example of two NPIs billing under the same TIN who are intending to submit Quality #317: *Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented*. Clinician A sees a patient on February 2, 2025 and documents in the medical record a normal blood pressure reading with follow-up not required and submits the appropriate QDC, G8783, for Quality #317. Clinician B sees the same patient at an encounter on July 16, 2025 and documents in the medical record a normal blood pressure reading with follow-up not required. Clinician B should also submit the appropriate QDC(s) for the patient at the July encounter to meet data completeness for submission of Quality #317.

Group, Virtual Group, Subgroup, or APM Entity Measure Submission
MIPS eligible clinicians under the same TIN participating in MIPS as a group, virtual group, subgroup, or APM Entity should be submitting on the same patient, as instructed by the submission frequency in the measure. For example, if submitting Quality #317: *Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented*, which should be submitted at each visit, all MIPS eligible clinicians under the same TIN would submit each denominator eligible instance as instructed by the Measure Specification.

If the group, virtual group, subgroup, or APM Entity selects a measure that requires the quality action assessed and submitted at least once per performance period (or patient-process submission frequency), then the data should be submitted according to the submission frequency within the Measure Specification by at least one MIPS eligible clinician under the TIN. As an example, Quality #006: *Coronary Artery Disease (CAD): Antiplatelet Therapy* represents a patient-process submission frequency. This means that when reporting the TIN would need to report this measure's denominator eligible patient at least once during the performance period. If the TIN reports the measure more than once, CMS untilizes the most advantageous numerator outcome reported to determine performance.

CMS recommends reviewing all measures that an individual MIPS eligible clinician, group, virtual group, subgroup, or

APM Entity intends to submit. The measures submission frequency is addressed within the Instructions of the measure and may also be located within the Measure Specification Measure Flow. Included within this guide is an example Measure Specification that will assist with illustrating the analytic, calculation, and different narrative components contained within all MIPS measures.

Need Assistance
If you have any questions, please contact the Quality Payment Program (QPP) Service Center by emailing QPP@cms.hhs.gov, by creating a QPP Service Center ticket, or by calling 1-866-288-8292 (Monday – Friday, 8 a.m. – 8 p.m. ET).

Example MIPS CQM Specification

MIPS Clinical Quality Measure Specification Format: Each MIPS CQM conforms to a standard format. The measure format includes the following fields.

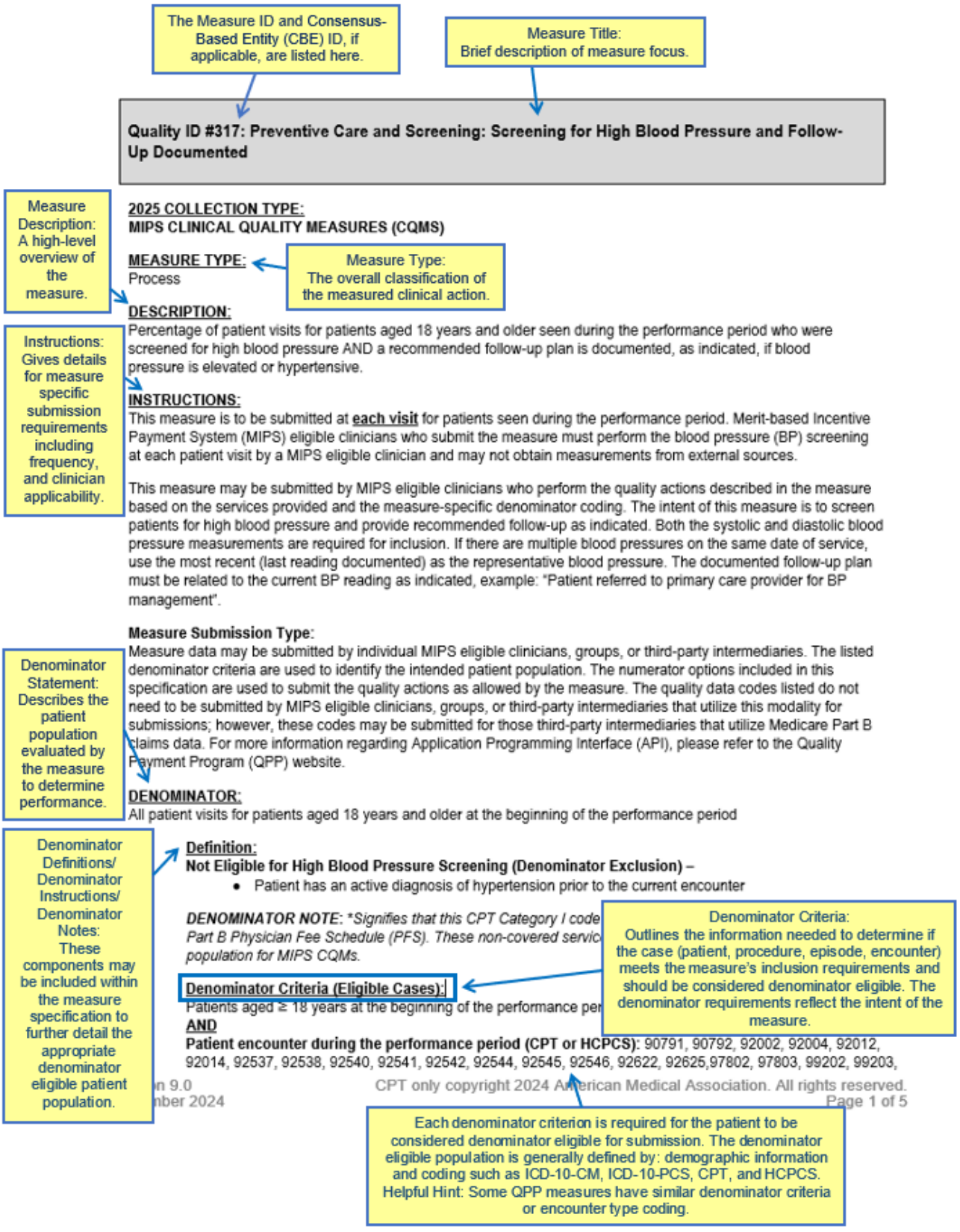
The measure header includes: Quality ID, Consensus-Based Entity (CBE) ID (if applicable), and Measure Title.

The body of the document includes the following sections:

- Collection Type
- Measure Type
- Measure Description
- Instructions on submitting including frequency, timeframes, and applicability
- Denominator Statement, Criteria, Exclusion(s), Exception(s), Instructions, Notes, and Definition(s) of terms where applicable
- Numerator Statement, Options (Performance Met, Denominator Exception, Performance Not Met), Instructions, Notes, and Definition(s) of terms where applicable
- Rationale
- Clinical Recommendation Statements

The Rationale and Clinical Recommendation Statement sections provide clinical guidelines and references supporting the quality actions described in the measure. Please contact the Measure Steward for section references and further information regarding the clinical rationale and recommendations for the described quality action. Measure Steward contact information is located on the "Measure Steward Contacts" tab of the 2025 MIPS Quality Measures List, which can be found on MIPS Explore Measures webpage (select Performance Year 2025).

Example MIPS Clinical Quality Measure (CQM) Specification:



Denominator Exclusion: Describe a circumstance where the patient should be removed from the denominator. If included, they define instances in which a patient shouldn't be included in the intended population for the measure even if other denominator criteria are applicable.

99204, 99205, 99212, 99213, 99214, 99215, 99236, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99 5*, 99386*, 99387*, 99395*, 99396*, 99397*, 99424, 99491, D3921, D7111, D714 0, D7241, D7250, D7251, G0101, G0270, G0402, G0438, G0439

Denominator Criteria to identify whether a measure is eligible for telehealth.

WITHOUT

Telehealth Modifier (including but not limited to): GQ, GT, 95, FQ, 93, PO

AND NOT

DENOMINATOR EXCLUSION:

Patient not eligible due to active diagnosis of hypertension: G9744

Numerator Statement: Describes the quality action being assessed for performance and counted as meeting the measure's requirements (e.g., a patient who received a particular clinical service or achieved a particular health status).

NUMERATOR:

Patient visits where patients were screened for high blood documented, as indicated, if the blood pressure is elevate

Numerator Definitions/ Numerator Instructions/ Numerator Notes: These components may be included within the measure specification to further detail the quality action being assessed for within the measure and what is considered acceptable for determining performance.

Definitions:

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

- Normal BP: Systolic BP (SBP) < 120 mmHg AND Diastolic BP (DBP) < 80 mmHg
- Elevated BP: SBP of 120-129 mmHg AND DBP < 80 mmHg
- First Hypertensive Reading: SBP of >= 130 mmHg OR DBP of >= 80 mmHg without a previous SBP of >= 130 mmHg OR DBP of >= 80 mmHg during the 12 months prior to the encounter
- Second Hypertensive Reading: Requires a SBP >= 130 mmHg OR DBP >= 80 mmHg during the current encounter AND a most recent BP reading within the last 12 months SBP >= 130 mmHg OR DBP >= 80 mmHg

Recommended BP Follow-Up – The 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults from the American College of Cardiology and American Heart Association (2017 Guideline) recommends BP screening and thresholds as defined under Blood Pressure Classifications and recommends interventions based on the current BP reading as listed in the "Recommended Blood Pressure Follow- Up" Table below. The time periods for follow-up actions specified for the elevated and the second hypertensive (130-139 DBP OR 80-89 SBP) BP classifications slightly differ from time periods given in the 2017 Guideline. This allows for clinician discretion due to patient condition and stability of the measure specification over time.

Recommended Nonpharmacologic Interventions (Lifestyle Modifica

outlines nonpharmacologic interventions which must include one or mor

- Weight Reduction
- A "heart-healthy diet", such as Dietary Approaches to Stop Hyp
- Dietary Sodium Restriction
- Increased Physical Activity
- Moderation in alcohol consumption

This is an example of a complex Numerator. Review the Numerator section carefully to ensure the appropriate quality-data codes (QDC's) are submitted and accurately reflect the quality action in alignment with the measure as specified.

Recommended Blood Pressure Follow-Up Table

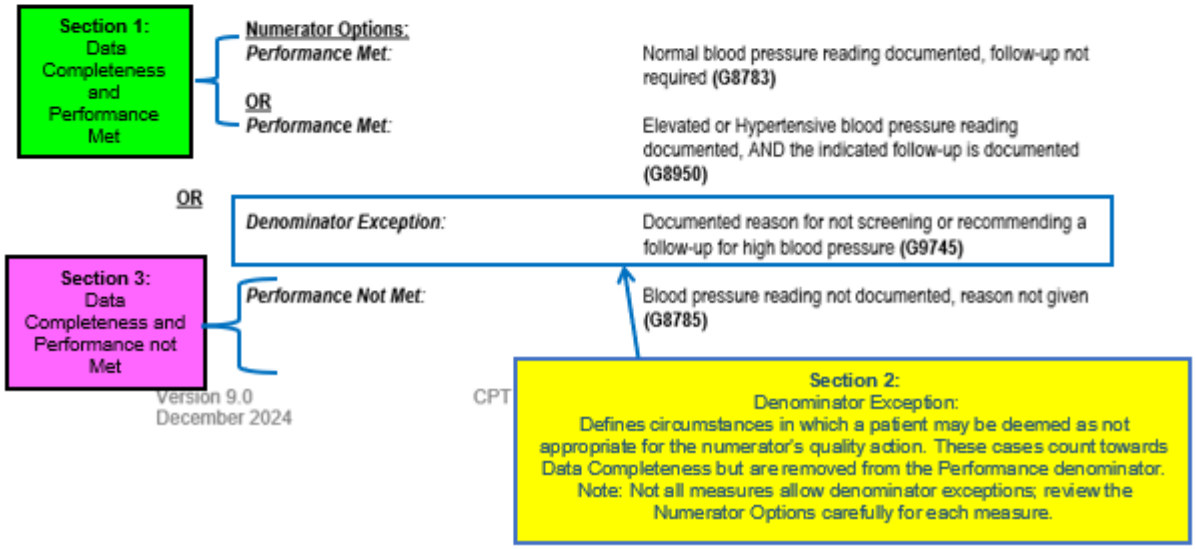
BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up *(must include all indicated actions for each BP Classification)*
Normal BP Reading	< 120	AND < 80	No Follow-Up required
Elevated BP Reading	120-129	AND < 80	Rescreen BP within 6 months **AND** recommended nonpharmacologic interventions **OR** Referral to Alternate/Primary Care Provider

BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up *(must include all indicated actions for each BP Classification)*
First Hypertensive BP Reading	>=130	OR >= 80	Rescreen BP within 4 weeks **AND** recommended nonpharmacologic interventions **OR** Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	130-139 and NOT >=140	OR 80-89 and NOT >=90	Recommended nonpharmacologic intervention **AND** reassessment in within6 months **AND** an order for laboratory test or ECG for hypertension **OR** Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	>=140	OR >=90	Recommended nonpharmacologic intervention **AND** BP-lowering medication **AND** reassessment within 4 weeks **AND** an order for laboratory test or ECG for hypertension **OR** Referral to Alternate/Primary Care Provider

Patients with a Documented Reason for not Screening or no Follow-Up Plan for High Blood Pressure (Denominator Exceptions) –

- Documentation of medical reason(s) for not screening for high blood pressure (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status).
- Documentation of patient reason(s) for not screening for blood pressure measurements or for not ordering an appropriate follow-up intervention if patient BP is elevated or hypertensive (e.g., patient refuses).

***NUMERATOR NOTE**: Although the recommended screening interval for a normal BP reading is every year, to meet the intent of this measure, BP screening and follow-up must be performed at every patient visit. For patients with Normal blood pressure, a follow-up plan is not required **(G8783)**. Denominator Exception(s) are determined on the date of the denominator eligible encounter.*



Section 3, cont.: Data Completeness and Performance not Met

OR
Performance Not Met:

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

RATIONALE:
Hypertension is a prevalent condition that affects approximately 66.9 million people in the United States. It is estimated that about 20-40 percent of the adult population has hypertension; the m
nsion diagnosis (1,2). Winter noted that 1 in 3 American adults ha
ing hypertension is 90 percent (3). The African American popula
s and those with chronic kidney disease are at increased risk of s
spanic Blacks have the highest prevalence at 38.6 percent (3). Hy
sease, left ventricular hypertrophy, renal failure, stroke and deme
nt of established hypertension are complementary approaches to
on, but prevention of hypertension provides the optimal means of reducing risk and avoiding harmful consequences. Periodic BP screening can identify individuals who develop elevated BP over time. More frequent BP screening may be particularly important for individuals with elevated atherosclerotic cardiovascular disease (ASCVD) risk (4).

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

Quality Data Codes (QDCs): Describe clinical concepts or outcomes required for determining the intended population for the measure and/or numerator outcome. Here, the QDCs describe a quality action that assist with determining the numerator outcome.

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

Appropriate follow-up after blood pressure measurement is a pivotal component in preventing the progression of hypertension and the development of heart disease. Detection of marginally or fully elevated blood pressure by a specialty clinician warrants referral to a provider familiar with the management of hypertension and prehypertension.

The American College of Cardiology/American Heart Association (ACC/AHA) 2017 Guidelines provide updated recommendations for ASCVD risk. For additional information please refer to the 2017 ACC/AHA guidelines: https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/11/09/11/41/2017-guideline-for-high-blood-pressure-in-adults (4).

Lifestyle modifications have demonstrated effectiveness in lowering blood pressure (6). The synergistic effect of several lifestyle modifications results in greater benefits than a single modification alone. Baseline diagnostic/laboratory testing establishes if a co-existing underlying condition is the etiology of hypertension and evaluates if end organ damage from hypertension has already occurred. Landmark trials such as the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) have repeatedly proven the efficacy of pharmacologic therapy to control blood pressure and reduce the complications of hypertension. A review of 35 studies found that the pharmacist-led interventions involved medication counseling and patient education. Twenty-nine of the 35 studies showed statistically significant improvement in BP levels of the intervention groups at follow-up (7). Follow-up intervals based on blood pressure control have been established by the 2017 ACC/AHA guideline and the United States Preventive Services Task Force (USPSTF).

References

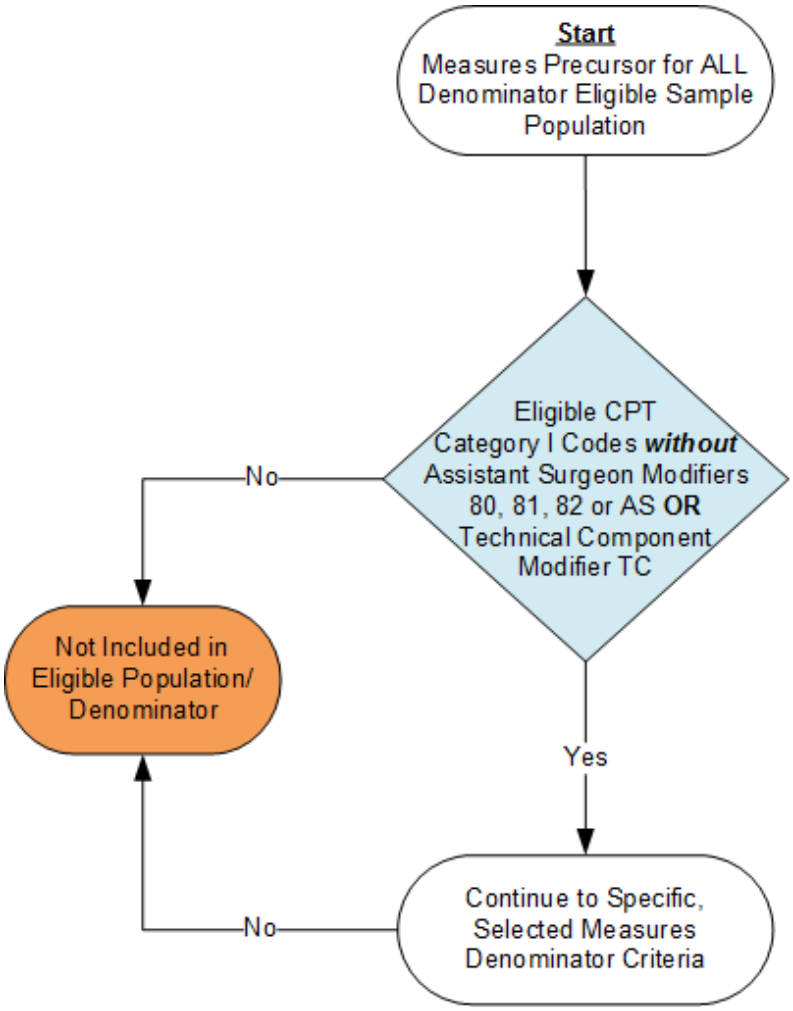
1. Appleton, S. L., Neo, C., Hill, C. L., Douglas, K. A., & Adams, R. J. (2013). Untreated hypertension: prevalence and patient factors and beliefs associated with under-treatment in a population sample. Journal of Human Hypertension, 27, 453-462. doi:10.1038/jhh.2012.62ID
2. 'Luehr, D., Woolley, T., Burke, R., Dohmen, F., Hayes, R., Johnson, M...., Schoenleber, M. (2012). Hypertension diagnosis and treatment; Institute for Clinical Systems Improvement health care guideline. Updated November, 2012

Interpretation of MIPS Clinical Quality Measure Flows

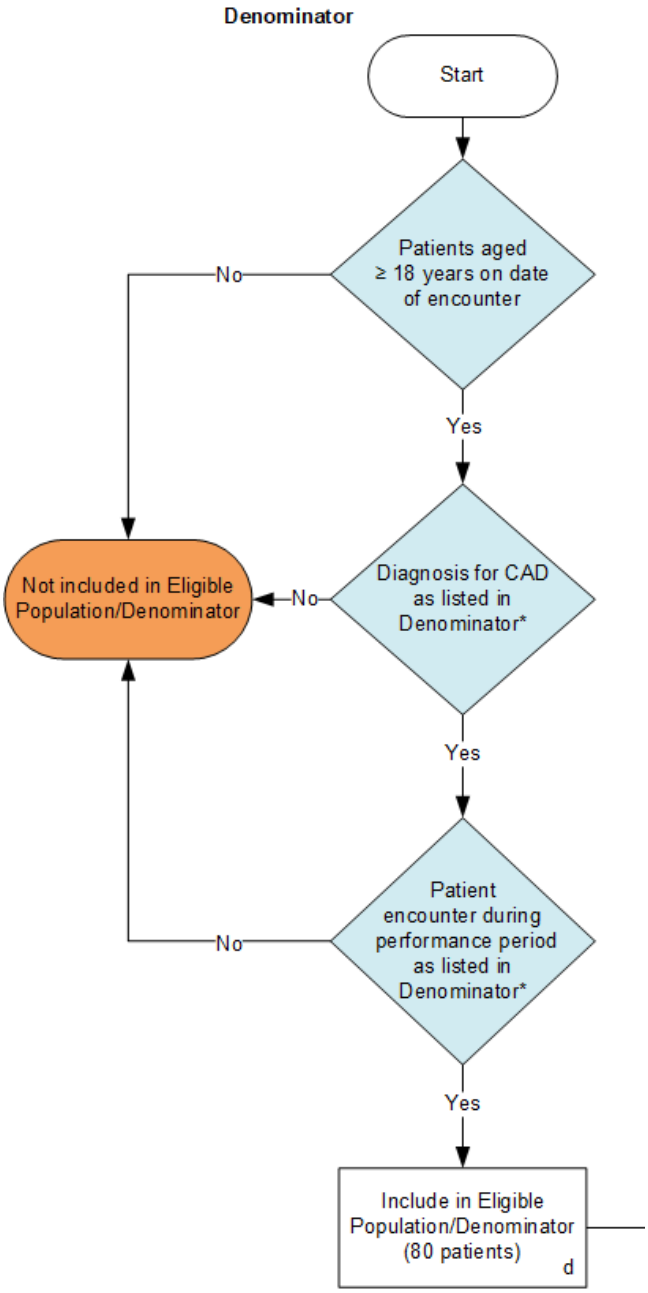
Denominator

The MIPS CQM Flow is designed to provide interpretation of the measure logic and calculation methodology for data completeness and performance rates. The measure flow starts 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.

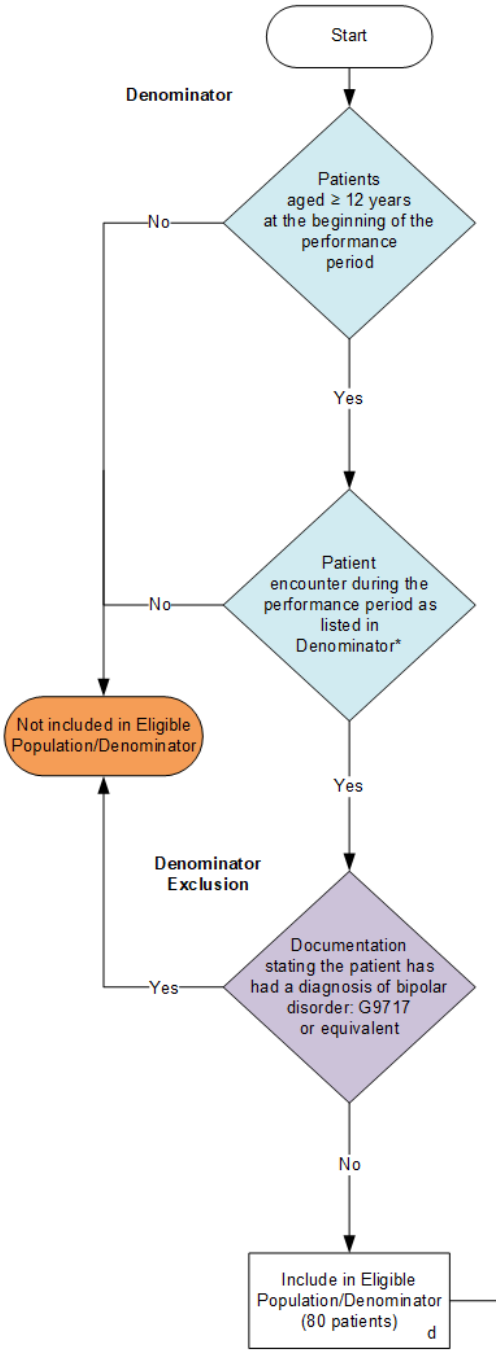
Below is an illustration of the above prerequisite denominator criteria to obtain the patient sample for all 2025 MIPS CQMs:



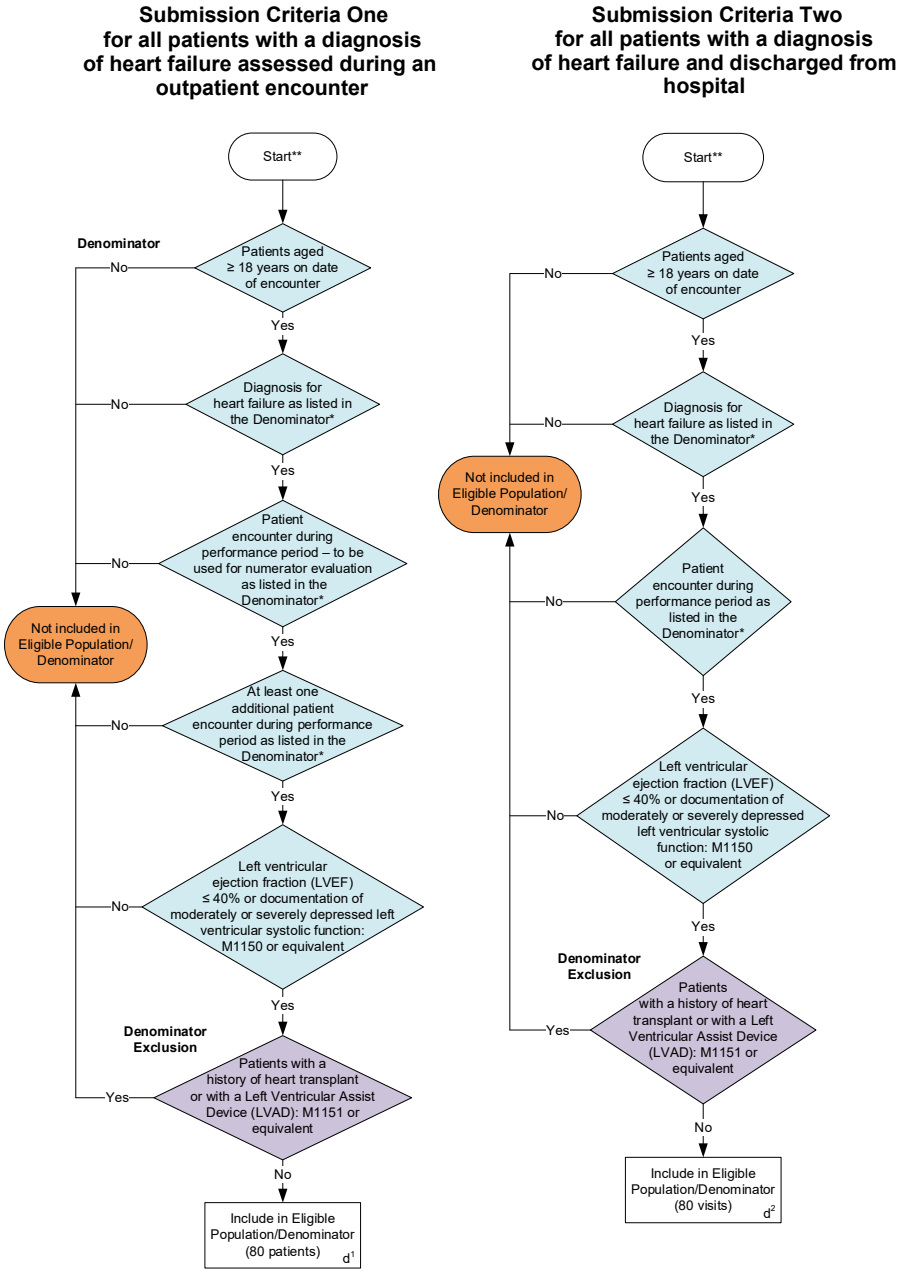
The MIPS CQM Flow in each Measure Specification begins with the appropriate age group and denominator population for the measure. The Eligible Population box equates to the letter "d" (as shown at the bottom right corner of the last box of the denominator diagram) by the patient population that meets the measure's inclusion requirements. Below is an example of the denominator criteria used to determine the eligible population for Quality #006: *Coronary Artery Disease (CAD): Antiplatelet Therapy*:



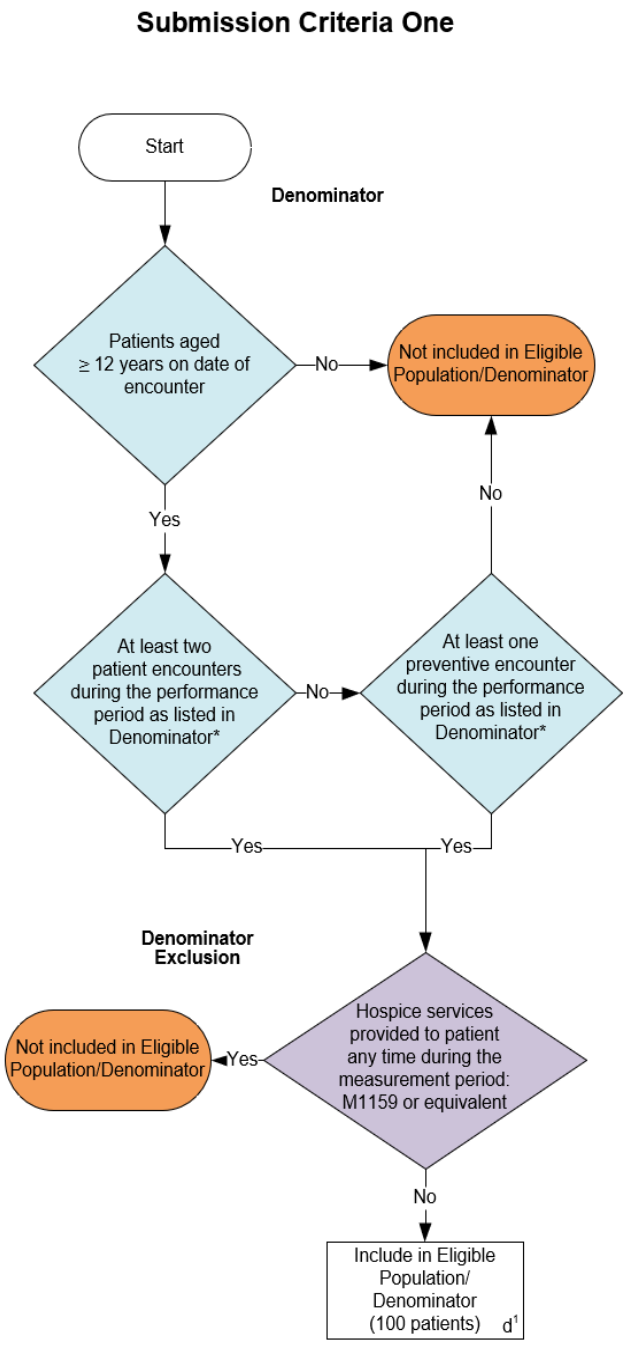
In some cases, denominator exclusions will be found within the denominator. Quality #134: *Preventive Care and Screening: Screening for Depression and Follow-Up Plan* below is an example of a measure that exhibits a denominator exclusion that is labeled and is represented by a purple diamond.

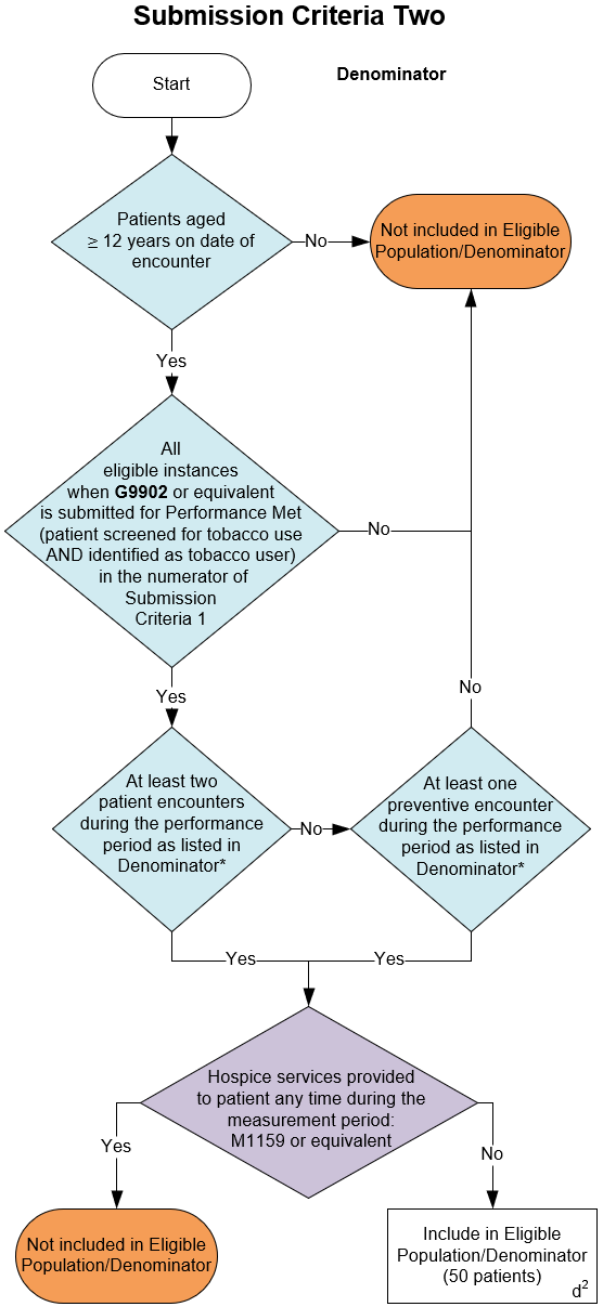


Some measures, such as Quality #005: *Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)*, have multiple options to determine the measure's denominator. Patients meeting the submission criteria for either denominator option are included as part of the eligible population. Review the Instructions section of the MIPS CQM Specification to determine if it contains multiple submission criteria, each of which will be fully detailed within Denominator section.



Some MIPS CQMs, such as Quality ID #226: *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 Denominator section of the MIPS CQM Specification to determine if there are multiple submission criteria to report. The example below shows two of three submission criteria for this example measure.



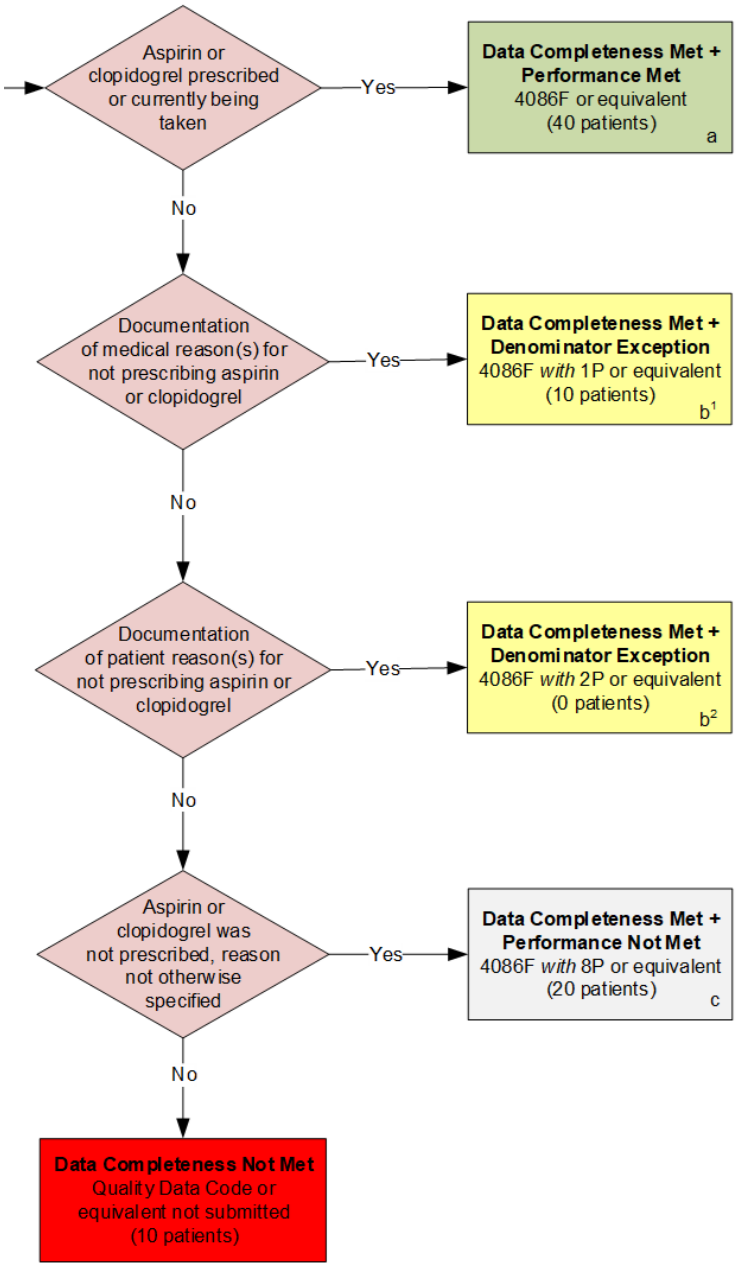


Numerator

Once the denominator is identified, the MIPS CQM Flow illustrates and stratifies the quality action (numerator) to assist with calculation of data completeness and performance. Depending on the measure, there are several outcomes that may be applicable for the measure's calculation. Each measure outcome is represented by a variable that is included in an algorithm. The number of patients within an outcome category will be used to populate the algorithm:

- Top right box - Performance Met = "a" and shaded green;
- Middle right boxes - Denominator Exception = "b^1" and "b^2" and shaded yellow;
- Bottom box - Performance Not Met = "c" and shaded gray; and
- Bottom box - Data Completeness Not Met = shaded red.

On the flow, these outcomes are color-coded and labeled as described to identify the particular outcome of the measure represented. An example is illustrated below for Quality ID #006: *Coronary Artery Disease (CAD): Antiplatelet Therapy*.



Algorithms

Please note that a Measure Specification includes a data completeness and performance algorithm for each submission criteria and/or performance rate. Information regarding submission requirements for each measure will be found within the Measure Narrative section (separate from the Flow Narrative section) of the Measure Specification.

Data Completeness Algorithm

The Data Completeness Algorithm calculation is based on the eligible population and the volume of performance data reported as described in the Measure Flow. 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 #006: *Coronary Artery Disease (CAD): Antiplatelet Therapy*. In the example, 80 patients met the denominator criteria for eligibility, 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).

Data Completeness =

$$\frac{\text{Performance Met (a=40 patients) + Denominator Exceptions } (b^1 + b^2 = 10 \text{ patients}) + \text{Performance Not Met (c=20 patients)}}{\text{Eligible Population/Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Algorithm

The Performance Algorithm calculation begins with only those patients where data completeness was met and reported for the measure. For those patients reported, the numerator is then determined based on completion of the quality action as indicated by Performance Met. Meeting the quality action for a patient, as indicated in the MIPS CQM specification, would add one patient to the denominator and one to the numerator. Patients reported as Denominator Exceptions are subtracted from the performance denominator when calculating the performance rate percentage. Below is a sample Performance Algorithm that represents this calculation for Quality ID #006: *Coronary Artery Disease (CAD): Antiplatelet Therapy*. In this scenario, the patient sample for data completeness per the numerator equals 70 patients where 40 of these patients had the quality action performed (Performance Met) and 10 patients were reported as meeting the Denominator Exception.

Performance Rate =

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

Multiple Performance Rates

MIPS measures may contain multiple performance rates. The Instructions section of the MIPS CQM will provide guidance if the measure is indeed a multiple performance rate measure. The Measure Flow for MIPS CQMs includes algorithm examples to understand the different data completeness and performance rates for the measure. Please note that only the performance rates outlined in the Measure Specification are to be submitted for meeting the reporting requirements for the MIPS CQM .