



2021 Quality Payment Program (QPP) Measure Specification and Measure Flow Guide for Medicare Part B Claims Measures

Utilized by Merit-based Incentive Payment System (MIPS) Eligible Clinicians

November 2020

Introduction

This document contains general guidance for the 2021 Quality Payment Program (QPP) Individual Measure Specifications and Measure Flows for Medicare Part B claims submissions. The individual measure specifications are detailed descriptions of the quality measures and are intended to be utilized by individual MIPS eligible clinicians submitting individual measures via Medicare Part B claims for the 2021 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

Other collection types will utilize different submission types as outlined below.

- There are separate documents for the MIPS Clinical Quality Measures (CQMs) 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 electronic clinical quality measures (eCQMs).
- Information regarding CG-CAHPS may be found at: <https://www.ahrq.gov/cahps/about-cahps/index.html>

Medicare Part B claims Measure Specifications

Each measure is assigned a unique number. Measure numbers for 2021 QPP represent a continuation in numbering from the 2020 QPP measures. Measure stewards have provided revisions for the measures that are finalized for use in 2021 QPP.

Frequency with Definitions

Frequency labels are provided in each measure 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 2021 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

There are several sections (Instruction, Description, or Numerator Statement) within the measure specification that may include information on the 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.

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. 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 Codes (Eligible Cases)

The denominator population is specified in the measure and submitted by individual MIPS eligible clinicians. The denominator population may be defined by the following criteria:

- Demographic information
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM),
- International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS),
- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS) codes

These criteria may be specified in the measure and submitted by individual MIPS eligible clinicians as part of a claim for covered services under the Medicare Part B Physician Fee Schedule (PFS) for Medicare Part B claims collection type. HCPCS coding may include G-codes, D-codes, S-codes, or M-codes. QDCs may be found in the denominator or numerator and may utilize HCPCS coding. These QDCs describe clinical outcomes or quality actions that assist with determining the intended population or numerator outcome.

If the specified denominator codes for a measure are not included on the patient's claim (for the same date of service) as submitted by the individual MIPS eligible clinician, then the patient does not fall into the measure's eligible denominator population, and the measure does not apply to the patient. Some measure specifications are adapted as needed for implementation in agreement with the measure steward. For example, CPT codes for non-covered services such as preventive visits may be included in the denominator but would not apply to the measure since only covered services can be analyzed via claims data.

Measure specifications include specific instructions regarding CPT Category I modifiers, place of service codes (POS), and other detailed information. Each MIPS eligible clinician should carefully review the measure's denominator coding to determine whether codes submitted on a given claim meet denominator inclusion criteria.

Numerator Quality-Data Codes

If the patient does fall into the denominator population, the applicable Quality-data codes (QDCs) that define the numerator should be submitted for data completeness of quality data for a measure for Medicare Part B claims submissions.

Denominator Exclusion:

Typically, a denominator exclusion describes a circumstance where the patient should be removed from

the denominator. Within Medicare Part B claims submissions, denominator exclusions identify circumstances where the patient should be removed from the performance rate calculation prior to determining which numerator outcome is appropriate. QDCs are available to describe the denominator exclusion within the measure specification and should be submitted on the claim. For Medicare Part B claims submission, these patients should be included within the data completeness calculation, but removed from the denominator of the performance rate. Please refer to the algorithm portion of this document below.

Performance Met:

If the intended quality action for the measure is performed for the patient, QDCs are available to describe that performance has been met and should be submitted on the claim.

Denominator Exception:

When a patient falls into the denominator, but the measure specifications define circumstances in which a patient may be appropriately deemed as a denominator exception. CPT Category II code modifiers such as 1P, 2P, and 3P or QDCs are available to describe medical, patient, or system reasons for denominator exceptions and must be submitted on the claim. 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 judgment by the MIPS eligible clinician.

Performance Not Met:

When the denominator exception does not apply, a measure-specific CPT Category II submitting modifier 8P or QDC may be used to indicate that the quality action was not provided for a reason not otherwise specified and must be submitted on the Medicare Part B claim.

Inverse Measure

A lower calculated performance rate for this type of measure would indicate better clinical care or control. The “Performance Not Met” numerator option for an inverse measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.

Medicare Part B claims 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 encounter(s) meet denominator inclusion. The following is an example of two provider NPIs (National Provider Identifiers), billing under the same TIN who are intending to submit Quality ID # 130 (NQF 0419): Documentation of Current Medications in the Medical Record. Provider A sees a patient on February 2, 2021 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, 2021 documents in the medical record that they obtained, updated or reviewed the patient’s current medications. Provider B should also submit the appropriate QDC, G8427, for the patient at the July encounter to meet data completeness for submission of Quality ID # 130.

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

Medicare Part B claims Measure Specification Format (Refer to the Example Measure 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 and coding

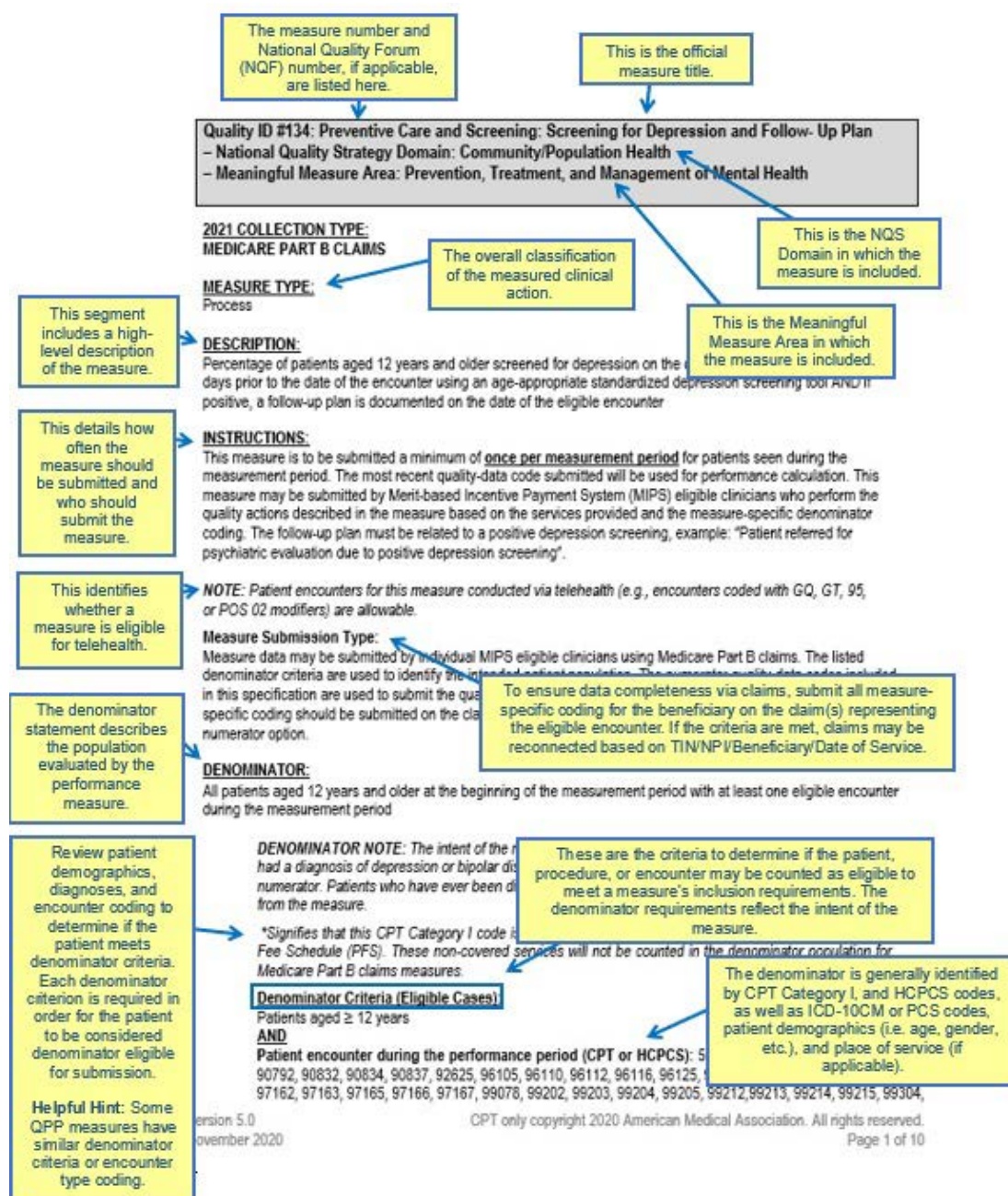
Numerator statement and coding options (denominator exclusion, performance met, denominator exception, performance not met)

Definition(s) of terms where applicable Rationale

Clinical recommendations statement or clinical evidence supporting the measure intent

The Rationale and Clinical Recommendation Statements sections provide limited 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 2021 MIPS Quality Measures List, which can be found on the MIPS Explore Measures page: <https://qpp.cms.gov/mips/explore-measures>.

Example Medicare Part B claims Measure Specification:



99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99341, 99342, 99343, 99344, 99345, 99346, 99347, 99348, 99349, 99350, 99351, 99352, 99353, 99354, 99355, 99356, 99357, 99358, 99359, 99360, 99361, 99362, 99363, 99364, 99365, 99366, 99367, 99368, 99369, 99370, 99371, 99372, 99373, 99374, 99375, 99376, 99377, 99378, 99379, 99380, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99388, 99389, 99390, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99398, 99399, 99400, 99401, 99402, 99403, 99404, 99405, 99406, 99407, 99408, 99409, 99410, 99411, 99412, 99413, 99414, 99415, 99416, 99417, 99418, 99419, 99420, 99421, 99422, 99423, 99424, 99425, 99426, 99427, 99428, 99429, 99430, 99431, 99432, 99433, 99434, 99435, 99436, 99437, 99438, 99439, 99440, 99441, 99442, 99443, 99444, 99445, 99446, 99447, 99448, 99449, 99450, 99451, 99452, 99453, 99454, 99455, 99456, 99457, 99458, 99459, 99460, 99461, 99462, 99463, 99464, 99465, 99466, 99467, 99468, 99469, 99470, 99471, 99472, 99473, 99474, 99475, 99476, 99477, 99478, 99479, 99480, 99481, 99482, 99483, 99484, 99485, 99486, 99487, 99488, 99489, 99490, 99491, 99492, 99493, 99494, 99495, 99496, 99497, 99498, 99499, 99500, 99501, 99502, 99503, 99504, 99505, 99506, 99507, 99508, 99509, 99510, 99511, 99512, 99513, 99514, 99515, 99516, 99517, 99518, 99519, 99520, 99521, 99522, 99523, 99524, 99525, 99526, 99527, 99528, 99529, 99530, 99531, 99532, 99533, 99534, 99535, 99536, 99537, 99538, 99539, 99540, 99541, 99542, 99543, 99544, 99545, 99546, 99547, 99548, 99549, 99550, 99551, 99552, 99553, 99554, 99555, 99556, 99557, 99558, 99559, 99560, 99561, 99562, 99563, 99564, 99565, 99566, 99567, 99568, 99569, 99570, 99571, 99572, 99573, 99574, 99575, 99576, 99577, 99578, 99579, 99580, 99581, 99582, 99583, 99584, 99585, 99586, 99587, 99588, 99589, 99590, 99591, 99592, 99593, 99594, 99595, 99596, 99597, 99598, 99599, 99600, 99601, 99602, 99603, 99604, 99605, 99606, 99607, 99608, 99609, 99610, 99611, 99612, 99613, 99614, 99615, 99616, 99617, 99618, 99619, 99620, 99621, 99622, 99623, 99624, 99625, 99626, 99627, 99628, 99629, 99630, 99631, 99632, 99633, 99634, 99635, 99636, 99637, 99638, 99639, 99640, 99641, 99642, 99643, 99644, 99645, 99646, 99647, 99648, 99649, 99650, 99651, 99652, 99653, 99654, 99655, 99656, 99657, 99658, 99659, 99660, 99661, 99662, 99663, 99664, 99665, 99666, 99667, 99668, 99669, 99670, 99671, 99672, 99673, 99674, 99675, 99676, 99677, 99678, 99679, 99680, 99681, 99682, 99683, 99684, 99685, 99686, 99687, 99688, 99689, 99690, 99691, 99692, 99693, 99694, 99695, 99696, 99697, 99698, 99699, 99700, 99701, 99702, 99703, 99704, 99705, 99706, 99707, 99708, 99709, 99710, 99711, 99712, 99713, 99714, 99715, 99716, 99717, 99718, 99719, 99720, 99721, 99722, 99723, 99724, 99725, 99726, 99727, 99728, 99729, 99730, 99731, 99732, 99733, 99734, 99735, 99736, 99737, 99738, 99739, 99740, 99741, 99742, 99743, 99744, 99745, 99746, 99747, 99748, 99749, 99750, 99751, 99752, 99753, 99754, 99755, 99756, 99757, 99758, 99759, 99760, 99761, 99762, 99763, 99764, 99765, 99766, 99767, 99768, 99769, 99770, 99771, 99772, 99773, 99774, 99775, 99776, 99777, 99778, 99779, 99780, 99781, 99782, 99783, 99784, 99785, 99786, 99787, 99788, 99789, 99790, 99791, 99792, 99793, 99794, 99795, 99796, 99797, 99798, 99799, 99800, 99801, 99802, 99803, 99804, 99805, 99806, 99807, 99808, 99809, 99810, 99811, 99812, 99813, 99814, 99815, 99816, 99817, 99818, 99819, 99820, 99821, 99822, 99823, 99824, 99825, 99826, 99827, 99828, 99829, 99830, 99831, 99832, 99833, 99834, 99835, 99836, 99837, 99838, 99839, 99840, 99841, 99842, 99843, 99844, 99845, 99846, 99847, 99848, 99849, 99850, 99851, 99852, 99853, 99854, 99855, 99856, 99857, 99858, 99859, 99860, 99861, 99862, 99863, 99864, 99865, 99866, 99867, 99868, 99869, 99870, 99871, 99872, 99873, 99874, 99875, 99876, 99877, 99878, 99879, 99880, 99881, 99882, 99883, 99884, 99885, 99886, 99887, 99888, 99889, 99890, 99891, 99892, 99893, 99894, 99895, 99896, 99897, 99898, 99899, 99900, 99901, 99902, 99903, 99904, 99905, 99906, 99907, 99908, 99909, 99910, 99911, 99912, 99913, 99914, 99915, 99916, 99917, 99918, 99919, 99920, 99921, 99922, 99923, 99924, 99925, 99926, 99927, 99928, 99929, 99930, 99931, 99932, 99933, 99934, 99935, 99936, 99937, 99938, 99939, 99940, 99941, 99942, 99943, 99944, 99945, 99946, 99947, 99948, 99949, 99950, 99951, 99952, 99953, 99954, 99955, 99956, 99957, 99958, 99959, 99960, 99961, 99962, 99963, 99964, 99965, 99966, 99967, 99968, 99969, 99970, 99971, 99972, 99973, 99974, 99975, 99976, 99977, 99978, 99979, 99980, 99981, 99982, 99983, 99984, 99985, 99986, 99987, 99988, 99989, 99990, 99991, 99992, 99993, 99994, 99995, 99996, 99997, 99998, 99999, 100000.

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 of the encounter using an age-appropriate standardized tool AND an eligible encounter

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.

Examples of standardized 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

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 completeness and performance.

Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QIDS-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (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

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

- 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:

- 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 behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options

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

- Patients who have been diagnosed with depression- 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
- Patients who have been diagnosed with bipolar disorder- 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) –

Patient Reason(s)

Patient refuses to participate

OR

Medical Reason(s)

Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; 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)

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, a follow-up plan must be documented on the date of the encounter, such as referral to a practitioner who is qualified to treat depression, pharmacological interventions or other interventions for the treatment of depression.

This is a patient-based measure. Depression screening is required once per measurement period, not at all encounters. An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance. 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 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 qualifying encounter or up to 14 days prior to the date of the qualifying encounter.

The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count towards a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a patient screening positively, the eligible clinician would need to provide one of the aforementioned follow-up actions, which does not include use of a standardized depression screening tool.

Should a patient screen positive for depression, a clinician should opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. However, for the purposes of this measure, a suicide risk assessment or additional screening using a standardized tool, will not qualify as a follow-up plan.

Numerator Quality Data Coding Options:

Depression Screening or Follow-Up Plan not Documented, Patient not Eligible

Denominator Exclusion: G9717:

Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder

OR

Screening for Depression Documented as Positive, AND Follow-Up Plan Documented

Performance Met: G8431:

Screening for depression documented as positive AND a follow-up plan documented

OR

Screening for Depression Documented as Negative, Follow-Up Plan Documented

Performance Met: G8510:

Screening for depression is documented as negative, AND a follow-up plan documented

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

Section 1:

Medicare Part B Claims measures may contain denominator exclusions within the Numerator.

Denominator exclusions are applied before determining if the quality action is met.

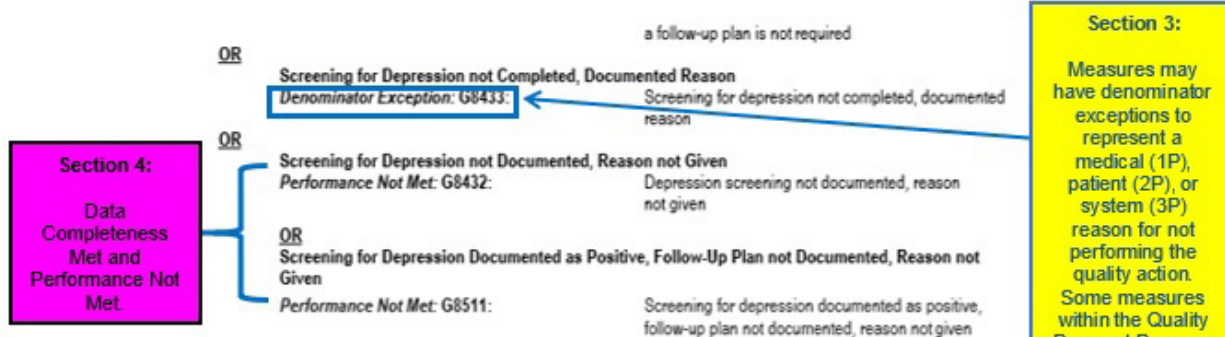
Helpful Hint: For Medicare Part B claims collection type, even though a denominator exclusion is applied before determining the quality actions, this encoded concept needs to be submitted to CMS so the claims data will be accurately calculated.

Section 2:

Data Completeness and Performance Met

Version 5.0
November 2020

CPT only copyright 2020 American Medical Association. All rights reserved.
Page 3 of 10



RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning (Katon, 2003; Wells et al., 1989). 2016 U.S. survey data indicate that 12.8 percent of adolescents (3.1 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. The same data indicate that 6.7 percent of adults aged 18 or older (16.2 million adults) had at least one MDE 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) have been found to have difficulty carrying out their daily activities, relating to others, growing up healthy, and also are at an increased risk of suicide (Siu on behalf of 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 12% of women (Woody, Ferrari, Siskind, Whiteford, & Harris, 2017). 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 (American College of Obstetricians and Gynecologists, 2018). Maternal suicide rates rise over hemorrhage and hypertensive disorders as a cause of maternal mortality (Palladino, Singh, Campbell, Flynn, & Gold, 2011).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Borner, Braunstein, St. Victor, & Pollack, 2010). "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" (Siu 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" (Siu & 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

Version 5.0
November 2020

CPT only copyright 2020 American Medical Association. All rights reserved.
Page 4 of 10

CLINICAL RECOMMENDATION STATEMENTS:

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)" (Siu on behalf of USPSTF, 2016, p. 360).

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)" (Siu & 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. 8 ~10)

COPYRIGHT:

These performance measures are intended to be used as a standard of medical care, and have not been tested for all potential applications.

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

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. PCPI disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

CPT® contained in the Measure specifications is copyright 2004-2020 American Medical Association. LOINC® is copyright 2004-2020 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2020 International Health Terminology Standards Development Organisation. ICD-10 is copyright 2020 World Health Organization. All Rights Reserved.

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

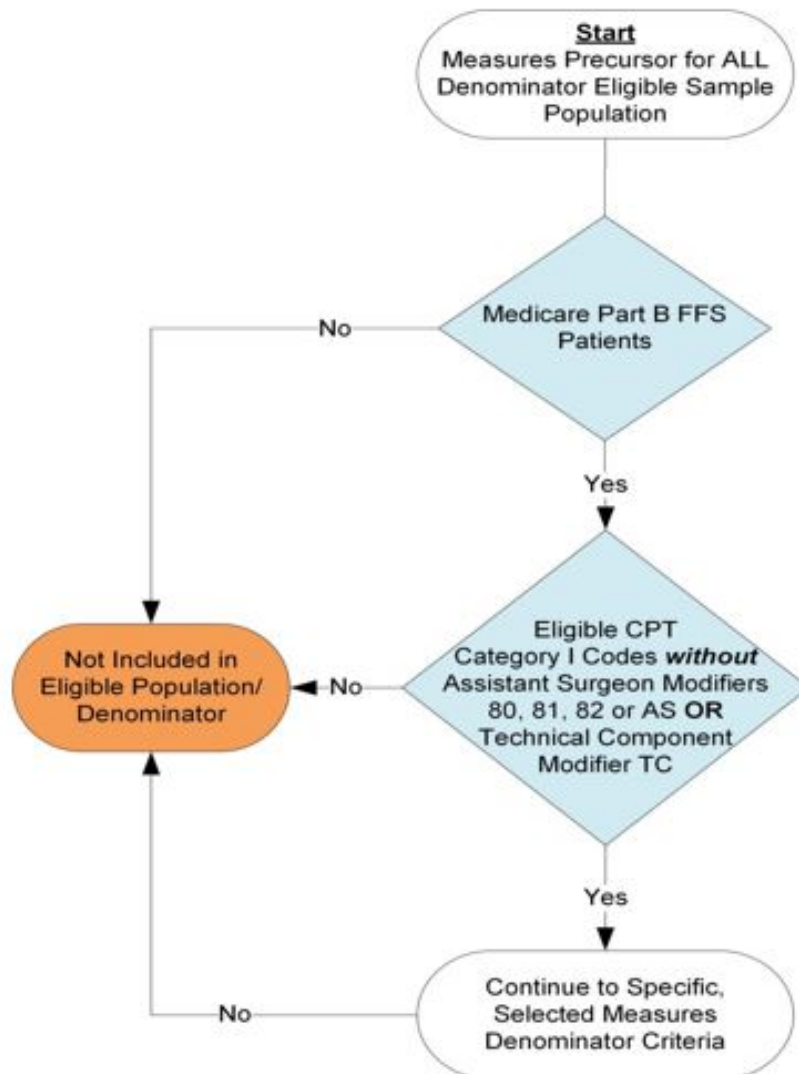
This is the copyright for the measure as indicated by the measure steward.

Interpretation of Medicare Part B claims Measure Flows

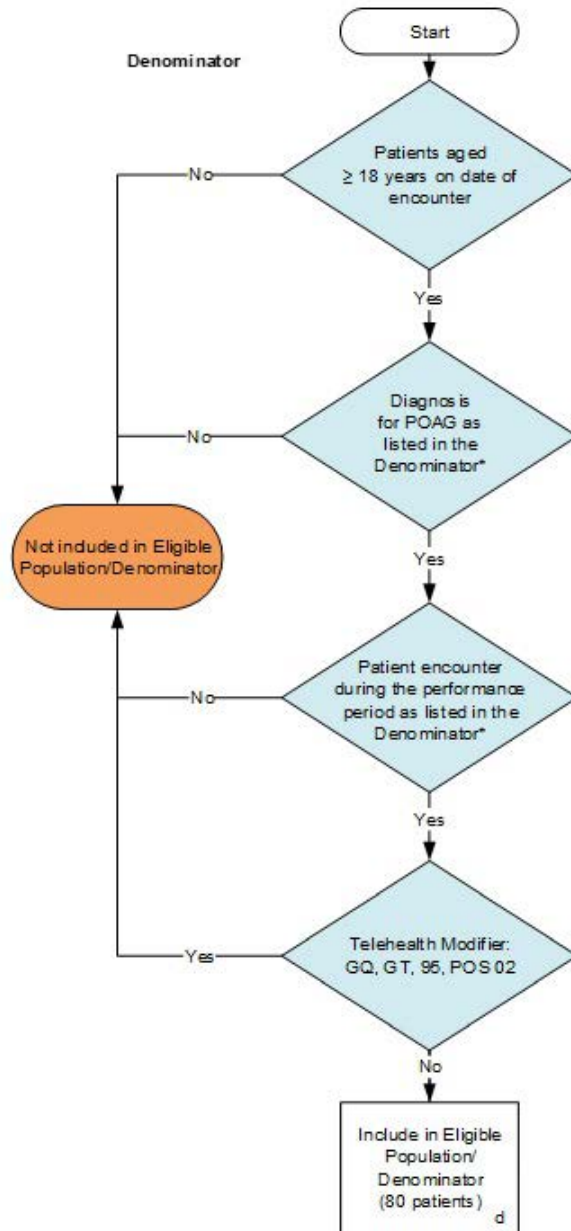
Denominator

The Medicare Part B claims Measure Flows are designed to provide interpretation of the measure logic and calculation methodology for data completeness and performance rates. The flows start with the identification of the patient population (denominator) for the applicable measure's quality action (numerator). When determining the denominator for all measures, please remember to include only Medicare Part B FFS (Fee for Service) patients and CPT I 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 2021 Medicare Part B claims Measures:

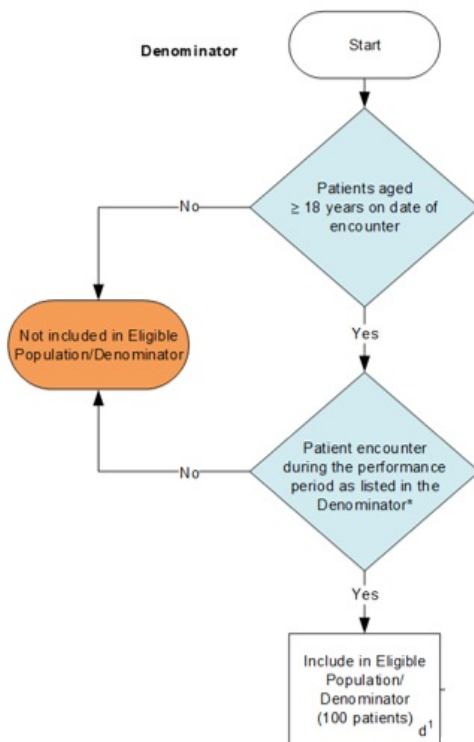


The Medicare Part B claims Measure Flows in each specification document begin with the appropriate age group and denominator population for the measure. The Eligible Population box equates to the letter “d” by the patient population that meets the measures inclusion requirements. Below is an example of the denominator criteria used to determine the eligible population for Quality ID # 12 (NQF # 0086): Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation:

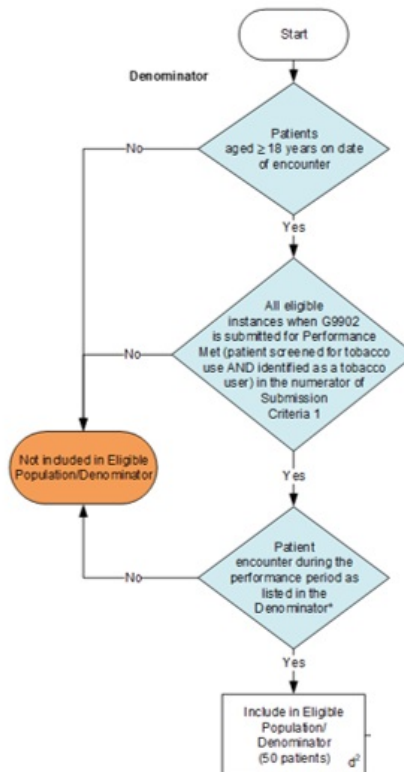


Some Medicare Part B claims measures, such as Quality ID # 226 (NQF #0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, have multiple submission criteria to determine the measure denominator. In the example below, the denominator also represents multiple performance rates. Patients meeting the submission criteria for either denominator option are included as part of the eligible population. Review the Medicare Part B claims measures specification to determine if multiple performance rates are required for each submission criteria.

**Submission Criteria One/
Performance Rate One for all
patients who were screened for
tobacco use**

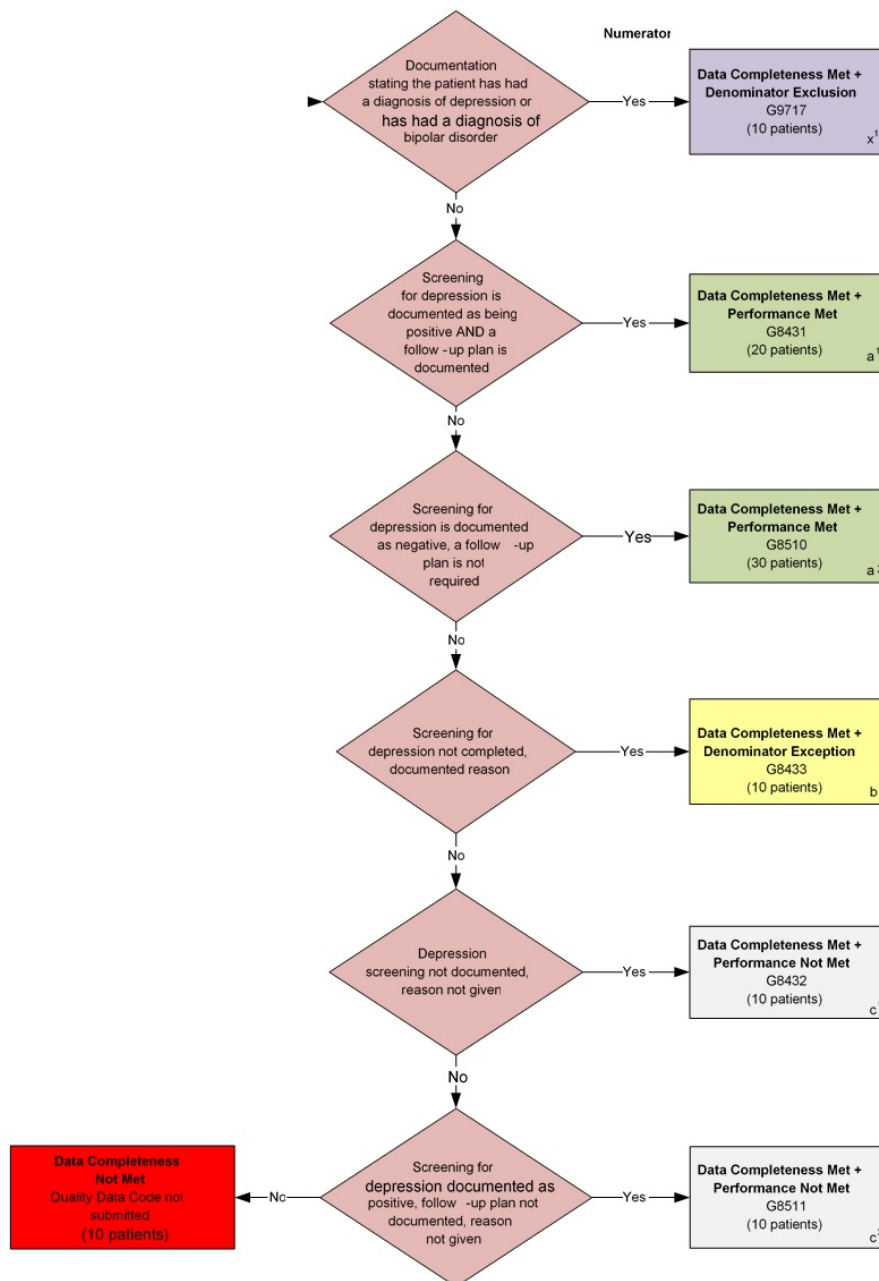


**Submission Criteria Two/ Performance
Rate Two for all patients who were
identified as a tobacco user and who
received tobacco cessation intervention**



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 - Denominator Exclusion = "x" and shaded purple; next two boxes below - Performance Met = "a" and shaded green; next box below - Denominator Exception = "b" and shaded yellow; bottom right box - Performance Not Met = "c" and shaded gray, and bottom left box - Data Completeness Not Met = red shaded box. On the flow, these outcomes are color-coded and labeled to identify the particular outcome of the measure represented. This is illustrated below for Quality ID # 134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan:



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 #134, have a clarifying code and/or language (e.g. G-code G8397 for Quality ID # 134) in the numerator to identify eligible patients when no CPT or ICD-10 diagnosis code exists. In the case of Quality ID # 134, 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 CQM collection type 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 calculation 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: Denominator Exclusion, Performance Met, Denominator Exception, and Performance Not Met. Below is a sample data completeness algorithm for Quality ID # 134. In the example, 80 patients met the denominator criteria for eligibility, where 0 patients were considered a denominator exclusion, 40 patients had the quality action performed (Performance Met), 10 patients did not receive the quality action for a documented reason (Denominator Exception), and 20 patients were reported as not receiving the quality action (Performance Not Met). **Note:** In the example, 10 patients were eligible for the measure but were not reported and are not represented in the algorithm (Data Completeness Not Met).

Data Completeness =

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

Performance Algorithm

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

Performance Rate =

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

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

Multiple Performance Rates

QPP measures may contain multiple performance rates. The Instructions section of the Medicare Part B claims measure will provide guidance if the measure is indeed a multiple performance type. The Medicare Part B claims measure flow for these measures includes algorithm examples to understand the different data completeness and performance rates required for the measure. The system will calculate the performance rates for the measure based on the submission of claims data by the MIPS eligible clinician.