ALL LEVELS

2022 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

December 2021

Introduction

This document contains general guidance for the 2022 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 used 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 2022 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 use different submission methods 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 use the Web Interface Measure documents.
- Measure specifications for electronic health record (EHR) based submission should be used for the electronic clinical quality measures (eCQMs).
- Information regarding Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician & Group Survey (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 2022 QPP represent a continuation in numbering from the 2021 QPP measures. Measure stewards have provided revisions for the measures that are finalized for use in 2022 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 2022 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 used 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 refers 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. For example, in Quality ID # 19 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. 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 Codes (Eligible Cases)

The denominator population is specified in the measure and submitted by individual MIPS eligible clinicians, groups, or third-party intermediaries. The denominator population may be defined by the following criteria:
- 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)
- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS) codes

The CQM collection type may include patients from all payers not just Medicare Part B Physician Fee Schedule (PFS) covered services. 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. These Quality Data Codes (QDCs) describe clinical outcomes that assist with determining the intended population.

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 during the annual update process 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. 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, HCPCS 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, HCPCS 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. The numerator clinical concepts described for each measure are to be followed when submitting data to a Qualified Registry or QCDR.

QDCs may be found in the numerator and may utilize CPT II or HCPCS coding. These QDCs describe quality actions that assist with determining the 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 National Provider Identifier (NPI) submitting if the patient meets denominator inclusion. The following is an example of two provider NPIs billing under the same TIN who are intending to submit Quality ID # 130 : Documentation of Current Medications in the Medical Record. Provider A sees a patient on February 2, 2022 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, 2022 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: 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: 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 demonstrating data completeness for a measure. For additional assistance, please contact the Quality Payment Program Service Now help desk at **1-866-288-8292 (TRS: 711)** (Monday – Friday 8:00AM – 8:00PM Eastern Time) or email via qpp@cms.hhs.gov.

Clinical Quality Measure Specification Format (Refer to the Example CQM Specification Below)
Each MIPS Clinical Quality Measure conforms to a standard format. The measure format includes the following fields.

The measure header includes: Quality ID number, National Quality Forum (NQF) number (if applicable), measure title, National Quality Strategy Domain, and Meaningful Measure Area.

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, 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 "Measure Steward Contacts" tab of the 2022 MIPS Quality Measures List, which can be found on the performance year 2022 MIPS Explore Measures page: https://qpp.cms.gov/mips/explore-measures.

Example Clinical Quality Measure (CQM) Specification:

The measure number and National Quality Forum (NQF) number, if applicable, are listed here.

This is the official measure title.

Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention, Treatment, and Management of Mental Health

This is the NQS Domain in which the measure is included.

This is the Meaningful Measure Area in which the measure is included.

2022 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

The overall classification of the measured clinical action.

This segment includes a high-level description of the measure.

DESCRIPTION:
Percentage of patients aged 12 years and older screened for depression on [...] days prior to the date of the encounter using an age-appropriate standardize[...] positive, a follow-up plan is documented on the date of the eligible encounter.

This details how often the measure should be submitted and who should submit the measure.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per measurement period** for patients seen during the measurement period. The most recent screening submitted will be used for performance calculation. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."

This will identify whether a measure is eligible for telehealth.

NOTE: Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.

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

The denominator statement describes the population evaluated by the performance measure.

DENOMINATOR:
All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

Definition:
Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusions) –
- **Patients who have been diagnosed with depression** – F01.51, F32.A, 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

DENOMINATOR NOTE: The intent of the measure is to screen for depression in patients who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. Patients who have ever been diagnosed with depression or bipolar disorder will be excluded from

Review patient demographics, diagnoses, and encounter coding to determine if the patient meets denominator criteria. Each denominator criterion is required in order for the patient to be considered denominator eligible for submission. **Helpful Hint:** Some QPP measures have similar denominator criteria or encounter type coding.

the measure.

*Signifies that this CPT Category I code is a non-covered ~~Schedule (PFS). These non-covered services should be~~

These callout box (right, top): These are the criteria to determine if the patient, procedure, or encounter may be counted as eligible to meet a measure's inclusion requirements. The denominator requirements reflect the intent of the measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 12 years at the beginning of the measure
AND
Patient encounter during the performance period (CPT or HCPCS): 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110*, 96112, 96116, 96125, 97162, 97163, 97165, 97166, 97167, 99078, 99202, 99203, 99204, 99205, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99335, 99336, 99337, 99339, 99340, 99401*, 99402*, 99403*, 99483, 99483, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, G0101, G0402, G0438,
AND NOT
DENOMINATOR EXCLUSION:
Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder: G9717

Callout box (left, top): 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.

Callout box (right, middle): The denominator is generally identified by CPT Category I and HCPCS codes, as well as ICD-10CM or PCS codes, patient demographics (i.e., age, gender, etc.), and place of service (if applicable).

NUMERATOR:
Patients screened for depression on the date of the encounter using an age-appropriate standardized tool AND if positive eligible encounter

Callout box (right): 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).

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.

Callout box (left): Definitions provide further information on the intent of key concepts to assist with measure submission.

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 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 Dep~~...~~ (EPDS), Duke Anxiety-Depression Scale (DADS), ~~...~~ Scale for Depression in Dementia (CSDD), PRIME ~~...~~ ession (HAM-D), Quick Inventory of Depressive Sy~~...~~ uterized Adaptive Testing Depression Inventory (CAT~~...~~ Screener (CAD-MDD)

- **Perinatal Screening Tools**
  Edinburgh Postnatal Depre~~...~~ ing Scale, Patient Health Questionnaire 9 (PHQ-9), ~~...~~ n Inventory–II, Center for Epidemiologic Studies Dep~~...~~ sion Scale

Callout box (center): 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.

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

- Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen
- 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 provider 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

Patients with a Documented Reason for not Screening for Depression (Denominator Exceptions) –
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 provider for additional evaluation, pharmacological interventions, or other interventions for the treatment of depression.
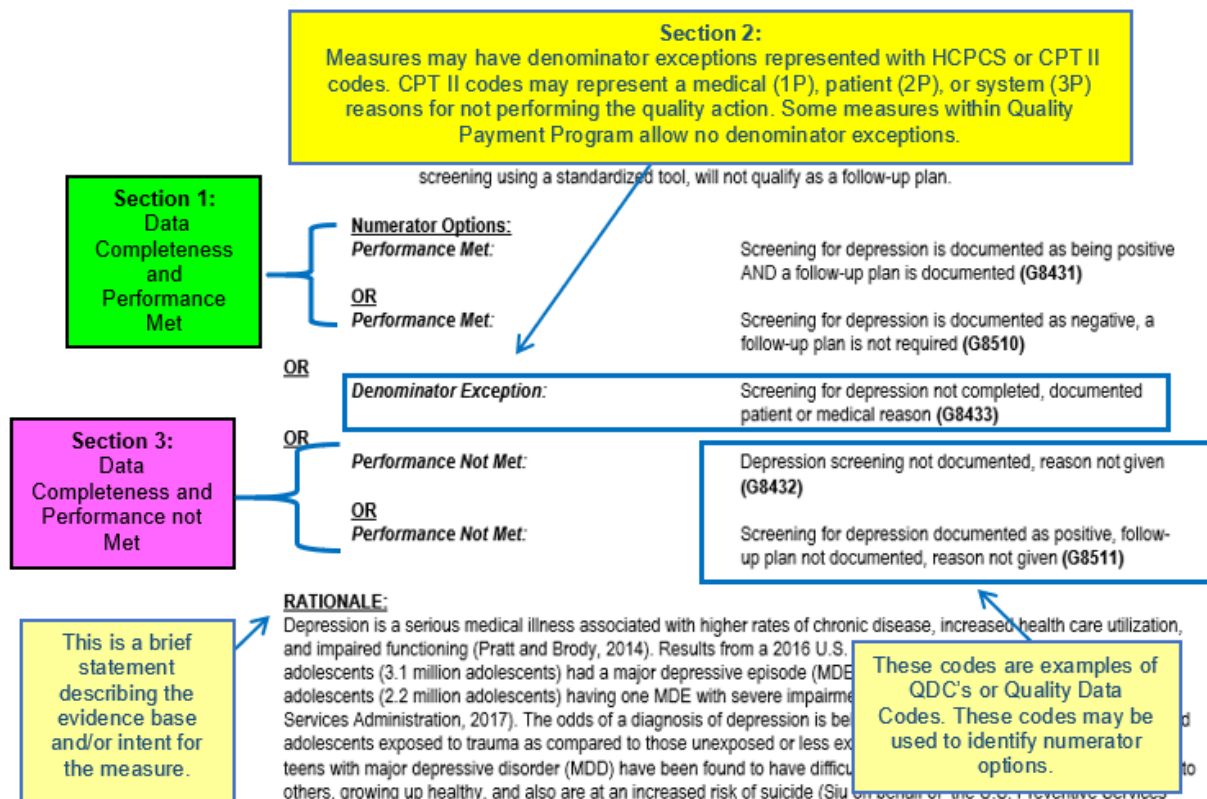
This is a patient-based measure. Depression screening is required once per measurement period, not at all encounters. An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. This measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression. The depression screening must be reviewed and addressed by 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:
- Only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan.
- 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 Options:

Performance Met:

Screening for depression is documented as being positive AND a follow-up plan is documented (**G8431**)

OR

Performance Met:

Screening for depression is documented as negative, a follow-up plan is not required (**G8510**)

OR

Denominator Exception:

Screening for depression not completed, documented patient or medical 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**)

RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning (Pratt and Brody, 2014). Results from a 2016 U.S. [...] adolescents (3.1 million adolescents) had a major depressive episode (MDE [...] adolescents (2.2 million adolescents) having one MDE with severe impairme [...] Services Administration, 2017). The odds of a diagnosis of depression is be [...] adolescents exposed to trauma as compared to those unexposed or less ex [...] teens with major depressive disorder (MDD) have been found to have difficu [...] 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).

The same 2016 study indicated that 6.7 percent of adults aged 18 or older (16.2 million adults) had at least one MDE with four point three 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). Moreover, it is estimated 22.9 percent of adult patients with chronic pain (2.2 million adults) were diagnosed with comorbid depression from 2011 to 2015, with an upward trend of prevalence among Black Americans, patients aged 65 to 84 years old, Medicare and Medicaid insured patients, and patients from zip code areas with low annual household incomes (Orhurhu et al., 2020).

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). It's estimated that the global prevalence of antenatal (or perinatal) depression ranges from 15 to 65 percent, with current or previous exposure to abuse and violence, lack of social support, and family history of mental disorders being risk factors. Depressive symptoms measured during pregnancy have been shown to influence the quality of the postpartum mother-infant relationship (Raine et al., 2020). Additionally, the risk of low birth weight and preterm birth is higher among infants born from depressed mothers (Dadi, Miller, Bisetegn, Mwanri, & 2020).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. Data indicates that as the severity of depressive symptoms increase, rates of having difficulty with work, home, or social activities related to depressive symptoms increase. For those twelve and older with mild depressive symptoms, 45.7 percent reported difficulty with activities, and for those with severe depressive symptoms, 88 percent reported difficulty (Pratt & Brody, 2014). Depression also imposes significant economic burden through direct and indirect costs, supporting the need for regular depression screening. "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).

Numerous studies have found significant disparities in depression prevalence and treatment among racial/ethnic minorities. One study revealed that Indigenous adults are at a high risk for posttraumatic stress disorder, depression, suicide, substance use disorder, and concurrent behavioral health disorders secondary to these initial health problems (Ka'apu and Burnette, 2019). Additionally, though rates of depression are lower among Blacks and Hispanics than among whites, depression among Blacks and Hispanics is likely to be more recurrent. Furthermore, 48 percent of whites receive mental health services, compared to just 31 percent of Blacks and Hispanics, and 22 percent of Asians (American Psychiatric Association, 2017). Asian Americans and Black Americans are also significantly more likely to utilize emergency rooms for depression treatment, which contributes to inconsistent follow-up care (Lee, et al., 2014).

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 46 percent of depressed patients (Borner, et al., 2010). "In nationally representative U.S. surveys, about eight percent of adolescents reported having major depression in the past year. Only 36 percent to 44 percent 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). Furthermore, 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.

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)" (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 USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions. (B recommendation)" (U.S. Preventive Services Task Force, 2019).

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).

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

Interpretation of Clinical Quality Measure Flow

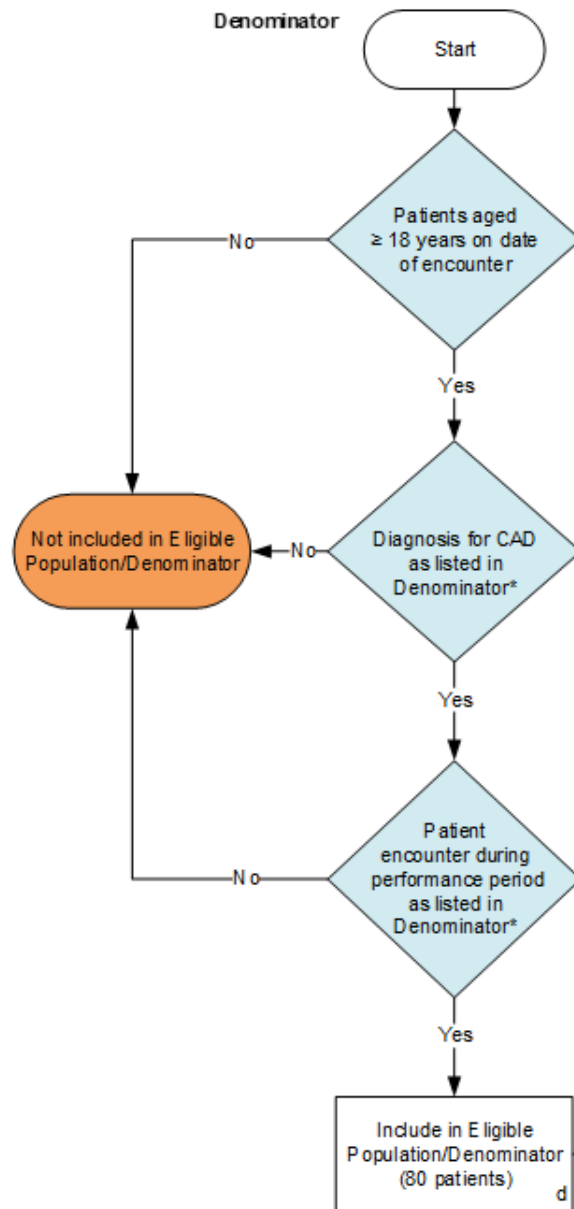**Denominator**

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 the above prerequisite denominator criteria to obtain the patient sample for all 2022 CQMs:

```
                                    ┌──────────────────────────┐
                                    │          Start           │
                                    │  Measures Precursor for ALL │
                                    │ Denominator Eligible Sample │
                                    │        Population        │
                                    └──────────────────────────┘
                                                 │
                                                 ▼
                                          ◇ Eligible CPT
                                         Category I Codes without
                          ── No ──────  Assistant Surgeon Modifiers
                          │             80, 81, 82 or AS OR
                          │             Technical Component
                          │             Modifier TC ◇
                          ▼                      │
                ┌────────────────────┐          │ Yes
                │  Not Included in    │          ▼
                │ Eligible Population/│   ┌────────────────────┐
                │    Denominator      │── No ──│ Continue to Specific,│
                └────────────────────┘        │  Selected Measures  │
                                              │ Denominator Criteria │
                                              └────────────────────┘
```
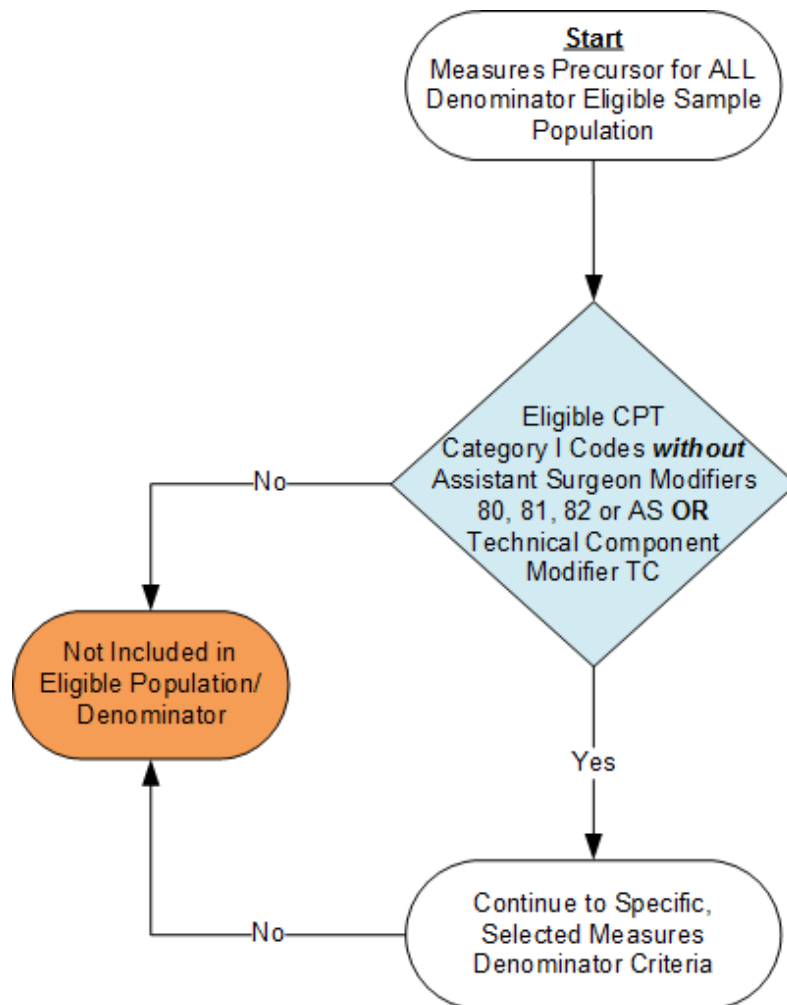
The CQM Flows in each specification document begin with the appropriate age group and denominator population for the measure. The Eligible Population box equates to the letter "d" by the patient population that meets the measures inclusion requirements. Below is an example of the denominator criteria used to determine the eligible population for Quality ID # 6: Coronary Artery Disease (CAD): Antiplatelet Therapy:
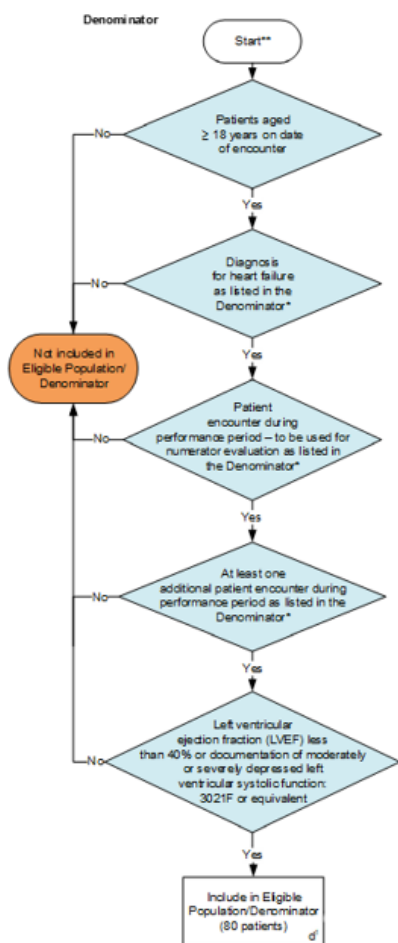
In some instances denominator exclusions will be found within the denominator. Quality ID # 134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan below is an example of a measure that exhibits a denominator exclusion that is labeled and is represented by a purple diamond.
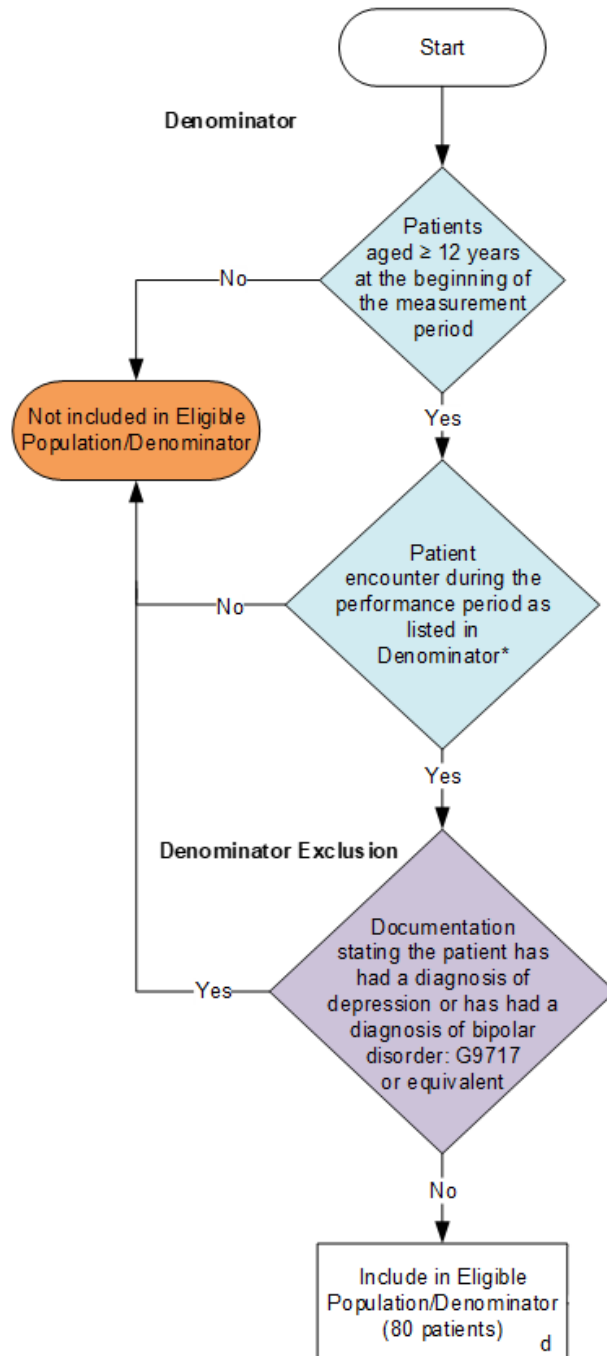
Some measures, such as Quality ID # 5: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD), have multiple options to determine the measure's 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.

Submission Criteria One/ Performance rate one for all patients with a diagnosis of heart failure assessed during an outpatient encounter
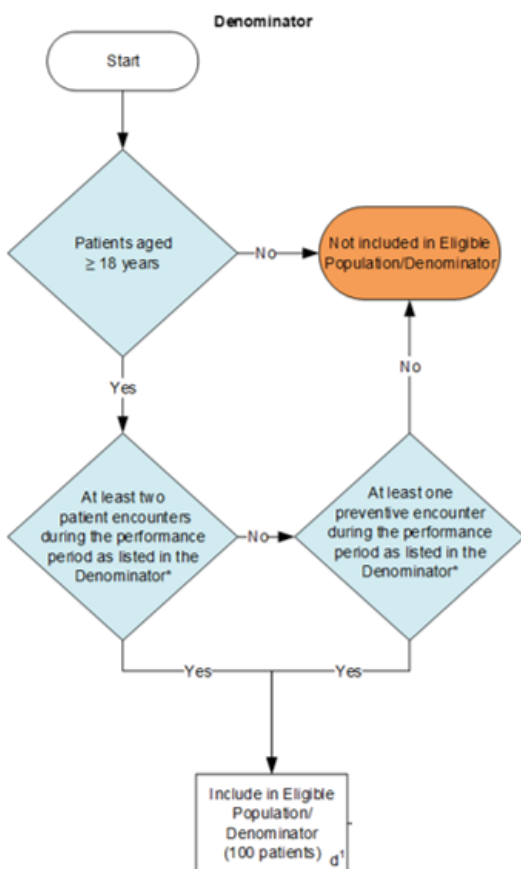
Denominator

Start**

Patients aged ≥ 18 years on date of encounter — No

Yes

Diagnosis for heart failure as listed in the Denominator* — No

Yes

Not included in Eligible Population/ Denominator

Patient encounter during performance period — to be used for numerator evaluation as listed in the Denominator* — No

Yes

At least one additional patient encounter during performance period as listed in the Denominator* — No

Yes

Left ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function: 3021F or equivalent — No

Yes

Include in Eligible Population/Denominator (80 patients) d¹

Submission Criteria Two/ Performance rate two for all patients with a diagnosis of heart failure and discharged from hospital

Denominator

Start**

Patients aged ≥ 18 years on date of encounter — No

Yes

Diagnosis for heart failure as listed in the Denominator* — No

Yes

Not included in Eligible Population/ Denominator

Patient encounter during performance period: 99238, 99239 — No

Yes

Left ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function: 3021F or equivalent — No

Yes

Include in Eligible Population/Denominator (80 visits) d²

Some 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 CQM to determine if multiple performance rates are required for each submission criteria.The example below shows two of three 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
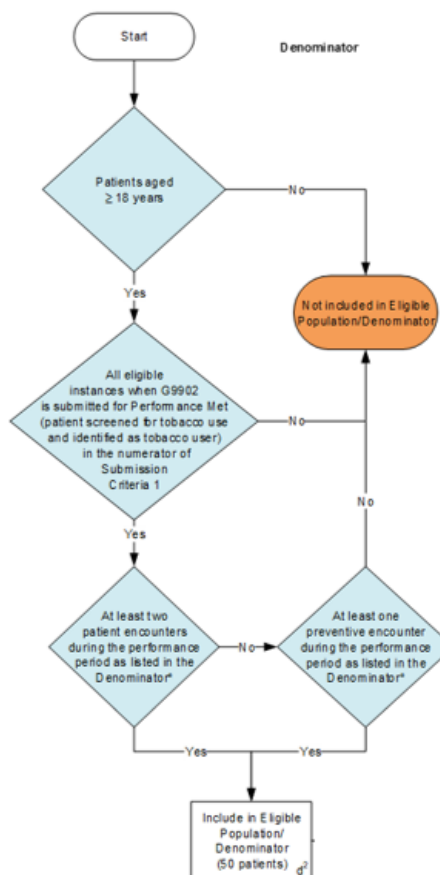
Numerator

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. 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" 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: Coronary Artery Disease (CAD): Antiplatelet Therapy:
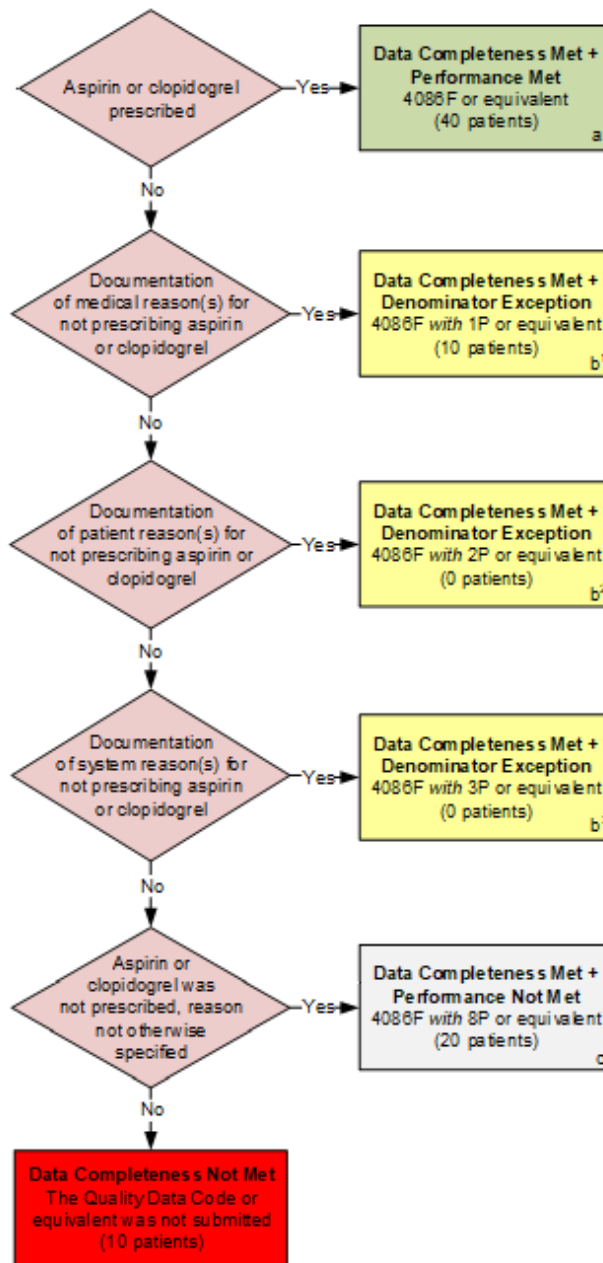
Denominator/Numerator Variation of Medicare Part B claims vs. CQM Collection Types

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. In the CQM measure specifications the denominator exclusion will appear in the denominator. For example, Quality ID # 134 Preventive Care and Screening: Screening for Depression and Follow-Up Plan, includes a clarifying G-code G9717 in the denominator to identify patients that meet the denominator exclusion when no CPT or ICD-10 diagnosis code exists. In QID#134, Medicare Part B Claims collection type, the numerator includes the code G9717 used to identify patients who meet the denominator exclusion. 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: 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 and are not represented in the algorithm (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 =

$$\frac{\text{Performance Met (a=40 patients) + Denominator Exception (b=10 patients) + Performance Met (c=20 patients)}}{\text{Eligible Population/Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

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 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 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 having a Denominator Exception.

Performance Rate =

$$\frac{\text{Performance Met (a=40 patients)}}{\text{Data Completeness Numerator (70 Patients)} - \text{Denominator Exception (b}_1 \text{ plus b}_2 \text{ plus b}_3 = 10 \text{ patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

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.