2022 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

December 2021

Introduction

This document contains general guidance for the 2022 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 used by individual MIPS eligible clinicians submitting individual measures via Medicare Part B claims 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

Other collection types will use different submission methods 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 use the Web Interface Measure documents.
- Measure specifications for electronic health record (EHR) based submission should be used for 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

Medicare Part B claims Measure 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.

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. 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. Quality Data Codes (QDCs) may be found in the denominator or numerator and may use 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 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 HCPCS 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 HCPCS 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 National Provider Identifier (NPI) submitting if the patient encounter(s) meet 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, 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 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 gpp@cms.hhs.gov.

Medicare Part B claims Measure Specification Format (Refer to the Example Measure Specification Below)
Each Medicare Part B claims measure conforms to a standard format. The measure format includes the following fields.

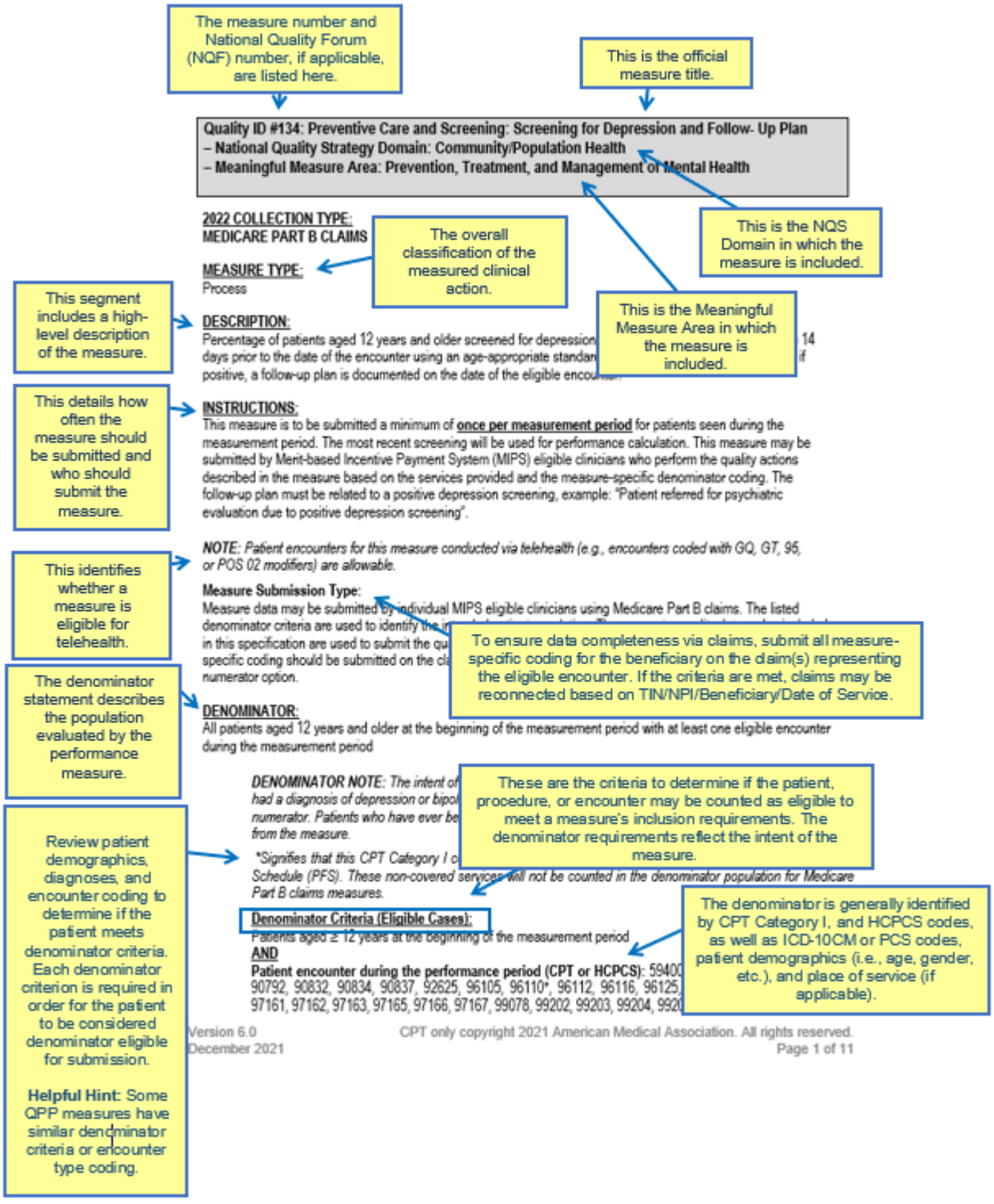
The measure header includes: Quality ID number, National Quality Forum (NQF) number (if applicable), measure title, National Quality Strategy Domain, and Meaningful Measure Area.

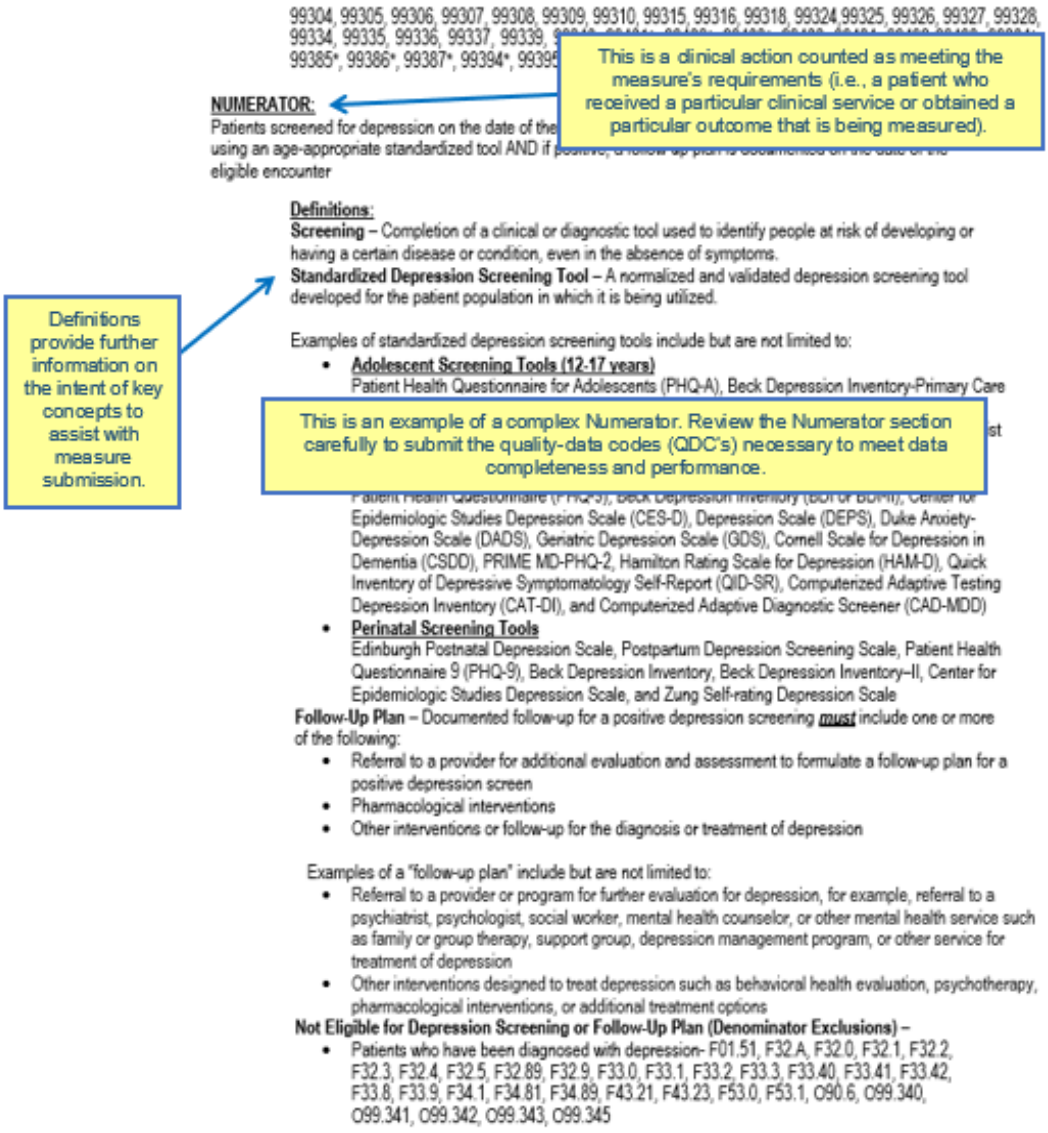
The body of the document includes the following sections:

- Collection type
- Measure type
- Measure description
- Instructions on submitting including frequency, timeframes, and applicability
- Denominator statement, denominator criteria 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 statement 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 "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 Medicare Part B claims Measure Specification:




99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324,99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339,
99385*, 99386*, 99387*, 99394*, 99395
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
using an age-appropriate standardized tool AND if
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.
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
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 (CSDD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-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 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
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
Version 6.0
December 2021
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Page 2 of 11

- 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 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 Quality Data Coding Options:

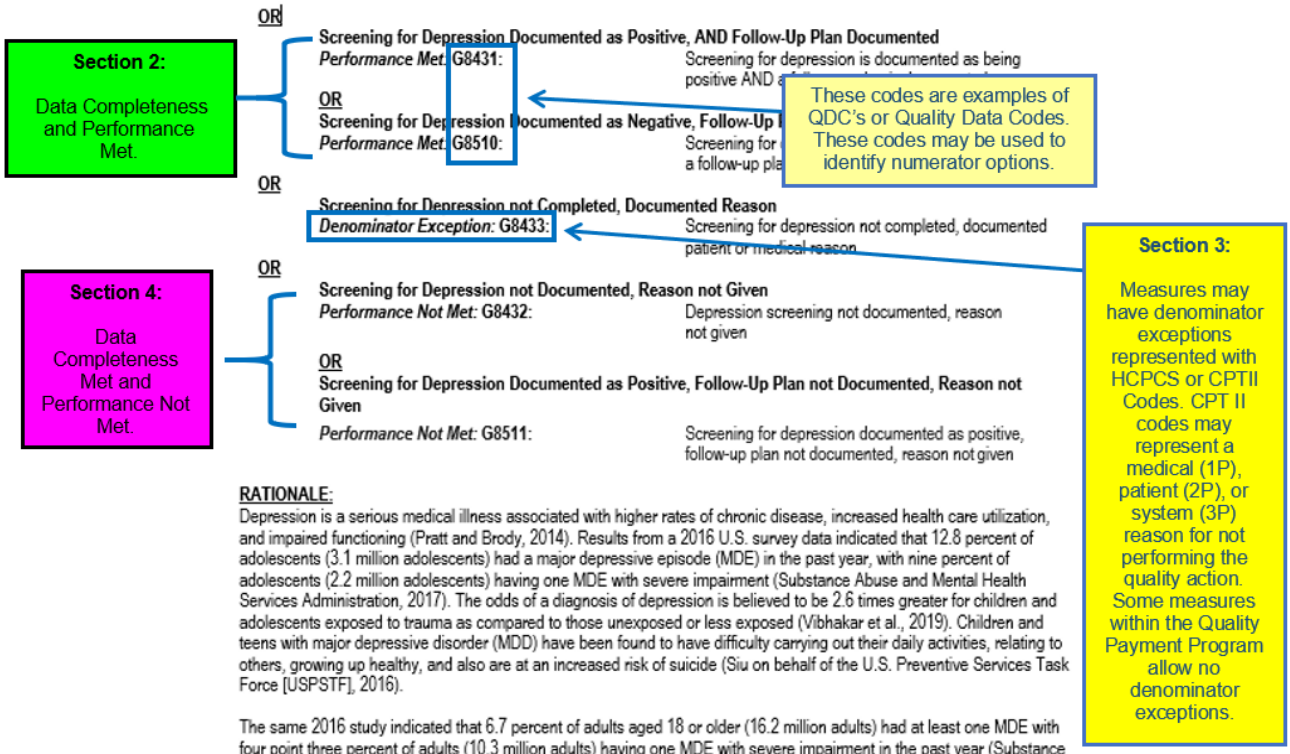
Depression Screening or Follow-Up Plan not Documented, Patient not Eligible

Denominator Exclusion: **G9717**: Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder

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.



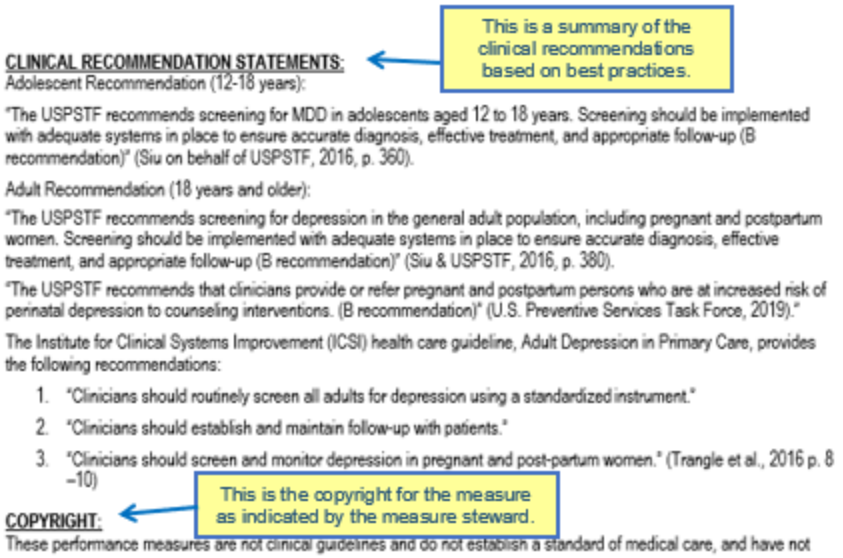
RATIONALE:

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. survey data indicated 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 (Substance Abuse and Mental Health Services Administration, 2017). The odds of a diagnosis of depression is believed to be 2.6 times greater for children and adolescents exposed to trauma as compared to those unexposed or less exposed (Vibhakar et al., 2019). 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).

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


This is a summary of the clinical recommendations based on best practices.
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 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)
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These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not
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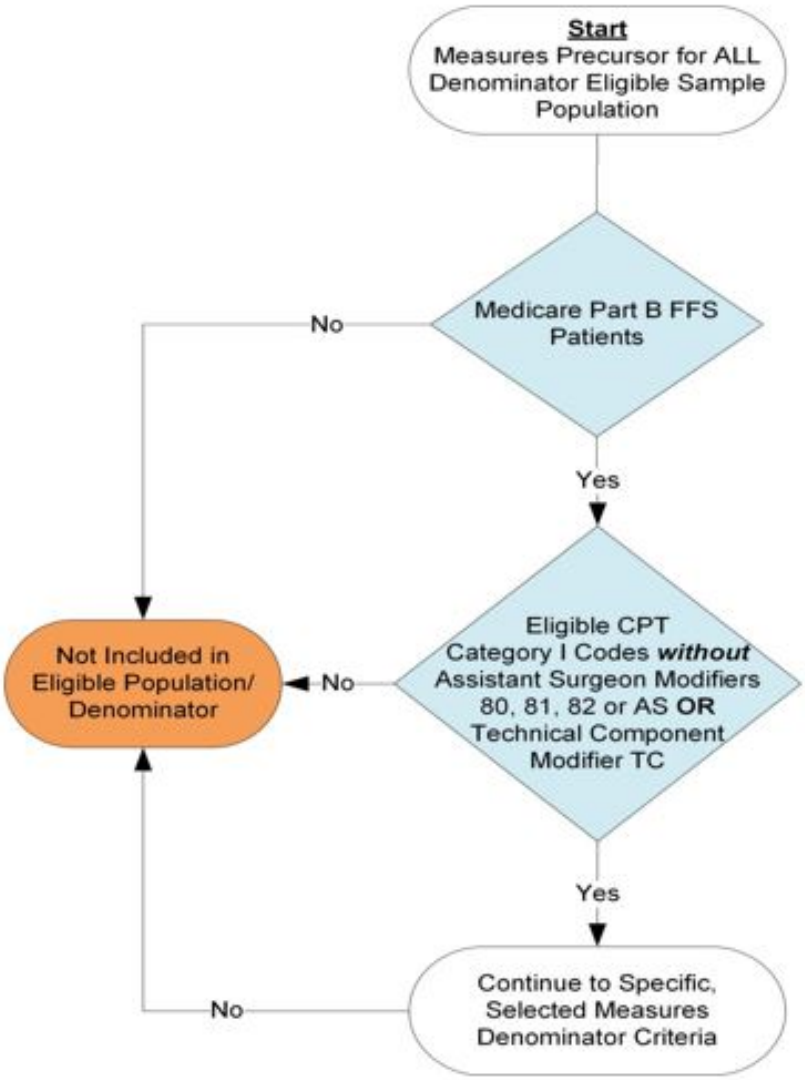
Page 5 of 11

Interpretation of Medicare Part B claims Measure Flow

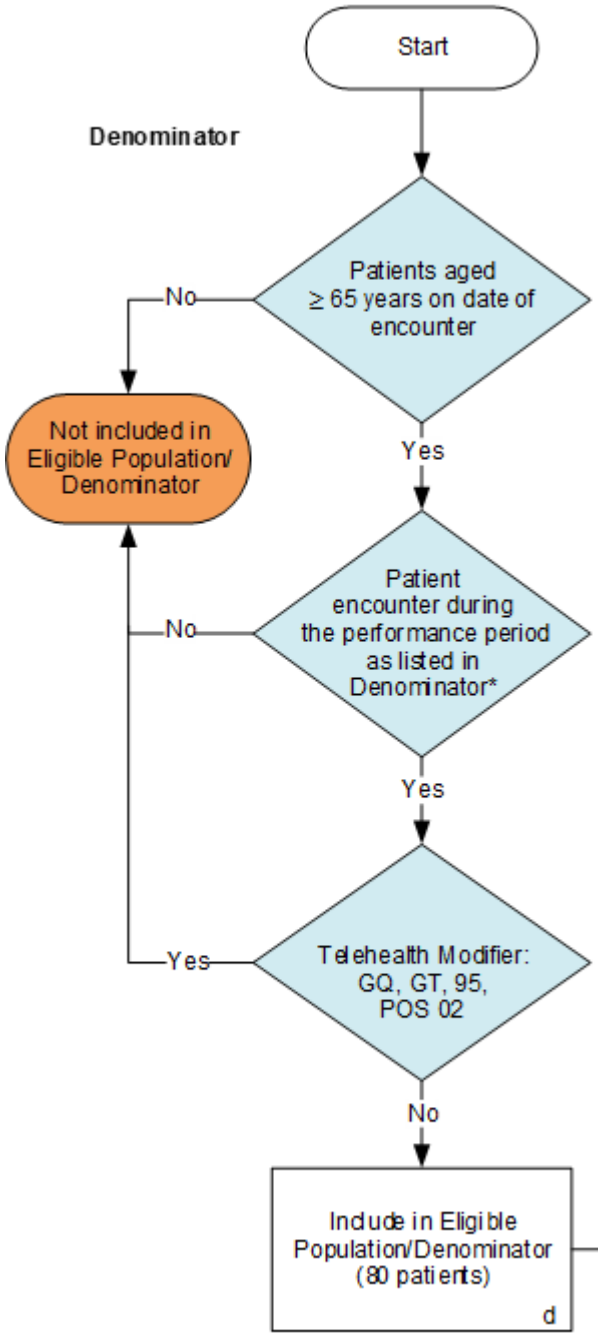
Denominator

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 2022 Medicare Part B claims Measures:

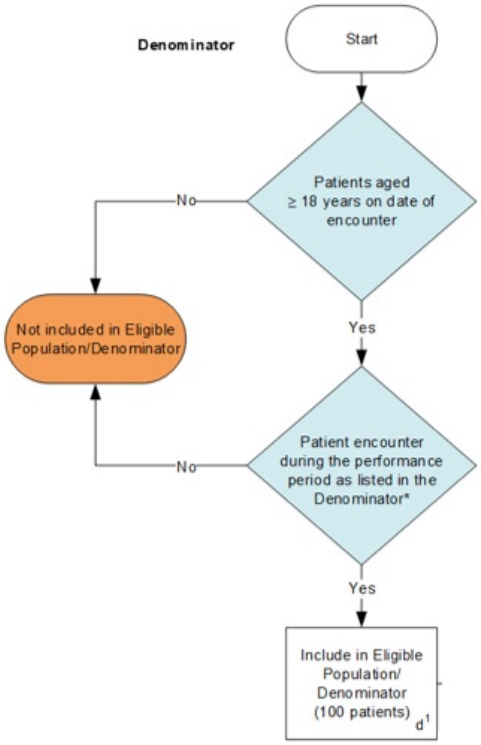


The Medicare Part B claims Measure Flows in each specification document begin with the appropriate age group and denominator population for the measure. The Eligible Population box equates to the letter “d” by the patient population that meets the measures inclusion requirements. Below is an example of the denominator criteria used to determine the eligible population for Quality ID # 181 : Elder Maltreatment Screen and Follow-Up Plan:

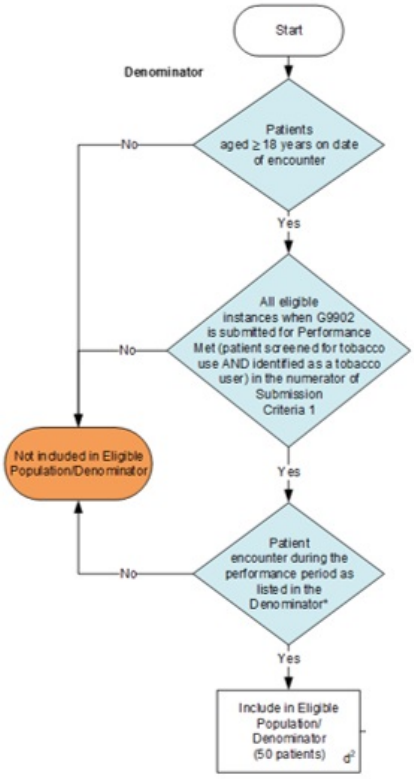


Some Medicare Part B claims measures, such as Quality ID # 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, have multiple submission criteria to determine the measure denominator. In the example below, the denominator also represents multiple performance rates. Patients 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. The example below shows two of three submission criteria.

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

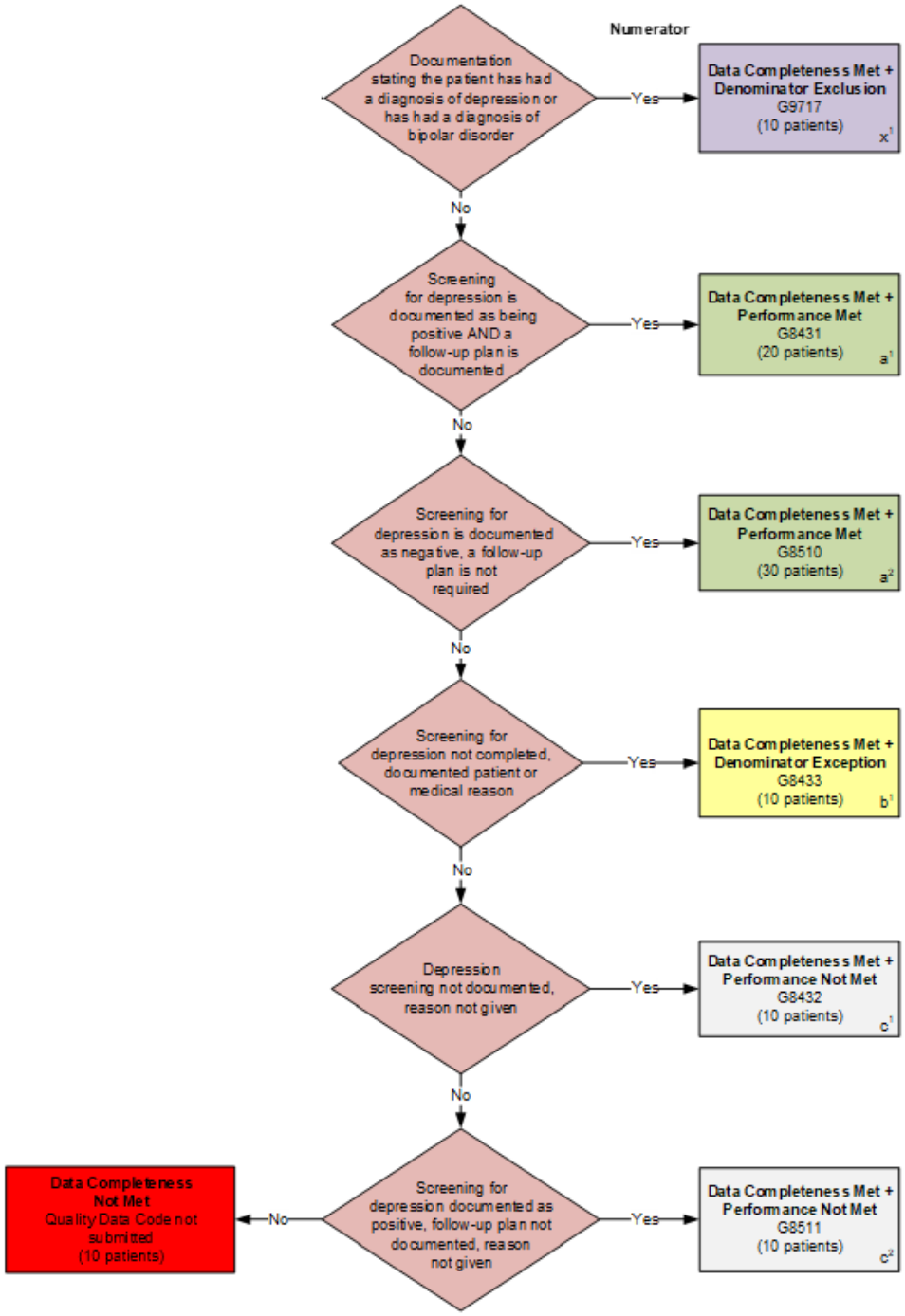


Submission Criteria Two/ Performance Rate Two for all patients who were identified as a tobacco user and who received tobacco cessation intervention



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. 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 - 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. In the Medicare Part B claims measure specifications the denominator exclusions appear in the numerator section of the specification. For example, Quality ID # 134 Preventive Care and Screening: Screening for Depression and Follow-Up Plan, includes a clarifying code G-code G9717 in the numerator to identify patients that meet the denominator exclusion when no CPT or ICD-10 diagnosis code exists. In QID#134, MIPS Clinical Quality Measure collection type, the denominator 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: 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 =

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

Performance Algorithm

The Performance Algorithm calculation 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 #134. In this scenario, the patient sample equals 70 patients where 40 of these patients had the quality action performed (Performance Met), zero patients were submitted as a Denominator Exclusion, and 10 patients were submitted as having a Denominator Exception.

Performance Rate =

$$\frac{\text{Performance Met (a=40 patients)}}{\text{Data Completeness Numerator (70 Patients) – Denominator Exclusion (x=0 patients) – Denominator Exception (b=10 patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

For measures with inverse performance rates, such as Quality ID #1: 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.