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CENTERS FOR MEDICARE & MEDICAID SERVICES

2017 Quality Payment Program (QPP) Measure Specification and Measure Flow Guide for Claims Submission of Individual Measures

Utilized by Individual Eligible Clinicians for Claims Submissions

12/15/16

Introduction

This document contains general guidance for the 2017 Quality Payment Program (QPP) Individual Measure Specifications and Measure Flows for claims submissions. The individual measure specifications are detailed descriptions of the quality measures and are intended to be utilized by individual eligible clinicians reporting individual measures via claims for the 2017 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.

Submission Methods

The individual measure specifications for claims submissions may be utilized for claims, registry, and Qualified Clinical Data Registries (QCDRs) data submission methods. Below outlines which measure specifications can be utilized for the other data submission methods.

- Measure specifications for individual measure reporting via registry also have separate measure documents.
- Group practices electing to submit via the Web Interface should utilize the Web Interface Measure documents.
- Measure specifications for electronic health record (EHR) based reporting should utilize the electronic clinical quality measures (eCQMs).
- Information regarding CG-CAHPS may be found at: http://acocahps.cms.gov/Content/Default.aspx#aboutSurvey
  Please note that this link is directed to the Accredited Care Organization webpage.

Individual Measure Specifications

Each measure is assigned a unique number. Measure numbers for 2017 QPP represents a continuation in numbering from the 2016 Physician Quality Reporting System (PQRS) measures. Measure stewards have provided revisions for the 2016 PQRS measures that are continuing forward in the 2017 QPP.

Frequency with Definitions

Frequency labels are provided for each measure and included in each measure instructions as well as the measure flow. The analytical submitting frequency defines the time period or event in which the measure should be submitted. Each individual eligible clinician participating in 2017 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 eligible clinician during the performance period.

Performance Period
Performance period for the measure may refer to the overall period of January 1st to December 31st. Although, there may be measures where the clinical action of the measure may have a different timeframe to determine if the quality action indicated within the measure was performed to meet performance. There are several sections (Instruction, Description, or Numerator Statement) within the measure specification that could include information on the performance period.

NOTE: The 2017 QPP offers a 90 day performance period to submit data on clinical measures. The performance period for each measure should be taken into consideration to ensure capture of quality action if the shortened timeframe is chosen.

Denominator and Numerator
Quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome. 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. Also called the measure focus, it is the target process, condition, event, or outcome. Numerator criteria are the processes or outcomes expected for each patient, procedure, or other unit of measurement defined in the denominator.

Denominator Codes (Eligible Cases)
The denominator population may be defined by demographic information, certain International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis, International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in the measure that are submitted **by individual eligible clinician** as part of a claim for **covered services** under the Medicare Part B Physician Fee Schedule (PFS) for claims-based submissions.

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 eligible clinician, then the patient does not fall into the 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, and other detailed information. Each **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 or QDCs (CPT Category II codes or G-codes) that define the numerator should be submitted for data completeness of quality data for a measure for claims-based submission.

> **Denominator Exclusion:**
> Typically, a denominator exclusion describes a circumstance where the patient should be removed from the denominator. Within claims submission, denominator exclusions identify circumstances where the patient should be removed from the performance prior to determining which numerator outcome is appropriate. Quality-data codes are available to describe the denominator exclusion within the measure specification and should be submitted on the claim. For claims submission, these patients should be

included within the data completeness, but removed from the denominator of the performance rate for the measure. Please refer to the algorithm portion of this document below.

Performance Met:
If the intended clinical action for the measure is performed for the patient, quality-data code(s) 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 quality-data codes are available to describe medical, patient, or system reasons for denominator exceptions and should be submitted on the claim. A denominator exception would remove a patient from the performance denominator only if the numerator criteria are not met. This allows for the exercise of clinical judgement.

Performance Not Met:
When the denominator exception does not apply, a measure-specific CPT Category II reporting modifier 8P or quality-data code may be used to indicate that the quality action was not provided for a reason not otherwise specified and should be submitted on the 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.

HCPCS coding may include G-codes, D-codes, or S-codes. These HCPCS codes may be found within the denominator and would be associated with billable charges. QDC's may be found in the denominator or numerator and may utilize HCPCS coding. These QDC's describe clinical outcomes or quality actions that assist with determining the intended population or numerator outcome.

Individual Measure Submission
For eligible clinicians reporting individually, measures (including patient-level measure[s]) may be submitted for the same patient by multiple 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 reporting 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 Measure #134 (NQF 0418): Preventive Care and Screening: Screening for Depression and Follow-Up Plan. Provider A sees a patient on February 2, 2017 and documents the patient's current medications in the medical chart and submits the appropriate quality-data code (QDC) for measure #134. Provider B sees the same patient at an encounter on July 16, 2017 and also verifies that the patient has documented the patient's current medications in the medical chart. Provider B should also submit the appropriate QDC's for the patient at the July encounter to meet data completeness for submission of measure #134.

CMS recommends review of any measures that an individual 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 QPP Service Desk at the following: 1-866-288-8292 (Monday – Friday 8:00AM – 8:00PM Eastern Time) or QPP@cms.hhs.gov.

Measure Specification Format (Refer to the Example Measure Specification Below)
Measure number, NQF number (if applicable), Measure title and domain

Submission method option
Measure type
Measure description
Instructions on reporting 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 supporting information 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 page of the Measures List document, which can be accessed at: https://qpp.cms.gov/measures/quality.

Example Individual Claims Measure Specification:

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

This is the official measure title.

Measure #134 (NQF 0418): Preventive Care and Screening: Screening for Depression a[...] Plan – National Quality Strategy Domain: Community/Population Health

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

2017 OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS ONLY

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 the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

This details when the measure should be submitted and who should submit.

INSTRUCTIONS:
This measure is to be reported a minimum of **once per performance period** for patients seen during the performance period. This measure may be reported by 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".

Measure Reporting:
The listed denominator criteria is used to identify the intended patient population. The numerator quality-data codes included in this specification are used to submit the quality actions allowed by the measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

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

DENOMINATOR:
All patients aged 12 years and older

To ensure data completeness via claims, submit all measure-specific coding for the beneficiary on the claim(s) representing the eligible encounter. If criteria are met, claims may be reconnected based on TIN/NPI/Beneficiary/Date of Service.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 12 years on date of encounter
AND

This is the patient population that may be counted as eligible to meet a measure's inclusion requirements.

Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834 90837, 92625, 96116, 96118, 96150, 96151, 97165, 97166, 97167, 99201, 99[...] 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444
WITHOUT
Telehealth Modifier: GQ, GT

These are identified by ICD-10-CM, CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc.) and place of service (if applicable).

Review patient demographics, diagnosis, and encounter coding to determine if the patient meets denominator criteria. Each denominator criteria is required in order for the patient to be considered denominator eligible for submitting.

Helpful Hint: Some QPP measures have similar denominator criteria or encounter type coding. Review other QPP measures to determine if there are more measures applicable to the type of patients/ procedures evaluated.

NUMERATOR:
Patients screened for dep[...]
positive, a follow-up plan is documented on the date of the positive screen

This is a clinical action counted as meeting the measure's requirements (i.e., patients who received the particular service or obtained a particular outcome that is being measured).

Numerator Instructions: The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter.

Definitions:

Measures may or may not contain definitions.

Screening – Com[...] tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**
  Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ2

- **Adult Screening Tools (18 years and older)**
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

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

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

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

- Patient has an active diagnosis of Depression
- Patient has a diagnosed Bipolar Disorder

Patients with a Documented Reason for not Screening for Depression (Denominator Exception) –
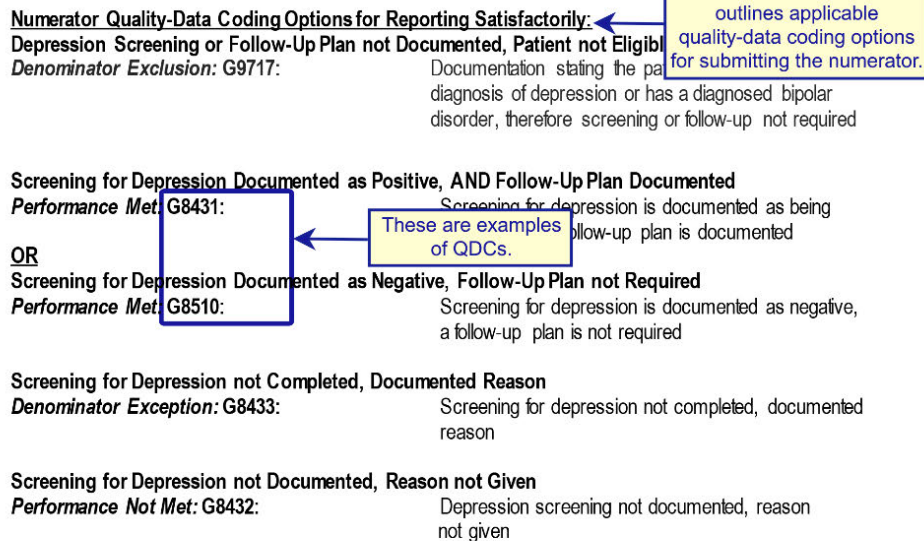One or more of the following conditions are documented:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Depression Screening or Follow-Up Plan not Documented, Patient not Eligible
Denominator Exclusion: G9717:   Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required

OR

Screening for Depression Documented as Positive, AND Follow-Up Plan Documented
Performance Met: G8431:   Screening for depression is documented as being positive and a follow-up plan is documented

OR

Screening for Depression Documented as Negative, Follow-Up Plan not Required
Performance Met: G8510:   Screening for depression is documented as negative, a follow-up plan is not required

OR

Screening for Depression not Completed, Documented Reason
Denominator Exception: G8433:   Screening for depression not completed, documented reason

OR

Screening for Depression not Documented, Reason not Given
Performance Not Met: G8432:   Depression screening not documented, reason not given

OR

Screening for Depression Documented as Positive, Follow-Up Plan not Documented, Reason not Given

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

RATIONALE:

In 2008, the Geriatric Mental Foundation reported that of the population aged 65 and older in the United States, 15-20 percent of adults had experienced depression (Geriatric Mental Health Foundation, 2008), while 7 million of the same population were affected by depression (Steinman, 2007, p. 175) and accounted for 16 percent of suicide deaths in 2004 (Centers for Disease Control and Prevention, 2007).

The World Health Organization (WHO), as cited by Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. "Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition, 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms" (Pratt & Brody, 2008, p.2). Pratt & Brody (2008) found that depression rates were higher in the 40-59 age brackets, is more common in females than in males, and higher in non-Hispanic black persons than in their non-Hispanic white counterparts (Pratt & Brody, 2008, p. 2). Disparities due to income have also been observed, as those with lower income (below the federal poverty line) in the 18-39 and 40-59 age brackets, whom experience higher depression rates than those with higher income. This disparity is not observable in other age categories (Pratt & Brody, 2008, p. 2).

Among children, the rate of current or recent depression stands at 3% and at 6% for adolescents, whose lifetime incidence rate of major depressive disorder (MDD) could be as high as 20% (Williams et al., 2009, p. e716). Borner (2010), states that 20% of adolescents are likely to have experienced depression by the time they are 18 years old and that there is an observed increased onset around puberty. Onset of MDD during adolescence is particularly significant because it is associated with higher risks of suicide attempt, death by suicide and MDD recurrence in young adulthood. Additionally MDD is "associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning during young adulthood" (Williams et al., 2009, p. e716). According to Zalsman et al., (2006) as reported in Borner et al. (2010), "depression ranks among the most commonly reported mental health problems in adolescent girls" (p. 947).

"The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages" (Borner, 2010, p. 948). 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, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments" (Borner, 2010, p. 948). "Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated" (Borner, 2010, p. 948).

The substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. This measure seeks to achieve this goal and aligns with 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). The measure makes important contribution to the quality domain of community and population health.

CLINICAL RECOMMENDATION STATEMENTS:
Adolescent Recommendation (12-18 years)

"The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow- up" (AHRQ, 2010, p.141).

"Clinicians and health care systems should try to consistently screen adolescents ages 12-18 for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up" (ICSI, 2013, p.16).

Adult Recommendation (18 years and older)

"The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up" (AHRQ, 2010, p.136).

"A system that has embedded the elements of best practice and has capacity to effectively manage the volume should consider routine screening of all patients, based on the recommendations of the U.S. Preventive Services Task Force"(ICSI, 2013, p.7). "Clinicians should use a standardized instrument to screen for depression if it is suspected based on risk factors or presentation. Clinicians should assess and treat for depression in patients with some comorbidities. Clinicians should acknowledge the impact of culture and cultural differences on physician and mental health. Clinicians should screen and monitor depression in pregnant and post-partum women" (ICSI, 2013, p.4).

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

These measures were de[veloped]... [s]pecial project under the Quality Insights' Medicare Quality Improvement Organization (QIO) contract HHSM-500-2005-PA001C with the Centers for Medicare & Medicaid Services. These measures are in the public domain.

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. Quality Insights of Pennsylvania disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT [R]) or other coding contained in the specifications. CPT® contained in the Measures specifications is copyright 2004- 2016 American Medical Association. All Rights Reserved. These performance measures are not clinical guidelines and do not establish 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.

Interpretation of Individual Claims Measure Flows

Denominator

The Individual 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 patients and CPT I Categories **without** modifiers 80, 81, 82, AS or TC.

Below is an illustration of additional prerequisite denominator criteria to obtain the patient sample for all 2017 Individual Measures:

```
                    ┌──────────────────────┐
                    │        Start         │
                    │ Measures Precursor   │
                    │ for ALL Denominator  │
                    │ Eligible Sample      │
                    │ Population           │
                    └──────────┬───────────┘
                               │
                               ▼
                          ◇─────────◇
              No ─────────◇ Medicare ◇
              │           ◇ Part B   ◇
              │           ◇ FFS      ◇
              │           ◇ Patients ◇
              │                │
              │               Yes
              │                ▼
              │          ◇───────────◇
   ┌──────────▼──┐       ◇ Eligible  ◇
   │ Not Included│  No ──◇ CPT Cat I ◇
   │ in Eligible │◀──────◇ Codes     ◇
   │ Population/ │       ◇           ◇
   │ Denominator │       ◇           ◇
   └──────────▲──┘            │
              │              Yes
              │               ▼
              │       ┌───────────────┐
              └─ No ──┤ Continue to   │
                      │ Specific,     │
                      │ Selected      │
                      │ Measures      │
                      │ Denominator   │
                      │ Criteria      │
                      └───────────────┘
```

Start
Measures Precursor for ALL Denominator Eligible Sample Population

Medicare Part B FFS Patients

No

Yes

Eligible CPT Category I Codes *without* Assistant Surgeon Modifiers 80, 81, 82 or AS **OR** Technical Component Modifier TC

No

Not Included in Eligible Population/ Denominator

Yes

No

Continue to Specific, Selected Measures Denominator Criteria

The Individual Measure Flows continue with the appropriate age group and denominator population for the measure. The Eligible Population box equates to the letter "d" by the patient population that meets the measures inclusion requirements. Below is an example of the denominator criteria used to determine the eligible population for Measure #12 NQF # 0086: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation:

```
                                          ┌─────────┐
                                          │  Start  │
                                          └────┬────┘
                                               │
                                               ▼
   Denominator                              ◇ Patient Age
                              ─No─          at Date of Service
                                │           ≥ 18 Years ◇
                                │                │
                                │               Yes
                                │                │
                                ▼                ▼
              ┌──────────────────────┐        ◇ Diagnosis
              │ Not Included in Eligible │─No─    of POAG
              │ Population/Denominator   │       as Listed in
              └──────────────────────┘       Denominator* ◇
                                               │
                                              Yes
                                               │
                                               ▼
                                            ◇ Encounter
                              ─No─             as Listed in
                                               Denominator*
                                               (1/1/2017 thru
                                               12/31/2017) ◇
                                               │
                                              Yes
                                               │
                                               ▼
                                            ◇ Telehealth Modifier:
                              ─Yes─            GQ, GT ◇
                                               │
                                               No
                                               │
                                               ▼
                                          ┌──────────────┐
                                          │ Include in Eligible │
                                          │ Population/   │
                                          │ Denominator   │
                                          │ (8 patients)  │
                                          │            d  │
                                          └──────────────┘
```
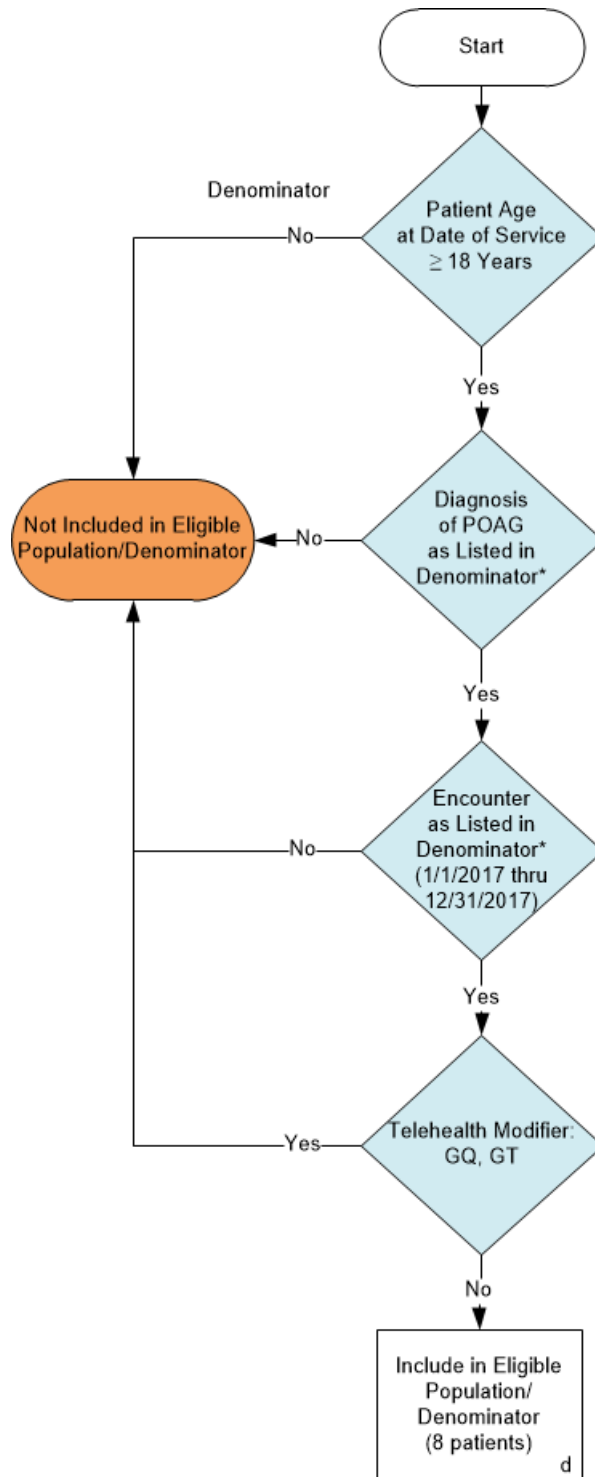
Some measures, such as Measure #46 Medication Reconciliation Post-Discharge have multiple options to determine the measure denominator. Patients meeting the criteria for either denominator option are included as part of the eligible population. Review the measures specification to determine if multiple performance rates are required for each reporting criteria.

Denominator Option 1

Start

- **Patient Age at Date of Service 18 through 64 years**
  - No → **Not Included in Eligible Population/Denominator**
  - Yes ↓
- **Encounter Codes as Listed in Denominator* (1/1/2017 thru 12/31/2017)**
  - No → **Not Included in Eligible Population/Denominator**
  - Yes ↓
- **Patient Discharged from Inpatient Facility (e.g. Hospital, Skilled Nursing Facility) Within the last 30 Days**
  - No → **Not Included in Eligible Population/Denominator**
  - Yes ↓
- **Include in Eligible Population/ Denominator (8 visits)** d^1

Denominator Option 2

Start

- **Patient Age at Date of Service ≥ 65 years**
  - No → **Not Included in Eligible Population/Denominator**
  - Yes ↓
- **Encounter Codes as Listed in Denominator * (1/1/2017 thru 12/31/2017)**
  - No → **Not Included in Eligible Population/Denominator**
  - Yes ↓
- **Patient Discharged from Inpatient Facility (e.g. Hospital, Skilled Nursing Facility) Within the last 30 Days**
  - No → **Not Included in Eligible Population/Denominator**
  - Yes ↓
- **Include in Eligible Population/ Denominator (8 visits)** d^2

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: Denominator Exclusion = "x"/purple, Performance Met = "a"/green, Denominator Exception = "b"/yellow, Performance Not Met = "c"/gray, and Data Completeness Not Met = red 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 Measure #19 NQF # 0089: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care:
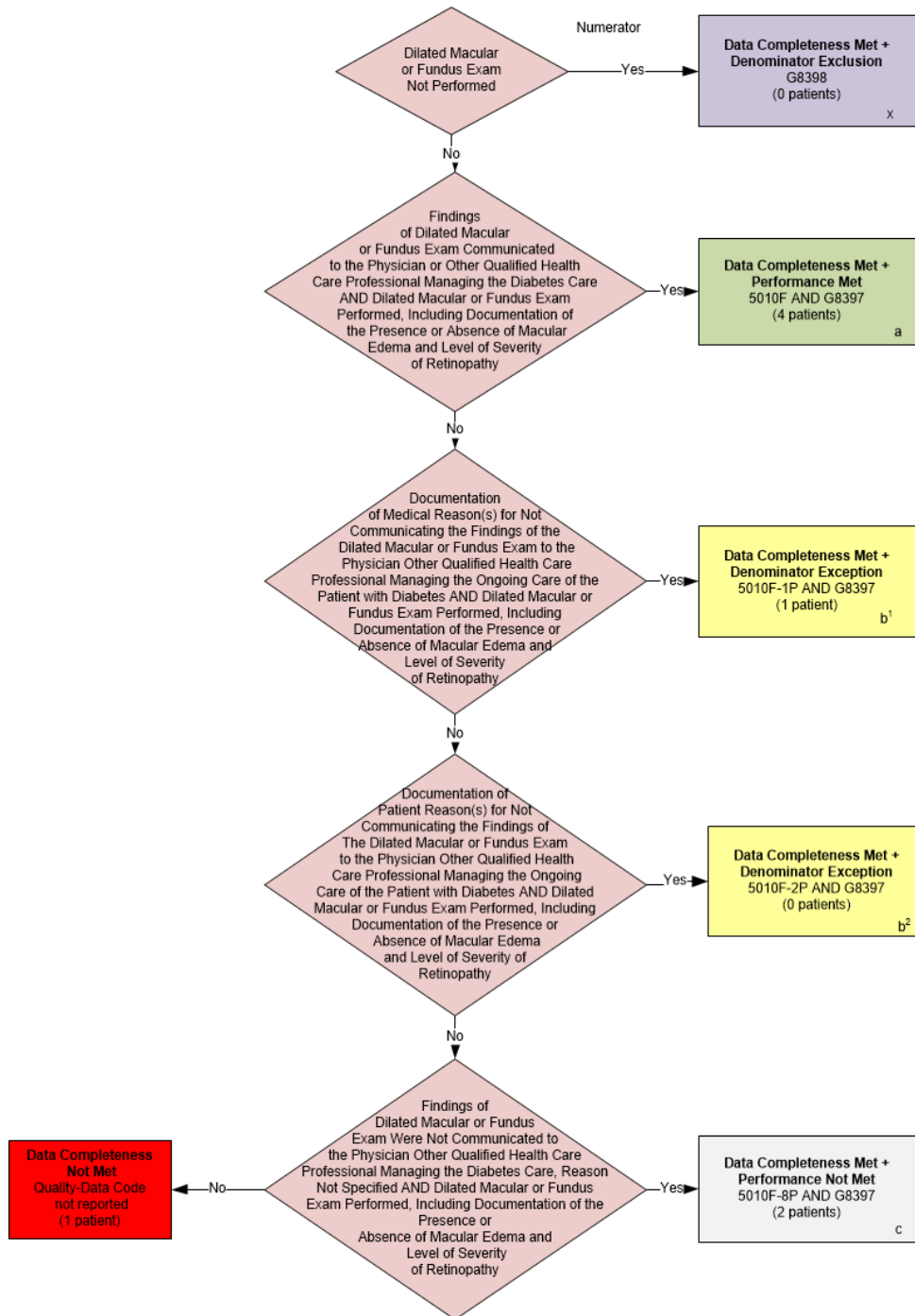
Algorithms

Data Completeness Algorithm

The Data Completeness Algorithm is based on the eligible population and sample outcomes of the possible quality actions as described in the flow of the measure. The Data Completeness Algorithm provides the calculation logic for patients who have been submitted in the 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 Measure #19. In the example, 8 patients met the denominator criteria for eligibility, where 0 patients were considered a denominator exclusion, 4 patients had the quality action performed (Performance Met), 1 patient did not receive the quality action for a documented reason (Denominator Exception), and 2 patients were reported as not receiving the quality action (Performance Not Met). **Note**: In the example, 1 patient was eligible for the measure but was not reported (Data Completeness Not Met).

Data Completeness =

$$\frac{\text{Denominator Exclusion (x=0 pts)+Performance Met (a=4 pts)+Denominator Exception (}b^1+b^2=1pt\text{)+Performance Not Met (c=2 pts)}}{\text{Eligible Population / Denominator (d=8 pts)}} = \frac{7 \text{ pts}}{8 \text{ pts}} = \mathbf{87.50\%}$$

Performance Algorithm

The Performance Algorithm calculation is based on only those patients where data completeness was met for the measure. For those patients, the numerator is determined by completing the quality action as indicated by Performance Met. Meeting the quality action for a patient, as indicated in the Claims Individual Measure Specification, would add one patient to the denominator and one to the numerator. Patients reporting 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 Measure #19. In this scenario, the patient sample equals 7 patients where 4 of these patients had the quality action performed (Performance Met), zero patients was submitted as a Denominator Exclusion, and one patient was submitted as having a Denominator Exception.

Performance Rate=

$$\frac{\text{Performance Met (a=4 patients)}}{\text{Data Completeness Numerator (7 patients)} - \textbf{Denominator Exclusion (x=0 patients)} - \text{Denominator Exception (b1+b2=1 patient)}} = \frac{4 \text{ patients}}{6 \text{ patients}} = \mathbf{66.67\%}$$

For measures with inverse performance rates, such as Measure #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 individual measure will provide guidance if the measure is indeed a multiple performance. The Individual 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-based data by the eligible clinician.