Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measure Area: Transfer of Health Information and Interoperability

2019 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for all patients with a referral during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure for the patients for whom a referral was made during the performance period based on the services provided and the measure-specific denominator coding. All Merit-based Incentive Payment System (MIPS) eligible professionals or eligible clinicians reporting on this measure should note that all data for the reporting year is to be submitted by the deadline established by CMS. Therefore, all Merit-based Incentive Payment System (MIPS) eligible professionals or eligible clinicians who see patients towards the end of the reporting period (ie, December in particular), should communicate the consultant report as soon as possible in order for those patients to be counted in the measure numerator. Communicating the report as soon as possible will ensure the data is included in the submission to CMS.

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.

DENOMINATOR:
Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period

> ***DENOMINATOR NOTE*:** *If there are multiple referrals for a patient during the performance period, use the first referral.*
>
> **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients regardless of age on the date of the encounter
> **AND**

Patient encounter during the performance period (CPT or HCPCS): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99381*, 99382*, 99383*, 99384*, 99385*, 99386*, 99387*, 99391*, 99392*, 99393*, 99394*, 99395*, 99396*, 99397*
WITHOUT
Telehealth Modifier: GQ, GT, 95, POS 02
AND
Patient was referred to another provider or specialist during the performance period: G9968

NUMERATOR:
Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred

Definitions:
Referral: A request from one physician or other eligible provider to another practitioner for evaluation, treatment, or co-management of a patient's condition. This term encompasses referral and consultation as defined by Centers for Medicare and Medicaid Services.

NUMERATOR NOTE: *The consultant report that will fulfill the referral should be completed after the referral, and should be related to the referral for which it is attributed. If there are multiple consultant reports received by the referring provider which pertain to a particular referral, use the first consultant report to satisfy the measure.*

The provider to whom the patient was referred should be the same provider that sends the report.

Numerator Options:

Performance Met:	Provider who referred the patient to another provider received a report from the provider to whom the patient was referred **(G9969)**
OR	
Performance Not Met:	Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred **(G9970)**

RATIONALE:
Problems in the outpatient referral and consultation process have been documented, including lack of timeliness of information and inadequate provision of information between the specialist and the requesting physician (Gandhi, 2000; Forrest, 2000; Stille, 2005). In a study of physician satisfaction with the outpatient referral process, Gandhi et al. (2000) found that 68% of specialists reported receiving no information from the primary care provider prior to referral visits, and 25% of primary care providers had still not received any information from specialists 4 weeks after referral visits. In another study of 963 referrals (Forrest, 2000), pediatricians scheduled appointments with specialists for only 39% and sent patient information to the specialists in only 51% of the time.

In a 2006 report to Congress, MedPAC found that care coordination programs improved quality of care for patients, reduced hospitalizations, and improved adherence to evidence-based care guidelines, especially among patients with diabetes and CHD. Associations with cost-savings were less clear; this was attributed to how well the intervention group was chosen and defined, as well as the intervention put in place. Additionally, cost-savings were usually calculated in the short-term, while some argue that the greatest cost-savings accrue over time (MedPAC, 2006).

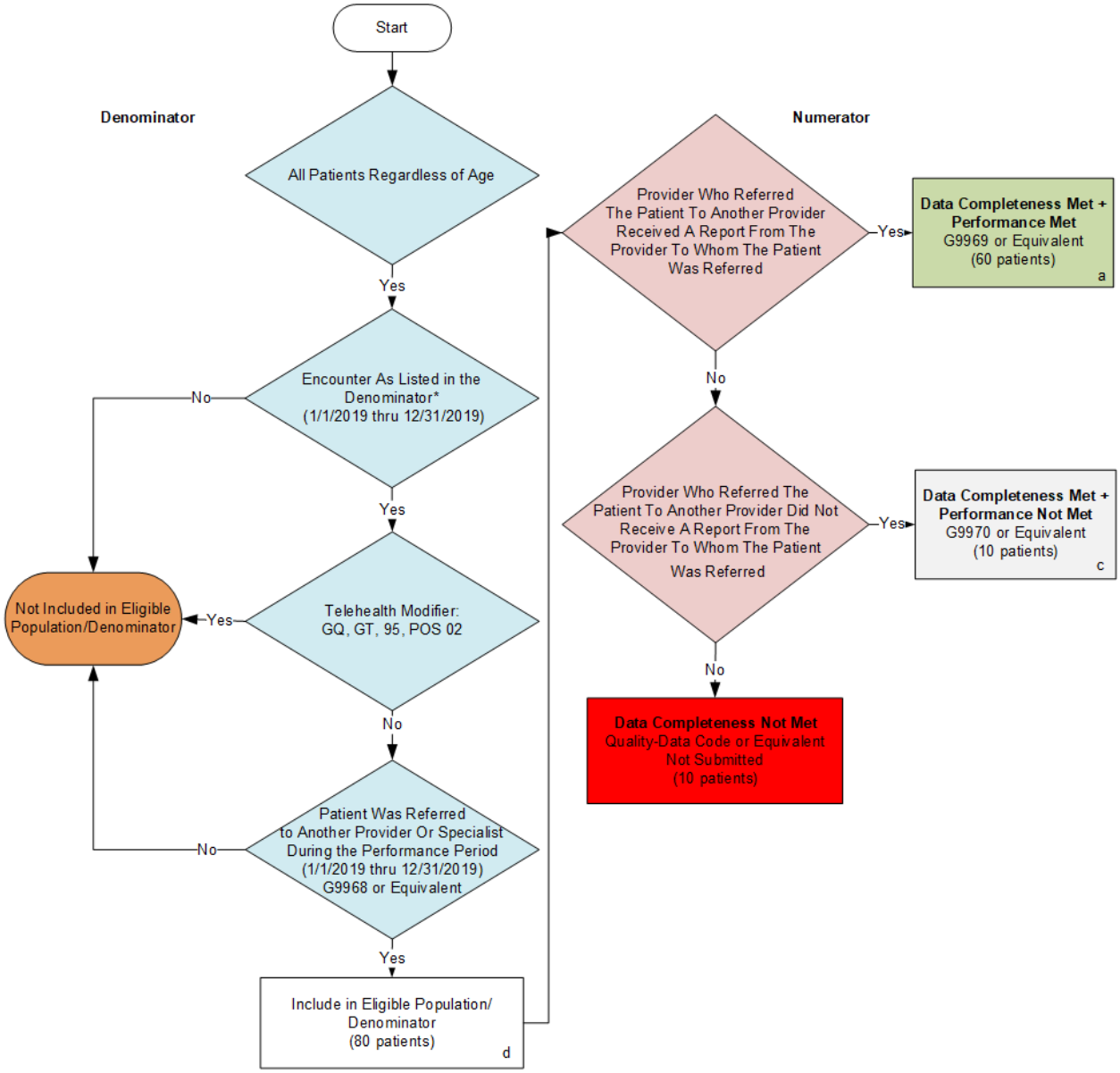
Improved mechanisms for information exchange could facilitate communication between providers, whether for time-limited referrals or consultations, on-going co-management, or during care transitions. For example, a study by Branger et al. (1999) found that an electronic communication network that linked the computer-based patient records

of physicians who had shared care of patients with diabetes significantly increased frequency of communications between physicians and availability of important clinical data. There was a 3-fold increase in the likelihood that the specialist provided written communication of results if the primary care physician scheduled appointments and sent patient information to the specialist (Forrest, 2000).

Care coordination is a focal point in the current health care reform and our nation's ambulatory health information technology (HIT) framework. The National Priorities Partnership recently highlighted care coordination as one of the most critical areas for development of quality measurement and improvement (NPP, 2008).

CLINICAL RECOMMENDATION STATEMENTS:
None

2019 Clinical Quality Measure Flow for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report



SAMPLE CALCULATION:

Data Completeness=

Performance Met (a=60 patients) + Performance Not Met (c=10 patients) = 70 patients= **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a=60 patients) = 60 patients= **85.71%**

Data Completeness Numerator (70 patients) = 70 patients

* See the posted Measure Specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Process

v3

2019 Clinical Quality Measure Flow Narrative for Quality ID # 374: Closing the Referral Loop: Receipt of Specialist Report

Please refer to the specific section of the Measure Specification to identify the denominator and numerator information for use in submitting this Individual Specification.

1. Start with Denominator
2. Check Patient Age
    a. All Patients Regardless of Age, proceed to check Encounter Performed.
3. Check Encounter Performed:
    a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If Encounter as Listed in the Denominator equals Yes, proceed to check Telehealth Modifier.
4. Check Telehealth Modifier:
    a. If Telehealth Modifier equals Yes, do not include in Eligible Population. Stop Processing.
    b. If Telehealth Modifier equals No, proceed to check Patient Was Referred to Another Provider Or Specialist During the Performance Period.
5. Check Patient Was Referred to Another Provider Or Specialist During the Performance Period.
    a. If Patient Was Referred to Another Provider Or Specialist During the Performance Period equals No, do not include in Eligible Population. Stop Processing.
    b. If Patient Was Referred to Another Provider Or Specialist During the Performance Period equals Yes, include in Eligible Population.
6. Denominator Population
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
7. Start Numerator
8. Check Provider Who Referred The Patient To Another Provider Received A Report From The Provider To Whom The Patient Was Referred:
    a. If Provider Who Referred The Patient To Another Provider Received A Report From The Provider To Whom The Patient Was Referred equals Yes, include in Data Completeness Met and Performance Met.
    b. Data Completeness Met and Performance Met letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 60 patients in the Sample Calculation.
    c. If Provider Who Referred The Patient To Another Provider Received A Report From The Provider To Whom The Patient Was Referred equals No, proceed to check Provider Who Referred The Patient To Another Provider Did Not Receive A Report From The Provider To Whom The Patient Was Referred.

9. Check Provider Who Referred The Patient To Another Provider Did Not Receive A Report From The Provider To Whom The Patient Was Referred:

    a. If Provider Who Referred The Patient To Another Provider Did Not Receive A Report From The Provider To Whom The Patient Was Referred equals Yes, include in Data Completeness Met and Performance Not Met.

    b. Data Completeness Met and Performance Not Met letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 10 patients in the Sample Calculation.

    c. If Provider Who Referred The Patient To Another Provider Did Not Receive A Report From The Provider To Whom The Patient Was Referred equals No, proceed to Data Completeness Not Met.

10. Check Data Completeness Not Met:

    a. If Data Completeness Not Met, the Quality-Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

SAMPLE CALCULATION:

Data Completeness=

Performance Met (a=60 patients) + Performance Not Met (c=10 patients) = 70 patients= **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a=60 patients) = 60 patients= **85.71%**

Data Completeness Numerator (70 patients) = 70 patients