



2025 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 2024

Introduction

This document contains general guidance for the 2025 Measure Specifications and Measure Flows for Medicare Part B claims collection type. The individual Measure Specifications are detailed descriptions of the quality measures and are intended to be used for the purposes of reporting the measures. In addition, each quality Measure Specification includes a Measure Flow and associated measure calculation algorithm as a resource. This information assists users with understanding quality measure logic related to data completeness and measure performance. The Measure Flow shouldn't be used as a substitute for the quality Measure Specification, but used as an additional visual resource.

Collection Types

Medicare Part B claims collection type utilizes unique specifications that are specific for collecting and submitting quality data via Medicare Part B claims. Measure data are reported on Medicare Part B claims when they're submitted for reimbursement. (Medicare Part B claims measures can only be reported by solo practitioners and small practices (15 or fewer clinicians).) Data are only reported for Medicare patients. The following are the other collection types available for meeting the reporting requirements for the quality performance category. These specifications are located on the QPP Resource Library. Other collection types will use different submission methods as outlined below.

- [MIPS Clinical Quality Measures \(CQMs\)](#): Utilize unique specifications that may be collected by individual MIPS eligible clinicians, groups, virtual groups, subgroups, or APM Entities in preparation for submission to CMS. MIPS CQM data may be gathered from paper, electronic charts, or collected with the assistance of a third party intermediary. Data are collected for all patients that qualify for the measure, not just Medicare patients.
- [Electronic Clinical Quality Measures \(eCQMs\)](#): Utilize unique specifications that are specific for collecting and submitting quality data via electronic health records (EHRs). Measure data are collected at the point of care in electronic health record technology that's been certified by the Office of the National Coordinator for Health Information Technology (ONC). Data are collected for all patients that qualify for the measure, not just Medicare patients.
- [Medicare Clinical Quality Measures \(Medicare CQMs\)](#): Utilize unique specifications that are specific for collecting quality data (only available for Medicare Shared Savings Program Accountable Care Organizations).
- [Qualified Clinical Data Registry \(QCDR\) Measures](#): QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures. Data are collected in a manner specified by the QCDR for all patients that qualify for the measure, not just Medicare patients.
- [Consumer Assessment of Healthcare Providers and Systems \(CAHPS\) for MIPS Survey Measure](#): Assess patients' experiences of care and must be administered by a CMS-approved survey vendor. Advance registration is required.
- [Administrative Claims Measures](#): Automatically assess performance (conducted by CMS) based on Medicare claims and automatically scored if measure requirements are met. Data are only collected for Medicare patients.

Medicare Part B Claims Quality Measure Specifications

Each quality measure is assigned a unique number. Measure numbers represent a continuation in numbering since the inception of MIPS (2017 through the 2025 performance period). Measure stewards provided revisions to the measures that were finalized in Calendar Year (CY) 2025 Physician Fee Schedule (PFS) final rule.

MIPS Submission Frequency with Definitions

Submission frequency labels are provided in each instructions of the Measure Specification and Measure Flow for each measure. Each individual MIPS eligible clinician participating in MIPS should submit data for the 2025 performance period according to the frequency defined for the measure. The following for submitting frequencies that are used for the 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 (QDC) 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 QDC 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 QDC 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 QDC.
- **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 has a denominator eligible encounter during the performance period.

Performance Period

Each Measure Specification includes information on the performance period and/or measurement period used to capture the intended numerator and denominator. In general, the performance period for the measure refers to the calendar year of January 1 to December 31. However, a measure may have a different timeframe for determining the measure's intended eligible population or the quality action as defined within the Measure Specification.

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 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, and their specifications may be found on the [QPP Resource Library](#):

- 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) procedure.
- Current Procedural Terminology (CPT) code.
- Healthcare Common Procedure Coding System (HCPCS) code.

These denominator criteria are specified in the measure specification 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.

If the specified denominator criteria for a measure is not applicable to 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 and the measure does not apply to the patient. With measure steward guidance, some Measure Specifications are revised annually for implementation in MIPS to ensure that the measures represent the most current clinical concepts and have analytical integrity. 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 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 criteria to determine whether submitted data meets denominator inclusion criteria.

Numerator Quality Data Codes

If the patient falls into the denominator eligible population, the applicable QDCs defining the appropriate numerator option should be submitted for data completeness of quality data for Medicare Part B claims submissions. QDCs found in the Numerator section of the Measure Specification are HCPCS and CPT Category II codes that describe the quality action that assist with determining the numerator outcome.

Denominator Exclusion:

Denominator exclusions describe 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. 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 eligible population, but the Measure Specification define circumstances in which a patient may be deemed as not appropriate for the numerator's quality action, they will be reported as a denominator exception. QDCs such as CPT Category II codes with modifiers such as 1P, 2P, and 3P, are referenced in the Measure Specification 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 compliant option isn't met and the criteria defined by the exception are met. This allows for the exercise of clinical judgment by the MIPS eligible clinician or consideration of system limitations.

Performance Not Met:

When the denominator exception doesn't apply, measure-specific QDCs, such as CPT Category II codes with or without modifier 8P, are reference in the Measure Specification to indicate that the quality action wasn't 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.

Please note that for an inverse measure, the denominator exception would be considered if the data doesn't support the "Performance Not Met" numerator option(s).

Each Measure Specification provides detailed numerator options for submitting data for the quality action described by the measure. The numerator clinical concepts described for each measure are to be followed when submitting data to CMS.

Individual Measure Submission

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 criteria. The following is an example of two NPIs billing under the same TIN who are intending to submit Quality #317: *Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented*. Clinician A sees a patient on February 2, 2025 and documents in the medical record a normal blood pressure reading with follow-up not required and submits the appropriate QDC, G8783, for Quality #317. Clinician B sees the same patient at an encounter on July 16, 2025 and documents in the medical record a normal blood pressure reading with follow-up not required. Clinician B should also submit the appropriate QDC(s), for the patient at the July encounter to meet data completeness for submission of Quality #317.

Need Assistance

If you have any questions, please contact the Quality Payment Program (QPP) Service Center by emailing QPP@cms.hhs.gov, by creating a [QPP Service Center ticket](#), or by calling 1-866-288-8292 (Monday – Friday, 8 a.m. – 8 p.m. ET).

Example Medicare Part B Claims Specification

Medicare Part B Claims Measure Specification format: Each Medicare Part B Claims conforms to a standard format. The measure format includes the following fields:

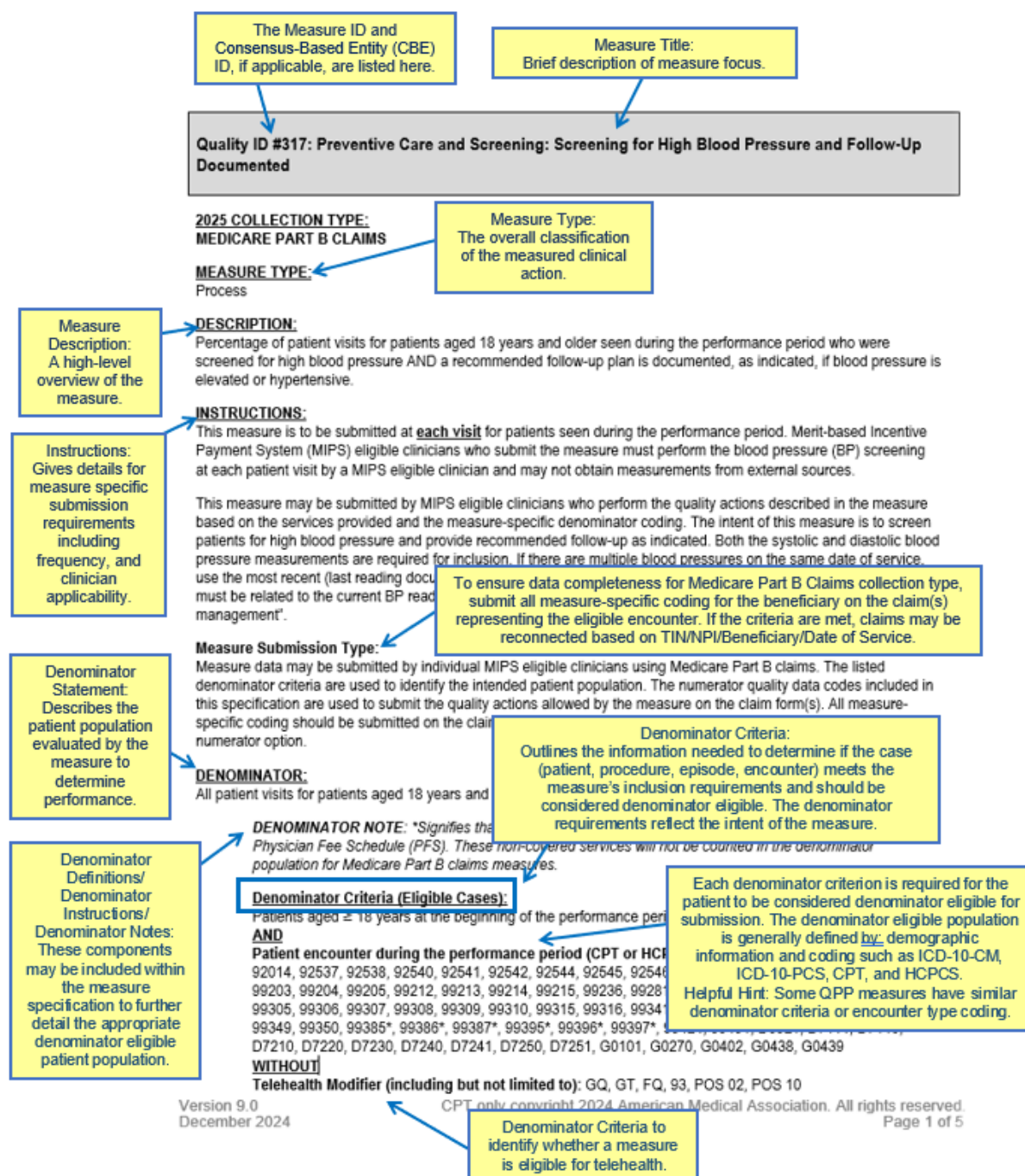
The measure header includes: Quality ID, Consensus-Based Entity (CBE) ID (if applicable), and Measure Title.

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, Criteria, Instructions, Notes, and Definition(s) of terms where applicable
- Numerator Statement, Options (Denominator Exclusion, Performance Met, Denominator Exception, Performance Not Met); Instructions, Notes, and Definition(s) of terms where applicable
- Rationale
- Clinical Recommendations Statement

The Rationale and Clinical Recommendation Statement sections provide limited clinical guidelines and references supporting 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 2025 MIPS Quality Measures List, which can be found on [MIPS Explore Measures](#) webpage (select Performance Year 2025)..

Example Medicare Part B Claims Measure Specification:



Numerator Statement:
Describes the quality action being assessed for performance and counted as meeting the measure's requirements (e.g., a patient who received a particular clinical service or achieved a particular health status).

NUMERATOR:

Patient visits where patients were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is elevated or hypertensive

Definitions:

Blood Pressure (BP) Classification – BP is defined by four (4) BP reading classifications: Normal, Elevated, First Hypertensive, and Second Hypertensive Readings

- Normal BP: Systolic BP (SBP) < 120 mmHg AND Diastolic BP (DBP) < 80 mmHg
- Elevated BP: SBP of 120-129 mmHg AND DBP < 80 mmHg
- First Hypertensive Reading: SBP of ≥ 130 mmHg OR DBP of ≥ 80 mmHg without a previous SBP of ≥ 130 mmHg OR DBP of ≥ 80 mmHg during the 12 months prior to the encounter
- Second Hypertensive Reading: Requires a SBP ≥ 130 mmHg OR DBP ≥ 80 mmHg during the current encounter AND a most recent BP reading within the last 12 months SBP ≥ 130 mmHg OR DBP ≥ 80 mmHg

Recommended BP Follow-Up – The 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults from the American College of Cardiology and American Heart Association (2017 Guideline) recommends BP screening and thresholds as defined under Blood Pressure Classifications and recommends interventions based on the current BP reading as listed in the Recommended Blood Pressure Follow-Up Table below. The time periods for follow-up actions specified for the elevated and the second hypertensive (130-139 DBP OR 80-89 SBP) BP classifications slightly differ from time periods given in the 2017 Guideline. This allows for clinician discretion due to patient condition and stability of the measure specification over time.

Recommended Nonpharmacologic Interventions (Lifestyle Modifications) – The 2017 Guideline outlines nonpharmacologic interventions which must include one or more of the following as indicated:

- Weight Reduction
- A "heart-healthy diet", such as Dietary Approaches to Stop Hypertension (DASH)
- Dietary Sodium Restriction
- Increased Physical Activity
- Moderation in alcohol consumption

This is an example of a complex Numerator. Review the Numerator section carefully to ensure the appropriate quality-data codes (QDC's) are submitted and accurately reflect the quality action in alignment with the measure as specified.

Numerator Definitions/ Numerator Instructions/ Numerator Notes:
These components may be included within the measure specification to further detail the quality action being assessed for within the measure and what is considered acceptable for determining performance.

Recommended Blood Pressure Follow-Up Table

BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up (must include all indicated actions for each BP Classification)
Normal BP Reading	< 120	AND < 80	No Follow-Up required
Elevated BP Reading	120 - 129	AND < 80	Rescreen BP within 6 months <u>AND</u> recommended nonpharmacologic interventions <u>OR</u> Referral to Alternate/Primary Care Provider
First Hypertensive BP Reading	≥ 130	OR ≥ 80	Rescreen BP within 4 weeks <u>AND</u> recommended nonpharmacologic interventions <u>OR</u> Referral to Alternate/Primary Care Provider

BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up (must include all indicated actions for each BP Classification)
Second Hypertensive BP Reading	130-139 and NOT $\geq$ 140	OR 80-89 and NOT $\geq$ 90	Recommended nonpharmacologic intervention AND reassessment within 6 months AND an order for laboratory test or ECG for hypertension OR Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	$\geq$ 140	OR $\geq$ 90	Recommended nonpharmacologic intervention AND BP-lowering medication AND reassessment within 4 weeks AND an order for laboratory test or ECG for hypertension OR Referral to Alternate/Primary Care Provider

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.

Not Eligible for High Blood Pressure Screening (Denominator Exclusion) –

- Patient has an active diagnosis of hypertension prior to the current encounter.

Patients with a Documented Reason for not Screening or no Follow-Up Plan for High Blood Pressure (Denominator Exception) –

- Documentation of medical reason(s) for not screening for high blood pressure (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status).
- Documentation of patient reason(s) for not screening for high blood pressure and an appropriate follow-up intervention if patient is not screened.

NUMERATOR NOTE: Although the recommended screening and follow-up plan meet the intent of this measure, BP screening and follow-up plan determined on the date of the denominator eligible encounter.

Denominator Exclusion:
Describe a circumstance where the patient should be removed from the denominator. If included, they identify circumstances where the patient should be removed from the performance rate calculation prior to determining which numerator outcome is appropriate.

Numerator Quality Data Coding Options:

*Screening for High Blood Pressure not Documented
Denominator Exclusion: G9744:

Normal Blood Pressure Reading Documented, Follow-up not required
Performance Met: G8783:

OR
Elevated or Hypertensive Blood Pressure Reading Documented
Performance Met: G8950:

Quality Data Codes (QDCs):
Describe clinical concepts or outcomes required for determining the intended population for the measure and/or numerator outcome. Here, the QDCs describe a quality action that assist with determining the numerator outcome.

****Screening or Follow-Up for High Blood Pressure not Completed, Documented Reason**

Denominator Exception: G9745:

Documented reason for not screening or recommending a follow-up for high blood pressure

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Section 3:
Denominator Exception:
Defines circumstances in which a patient may be deemed as not appropriate for the numerator's quality action. These cases count towards Data Completeness but are removed from the Performance denominator.
Note: Not all measures allow denominator exceptions; review the Numerator Options carefully for each measure.

Section 4: Data Completeness Met and Performance Not Met.	OR	Blood Pressure Reading not Documented, Reason not Given <i>Performance Not Met: G8785:</i>	Blood pressure reading not documented, reason not given
	OR	Elevated or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up not Documented, Reason not Given <i>Performance Not Met: G8952:</i>	Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given
RATIONALE: Hypertension is a prevalent condition that affects about 20-40 percent of the adult population with a hypertension diagnosis (1, 2). Winter noted that the prevalence of developing hypertension is 90 percent (3). The prevalence of hypertension is higher in African Americans, Hispanics, diabetics and those with chronic kidney disease are at increased risk of stroke, myocardial infarction and renal disease. Non-Hispanic Blacks have the highest prevalence at 38.6 percent (3). Hypertension is a major risk factor for ischemic heart disease, left ventricular hypertrophy, renal failure, stroke and dementia (2). Prevention of hypertension and the treatment of established hypertension are complementary approaches to reducing cardiovascular disease risk in the population, but prevention of hypertension provides the optimal means of reducing risk and avoiding harmful consequences. Periodic BP screening can identify individuals who develop elevated BP over time. More frequent BP screening may be particularly important for individuals with elevated atherosclerotic cardiovascular disease (ASCVD) risk (4). Hypertension is the most common reason for adult office visits other than pregnancy. Garrison stated that in 2007, 42 million ambulatory visits were attributed to hypertension (5). It also has the highest utilization of prescription drugs. Numerous resources and treatment options are available, yet only about 40- 50 percent of the hypertensive patients have their blood pressure under control (<140/90) (1,2). In addition to medication non-compliance, poor outcomes are also attributed to poor adherence to lifestyle changes such as a low-sodium diet, weight loss, increased exercise and limiting alcohol intake. Many adults find it difficult to continue medications and lifestyle changes when they are asymptomatic. Symptoms of elevated blood pressure usually do not occur until secondary problems arise such as with vascular diseases (myocardial infarction, stroke, heart failure and renal insufficiency) (2). Appropriate follow-up after blood pressure measurement is a pivotal component in preventing the progression of hypertension and the development of heart disease. Detection of marginally or fully elevated blood pressure by a specialty clinician warrants referral to a provider familiar with the management of hypertension and prehypertension. The American College of Cardiology/American Heart Association (ACC/AHA) 2017 Guidelines provide updated recommendations for ASCVD risk. For additional information please refer to the 2017 ACC/AHA guidelines: https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/11/09/11/4/2017-guideline-for-high-blood-pressure-in-adults (4). Lifestyle modifications have demonstrated effectiveness in lowering blood pressure (6). The synergistic effect of several lifestyle modifications results in greater benefits than a single modification alone. Baseline diagnostic/laboratory testing establishes if a co-existing underlying condition is the etiology of hypertension and evaluates if end organ damage from hypertension has already occurred. Landmark trials such as the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) have repeatedly proven the efficacy of pharmacologic therapy to control blood pressure and reduce the complications of hypertension. A review of 35 studies found that the pharmacist-led interventions involved medication counseling and patient education. Twenty-nine of the 35 studies showed statistically significant improvement in BP levels of the intervention groups at follow-up (7). Follow-up intervals based on blood pressure control have been established by the 2017 ACC/AHA guideline and the United States Preventive Services Task Force (USPSTF).			
Rationale: This is a brief statement describing the evidence base and/or intent for the measure.			

References

1. Appleton, S. L., Neo, C., Hill, C. L., Douglas, K. A., & Adams, R. J. (2013). Untreated hypertension: prevalence and patient factors and beliefs associated with under-treatment in a population sample. *Journal of Human Hypertension*, 27, 453-462. doi:10.1038/jhh.2012.62ID
2. Luehr, D., Woolley, T., Burke, R., Dohmen, F., Hayes, R., Johnson, M., Schoenleber, M. (2012). Hypertension diagnosis and treatment; Institute for Clinical Systems Improvement health care guideline. Updated November, 2012
3. Winter, K. H., Tuttle, L. A. & Viera, A.J. (2013). Hypertension. *Primary Care Clinics in Office Practice*, 40, 179-194. doi:10.1016/j.pop.2012.11.008
4. Whelton, P.K., Carey, R.M., Aronow, W.S., Casey, D.E., Collins, K., Dennison Himmelfarb, C., Depalma, S.M., Gidding, S., Jamerson, K.A., Jones, D.W., MacLaughlin, E.J., Muntener, P., Oviaggele, B., Smith, S.C., Spencer, C.C., Stafford, R.S., Taler, S.J., Thomas, R.J., Williams, K. A., Williamson, J.D., Wright, J.T., (2018). 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Hypertension*, 71(6), e13-e115. doi.org/10.1161/HYP.0000000000000065
5. Garrison, G. M. & Oberhelman, S. (2013). Screening for hypertension annually compared with current practice. *Annals of Family Medicine*, 11 (2), 116-121. doi:10.1370/afm.1467
6. U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute & National High Blood Pressure Education Program (2003). The Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-7). NIH Publication No. 03-5233
7. Reeves, L., Robinson, K., McClelland, T., Adedoyin, C., Broeseker, A., and Adunlin, G. (2020). "Pharmacist Interventions in the Management of Blood Pressure Control and Adherence to Antihypertensive Medications: A Systematic Review of Randomized Controlled Trials." *Journal of Pharmacy Practice*. Available at <https://doi.org/10.1177/0897190020903573>. Accessed Oct

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for hypertension in adults aged 18 years and older. This is a grade A recommendation (1).

Clinical Recommendation Statements:
This is a summary of the clinical recommendations based on best practices, guidelines, etc.

References

1. U.S. Preventive Services Task Force (2021). Screening for hypertension in adults. US Preventive Services Task Force reaffirmation recommendation statement. *Annals of Internal Medicine*, 174(12): 1650-1656.

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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.

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.

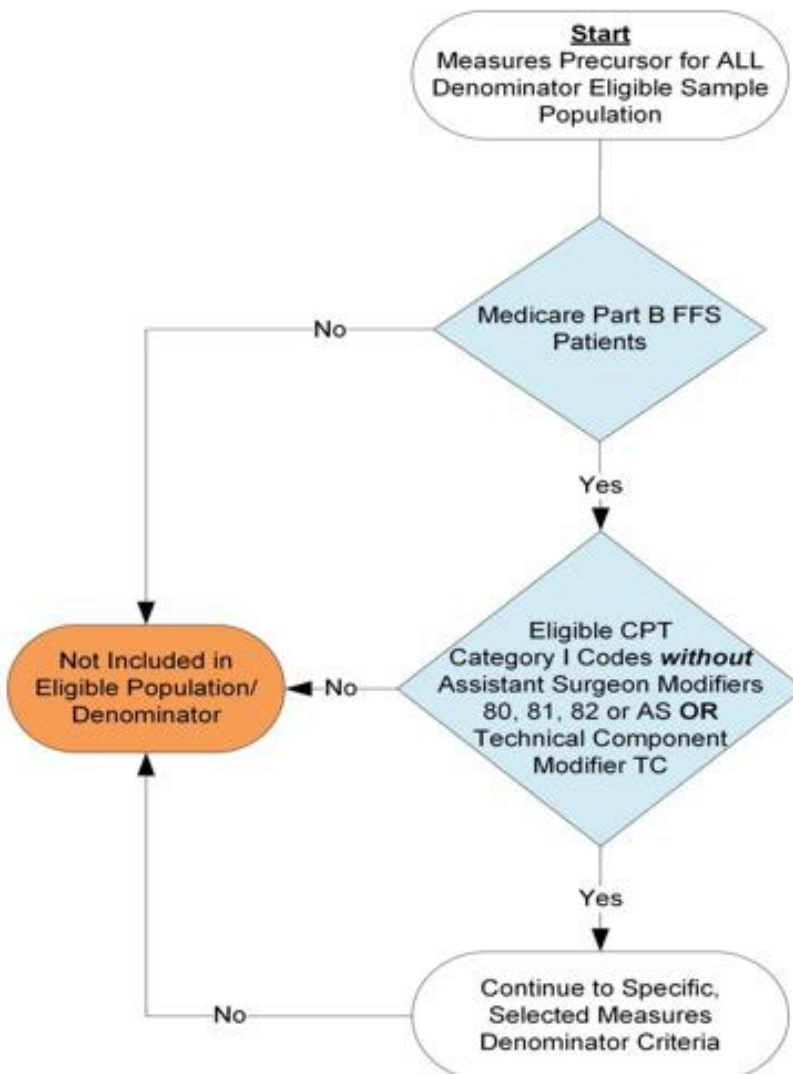
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Interpretation of Medicare Part B Claims Measure Flows

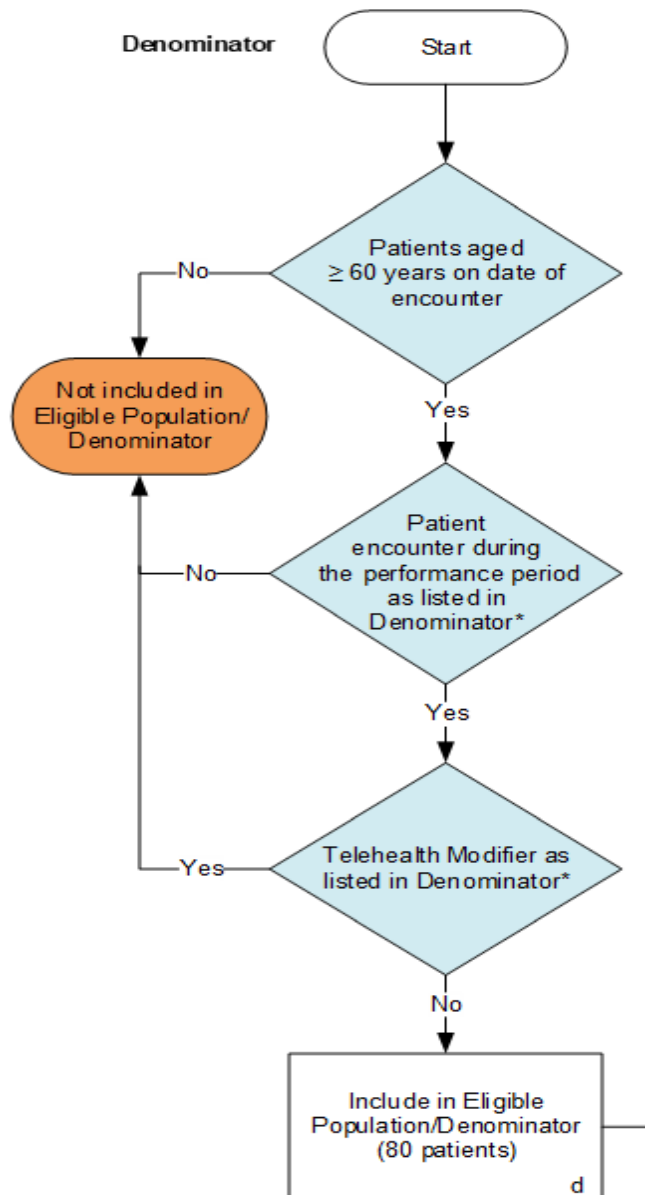
Denominator

The Medicare Part B Claims Measure Flow is designed to provide interpretation of the measure logic and calculation methodology for data completeness and performance rates. The measure flow starts 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 2025 Medicare Part B Claims Measures:

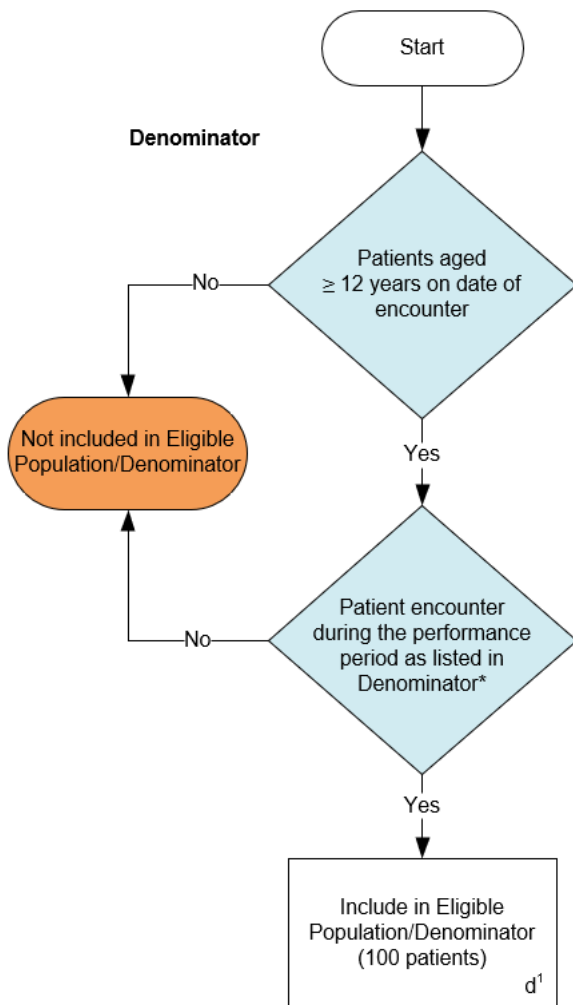


The Medicare Part B Claims Measure Flow in each Measure Specification begins with the appropriate age group and denominator population for the measure. The Eligible Population box equates to the letter “d” (as shown at the bottom right corner of the last box of the denominator diagram) by the patient population that meets the measure’s inclusion requirements. Below is an example of the denominator criteria used to determine the eligible population for Quality #181: Elder Maltreatment Screen and Follow-Up Plan:

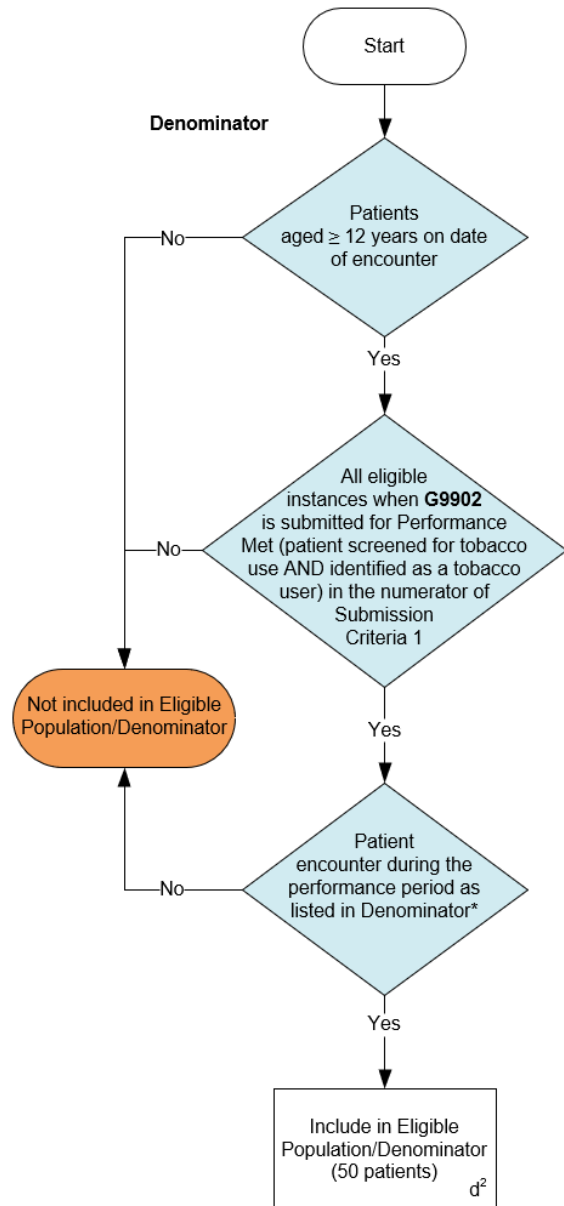


Some Medicare Part B Claims measures, such as Quality #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, have multiple submission criteria to determine the measure denominator. In the example below, the denominator also represents multiple performance rates. Patients meeting the submission criteria for either denominator option are included as part of the eligible population. Review the Instructions section of the Medicare Part B Claims Specification to determine if it contains multiple submission criteria, each of which will be fully detailed within the Denominator section..

Submission Criteria One



Submission Criteria Two

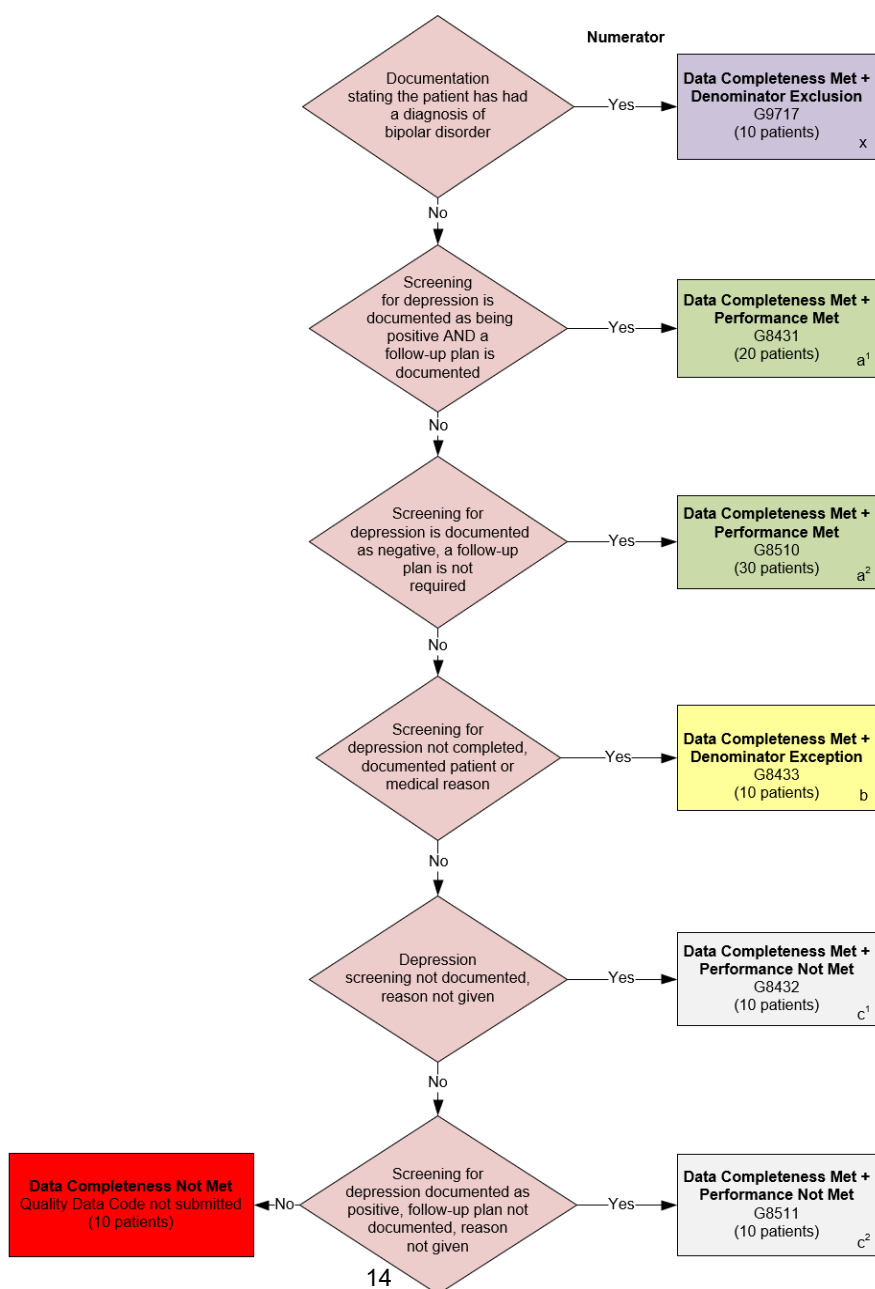


Numerator

Once the denominator is identified, the Medicare Part B Claims Measure Flow illustrates and stratifies the quality action (numerator) to assist with calculation of data completeness and performance. Depending on the measure, there are several outcomes that may be applicable for the measure's calculation. 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;
- Middle box - Denominator Exception = "b" and shaded yellow;
- Bottom right boxes below - 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 as described to identify the particular outcome of the measure represented. This is illustrated below for Quality #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan:



Algorithms

Please note that a Measure Specification includes a data completeness and performance algorithm for each submission criteria and/or performance rate. Information regarding submission requirements for each measure will be found within the Measure Narrative section (separate from the Flow Narrative section) of the Measure Specification.

Data Completeness Algorithm

The Data Completeness Algorithm calculation is based on the eligible population and the volume of performance data reported as described in the Measure Flow. 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 #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan. In the example, 90 patients met the denominator criteria for eligibility, 10 patients were considered a denominator exclusion, 50 patients had the quality action performed (Performance Met), 10 patients didn't receive the quality action for a documented reason (Denominator Exception), and 20 patients were reported as not receiving the quality action (Performance Not Met).

Data Completeness =

$$\frac{\text{Denominator Exclusion (x=10)} + \text{Performance Met (a1+a2=50)} + \text{Denominator Exception (b=10)} + \text{Performance Not Met (c1+c2=20)}}{\text{Eligible Population/Denominator (d=100 patients)}} = \frac{90 \text{ patients}}{100 \text{ patients}} = 90.00\%$$

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 Algorithm that represents this calculation for Quality #134. In this scenario, the patient sample equals 90 patients where 50 of these patients had the quality action performed (Performance Met), 10 patients were submitted as a Denominator Exclusion, and 10 patients were reported as meeting the Denominator Exception.

Performance Rate =

$$\frac{\text{Performance Met (a1+a2=50 patients)}}{\text{Data Completeness Numerator (90 Patients) - Denominator Exclusion (x=10 patients) - Denominator Exception (b=10 patients)}} = \frac{50 \text{ patients}}{70 \text{ patients}} = 71.43\%$$

Multiple Performance Rates

MIPS 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 rate measure. The Medicare Part B Claims Measure Flow for these measures includes algorithm examples to understand the different data completeness and performance rates for the measure. The system will calculate the data completeness and performance rates for the measure based on the submission of claims data by the MIPS eligible clinician.