MIPS

Quality Measures Guide

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Quality Category Requirements and Scoring Methodologies

The Quality performance category is worth 40 percent of the MIPS final score for 2021, which is five percentage points lower than in 2020. In certain situations, a clinician or group may be excluded from a specific performance category and the weight of that category may be shifted to the Quality category.

Depending on the measures selected, clinicians and groups may submit quality data to CMS via the following mechanisms:

- Claims (only available to individuals and groups in small practices – i.e., 15 or fewer eligible clinicians)
- Qualified Clinical Data Registry (QCDR)
- Qualified Registry (QR)
- Electronic Health Record (EHR)
- CMS Web Interface (groups of 25 or more)
- CMS-approved survey vendor for Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS (available to groups only and must be reported in conjunction with another data submission mechanism)

For 2021, clinicians and groups must report on at least six quality measures, including at least one outcome or high-priority measure. Additionally, for group practices with more than 15 MIPS-eligible clinicians, CMS automatically will calculate a Hospital-Wide All-Cause Readmission measure based on administrative claims. CMS will only score a group practice on this measure if at least 200 cases are attributed to the group based on the measure specifications. This measure requires no additional data submission on the part of the practice.

If you report on fewer than 6 measures, or fail to report on an outcome or high priority measure, CMS will apply a validation process to confirm whether there were truly no other applicable measures to report. If CMS determines you could have reported on additional measures, you will receive a 0 out of 10 possible points for any missing measure. More information about this 2021 MIPS Eligible Measures Applicability (EMA) process is available through the QPP Resource Library.

Clinicians and groups may generally earn between 3 and 10 performance achievement points for each quality measure submitted during the 2021 performance period so long as all of the following criteria are met:

- **Case minimum:** The measure is reported on for at least 20 cases; and
- **Data completeness threshold:** The measure is reported on for at least 70% of applicable Medicare patients (for claims reporting only) or 70% of applicable patients across all payers (when reporting through a QR, QCDR, or EHR); and
- **Benchmark:** The measure has an historic of performance year benchmark. The 2021 Quality Benchmark file is available for download through the CMS QPP Resource Library. Note that this file is updated throughout the year.

However, there are multiple scenarios where CMS will cap the number of points available for a specific measure:

- A clinician or group can only earn 3 points on a measure if they meet the data completeness criteria, but either 1) the measure does not have a benchmark and/or 2) the measure does not exceed the case minimum.
- A clinician or group will earn 0 points on a measure (or 3 points for those in small practices) for measures reported that do not meet the data completeness criteria, regardless of case minimum or benchmark.
- Certain measures that CMS has designated as "topped out" due to historically high performance rates are subject to a 7-point scoring cap. Clinicians with perfect performance on these measures can earn no more than 7 points.

Additionally, if the distribution of performance for a given measure is skewed, it is possible that anything other than a perfect score could result in lower-than-expected scores. Reviewing and understanding the benchmark file will therefore be important in determining a measure selection strategy.

At the same time, clinicians and groups may earn bonus points in the quality performance category for the following:

- **Additional high priority measures:** Two bonus points can be earned for each additional outcome measure and one bonus point for each additional high-priority measure reported beyond what is required for this category. CMS will only provide performance achievement points for a clinician's or group's top six performing measures, but any outcome and high priority measures reported beyond those six are still

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eligible for bonus points. These bonus points are added to the numerator of the Quality performance score and are capped at 10% of the Quality performance category denominator.

- **End-to-end electronic reporting:** Submitting quality measures using end-to-end electronic reporting, with quality data reported directly from certified EHR technology (CEHRT), will earn one bonus point for each measure (except claims-based measures). Bonus points will be added to the numerator of the Quality performance score and are capped at 10% of the Quality performance category denominator.
- **Performance Improvement:** Up to 10 percentage points may be earned based on the rate of improvement in the Quality performance category from the year before. Bonus points will be incorporated into the clinician's or group's overall Quality performance category score.
- **Small practice:** A bonus of 6 points will be added to the numerator of the Quality performance category score for those in small practices.
- **Complex patients:** Up to 5 bonus points may be added to a clinician or group's final MIPS score to account for the complexity of their patient population.

Keep in mind that clinicians and groups who earn the maximum score in the Quality category (60 Quality points) will earn only 40 points toward their overall MIPS final score. Since the MIPS performance threshold for 2021 (the minimum number of overall MIPS points needed to avoid a penalty in 2023) is 60 points, clinicians and groups will need to rely more heavily on points from the other performance categories to avoid a penalty than they have in the past.

2021 MIPS Quality Measure Guides for PM&R Physicians

For 2021 reporting, CMS has approved more than 200 quality measures that MIPS eligible clinicians can report on. Measures may be selected from either the MIPS clinical quality measure inventory or measures offered by specialty-specific Qualified Clinical Data Registries (QCDRs). Note that CMS makes changes to available measures each year, including adding and deleting measures from the inventory. Additionally, each measure has its own specifications, codes and reporting options, and these measure specifications may also change from year-to-year. As such, it is best to check the 2021 Quality Payment Program website prior to finalizing your reporting strategy to review reporting options and measure specifications for available measures for 2021.

Every quality measure has a denominator, numerator, reporting frequency and performance timeline.

THE DENOMINATOR:

The denominator describes eligible cases for a measure, including patient population and/or patient demographics. A key question to ask when looking at the measure is, "Do I provide a patient visit/service included in the denominator such that this quality measure would apply to me?"

THE NUMERATOR:

The numerator is the specific clinical action required by the measure for reporting and performance. This includes patients who received a particular service or obtained a particular outcome that is being measured.

REPORTING FREQUENCY:

Each measure has a frequency requirement that states how often ECs need to report the measure. Some measures are required to be reported for each visit or each unique patient while others may only require reporting once a year.

PERFORMANCE TIMELINE:

Some quality measures have a designated time frame when the measure should be completed. This may or may not coincide with the reporting frequency requirement.

The table on the next page is intended to help you identify individual quality measures that you can report on for 2021. CMS has also organized MIPS measures into specialty-specific sets to help clinicians navigate the large inventory of measures and identify those most relevant to a specialist. Specialty sets are simply suggestions meant to guide clinicians, but are not required. Many, but not all, of the measures listed below can be found in the "Physical Medicine Specialty Set[1]."

When choosing individual measures, keep in mind the scoring rules outlined above.

[1] **To view the Physical Medicine Specialty set, please use the filters in the 2021 Quality Measure search tool.**

MIPS QUALITY MEASURE NUMBER	MEASURE DESCRIPTION	MEASURE TYPE	HIGH-PRIORITY	REPORTING OPTIONS	REPORTING FREQUENCY	TOPPED OUT SCORING CAP (7 PTS)	HISTORIC BENCHMARK?
9	Anti-Depressant Medication Management	Process	No	EHR		N	Y
24	Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older	Process	Yes	Claims, Registry	Each occurrence	N	Y
39	Screening for Osteoporosis for Women Aged 65-85 Years of Age	Process	No	Claims, Registry	Once/year	N	Y
47^	Care Plan	Process	Yes	Claims, Registry	Once/year	N	Y
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Process	Yes	Claims, Registry	Once/year	N	Y
107^	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	No	EHR		N	Y
110^	Preventive Care and Screening: Influenza Immunization	Process	No	Claims, EHR, CMS Web Interface, Registry	2 time periods: once for each period	N	Y
111	Pneumococcal Vaccination Status for Older Adults	Process	No	Claims, EHR, Registry	Once/year	N	Y
126^	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Evaluation	Process	No	Registry	Once/year	N	Y
127^	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention—Evaluation of Footwear	Process	No	Registry	Once/year	N	Y
128^	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Process	No	Claims, EHR, Registry	Once/year	N	Y
130^	Documentation of Current Medications in the Medical Record	Process	Yes	Claims, EHR, Registry	Each visit	Y	Y
134^	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Process	No	Claims, EHR, CMS Web Interface, Registry	Once/year	N	Y

^ Measures have substantive changes to measure specifications relative to 2020.

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145^	Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy	Process	Yes	Claims, Registry	Each time	Y	Y
154	Falls: Risk Assessment	Process	Yes	Claims, Registry	Once/year	Y	N
155	Falls: Plan of Care	Process	Yes	Claims, Registry	Once/year	N	Y
178^	Rheumatoid Arthritis (RA): Functional Status Assessment	Process	No	Registry	Once/year	Y	Y
181^	Elder Maltreatment Screen and Follow-Up Plan	Process	Yes	Claims, Registry	Once/year	N	Y
182^	Functional Outcome Assessment	Process	Yes	Claims, Registry	Each eligible visit	N	Y
226^	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process	No	Claims, EHR, CMS Web Interface, Registry	Once/year	N	N
236^	Controlling High Blood Pressure	Intermediate Outcome	Yes	Claims, EHR, CMS Web Interface, Registry	Once/year	N	Y
238^	Use of High-Risk Medications in the Elderly	Process	Yes	EHR, Registry	Once/year	N	N
281^	Dementia: Cognitive Assessment	Process	No	EHR		N	Y
317^	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Process	No	Claims, EHR, Registry	Once/year	N	N
318^	Falls: Screening for Future Fall Risk	Process	Yes	EHR, CMS Web Interface		N	Y
342	Pain Brought Under Control Within 48 Hours	Outcome	Yes	Registry	Once/year	N	Y
370^	Depression Remission at 12 Months	Outcome	Yes	EHR, CMS Web Interface, Registry	Once/year	N	Y (for eCQM, but not for CQM)
374^	Closing the Referral Loop: Receipt of Specialist Report	Process	Yes	EHR, Registry	Once/year	N	Y
375	Functional Status Assessment for Total Knee Replacement	Process	Yes	EHR		N	Y
376	Functional Status Assessment for Total Hip Replacement	Process	Yes	EHR		N	Y

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402	Tobacco Use and Help with Quitting Among Adolescents	Process	No	Registry	Once/year	Y	Y
418^	Osteoporosis Management in Women Who Had a Fracture	Process	No	Claims, Registry	Each occurrence of a fracture	N	N
419^	Overuse of Neuroimaging for Patients with Primary Headache and a Normal Neurological Examination	Efficiency	Yes	Claims, Registry	Each visit	N	Y
431^	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	Process	No	Registry	Once/year	N	N
459^	Average Change in Back Pain following Lumbar Discectomy/Laminotomy	Outcome	Yes	Registry	Each occurrence	N	N
460^	Average Change in Back Pain following Lumbar Fusion	Outcome	Yes	Registry	Each occurrence	N	N
461^	Average Change in Leg Pain following Lumbar Discectomy/Laminotomy	Outcome	Yes	Registry	Each occurrence	N	N
468^	Continuity of Pharmacotherapy for Opioid Use Disorder	Process	Yes	Registry	Once/year	N	N
469^	Average Change in Functional Status Following Lumbar Spine Fusion Surgery	Outcome	Yes	Registry	Each occurrence	N	N
470^	Average Change in Functional Status Following Total Knee Replacement Surgery	Outcome	Yes	Registry	Each occurrence	N	N
471^	Average Change in Functional Status Following Lumbar Discectomy Laminotomy Surgery	Outcome	Yes	Registry	Each occurrence	N	N
473^	Average Change in Leg Pain Following Lumbar Spine Fusion Surgery	Outcome	Yes	Registry	Each occurrence	N	N
477	Multimodal Pain Management	Process	Yes	Registry	Each occurrence	N	N
478^	Functional Status Change for Patients with Neck Impairment	Outcome	Yes	Registry	Each treatment episode	N	N

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