2019 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

11/20/2018

Introduction

This document contains general guidance for the 2019 Quality Payment Program (QPP) Individual Measure Specifications and Measure Flows for Medicare Part B claims submissions. The individual measure specifications are detailed descriptions of the quality measures and are intended to be utilized by individual MIPS eligible clinicians submitting individual measures via Medicare Part B claims for the 2019 QPP. In addition, each measure specification document includes a measure flow and associated algorithm as a resource for the application of logic for data completeness and performance. Please note that the measure flows were created by CMS and may or may not have been reviewed by the Measure Steward. These diagrams should not be used in place of the measure specification but may be used as an additional resource.

Collection Types

Data submission from individual Medicare Part B claims measures may be collected by third party intermediaries. Other collection types will utilize different submission types as outlined below.

- There are separate documents for the MIPS Clinical Quality Measures (CQMs) collection type.
- Groups electing to submit via the Web Interface (WI) should utilize the Web Interface Measure documents.
- Measure specifications for electronic health record (EHR) based submission should be utilized for electronic clinical quality measures (eCQMs).
- Information regarding CG-CAHPS may be found at: https://www.ahrq.gov/cahps/about-cahps/index.html

Medicare Part B claims Measure Specifications

Each measure is assigned a unique number. Measure numbers for 2019 QPP represent a continuation in numbering from the 2018 QPP measures. Measure stewards have provided revisions for the measures that are finalized for use in 2019 QPP.

Frequency with Definitions

Frequency labels are provided in each measure instruction as well as the measure flow. The analytical submitting frequency defines the time period or event for which the measure should be submitted. Each individual MIPS eligible clinician participating in 2019 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 MIPS eligible clinician during the performance period.

Performance Period

Performance period for the measure may refer to the calendar year of January 1st to December 31st. However, measures may have a different timeframe for determining if the quality action indicated within the measure was performed. This may be referenced as the measurement period. There are several sections (Instruction, Description, or Numerator Statement) within the measure specification that may include information on the performance period.

Denominator and Numerator

Quality measures consist of a numerator and denominator that are used to calculate data completeness and performance for a defined patient population as an indication of achievement for a particular process of care being provided or clinical outcome being attained 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. The numerator focuses 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 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 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 codes for a measure are not included on the patient's claim (for the same date of service) as submitted by the individual MIPS eligible clinician, then the patient does not fall into the measure's eligible denominator population, and the measure does not apply to the patient. Some measure specifications are adapted as needed for implementation in agreement with the measure steward. For example, CPT codes for non-covered services such as preventive visits may be included in the denominator but would not apply to the measure since only covered services can be analyzed via claims data.

Measure specifications include specific instructions regarding CPT Category I modifiers, place of service codes (POS), and other detailed information. Each MIPS eligible clinician should carefully review the measure's denominator coding to determine whether codes submitted on a given claim meet denominator inclusion criteria.

Numerator Quality-Data Codes

If the patient does fall into the denominator population, the applicable Quality-data codes (QDCs) that define the numerator should be submitted for data completeness of quality data for a measure for Medicare Part B claims submissions.

Denominator Exclusion:

Typically, a denominator exclusion describes a circumstance where the patient should be removed from the denominator. Within Medicare Part B claims submissions, denominator exclusions identify circumstances where the patient should be removed from the performance rate calculation prior to determining which numerator outcome is appropriate. QDCs are available to describe the denominator exclusion within the measure specification and should be submitted on the claim. For Medicare Part B claims submission, these patients should be included within the data completeness calculation, but removed from the denominator of the performance rate. Please refer to the algorithm portion of this document below.

Performance Met:

If the intended quality action for the measure is performed for the patient, QDCs are available to describe that performance has been met and should be submitted on the claim.

Denominator Exception:
When a patient falls into the denominator, but the measure specifications define circumstances in which a patient may be appropriately deemed as a denominator exception. CPT Category II code modifiers such as 1P, 2P and 3P or QDCs are available to describe medical, patient, or system reasons for denominator exceptions and must be submitted on the claim. A denominator exception removes a patient from the performance denominator only if the numerator criteria are not met as defined by the exception. This allows for the exercise of clinical judgment by the MIPS eligible clinician.

Performance Not Met:
When the denominator exception does not apply, a measure-specific CPT Category II submitting modifier 8P or QDC may be used to indicate that the quality action was not provided for a reason not otherwise specified and must be submitted on the Medicare Part B claim.

Inverse Measure
A lower calculated performance rate for this type of measure would indicate better clinical care or control. The "Performance Not Met" numerator option for an inverse measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.

HCPCS coding may include G-codes, D-codes, S-codes, or M-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.

Medicare Part B claims Measure Collection Type
For MIPS eligible clinicians submitting individually, measures (including patient-level measure[s]) may be submitted for the same patient by multiple MIPS eligible clinicians practicing under the same Tax Identification Number (TIN). If a patient sees multiple providers during the performance period, that patient can be counted for each individual NPI submitting 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 Quality ID 6: Coronary Artery Disease (CAD): Antiplatelet Therapy. Provider A sees a patient on February 2, 2019 and prescribes aspirin and submits the appropriate QDC for Quality ID 6. Provider B sees the same patient at an encounter on July 16, 2019 and verifies that the patient has been prescribed and is currently taking aspirin. Provider B should also submit the appropriate QDC's for the patient at the July encounter to meet data completeness for submission of Quality ID 6.

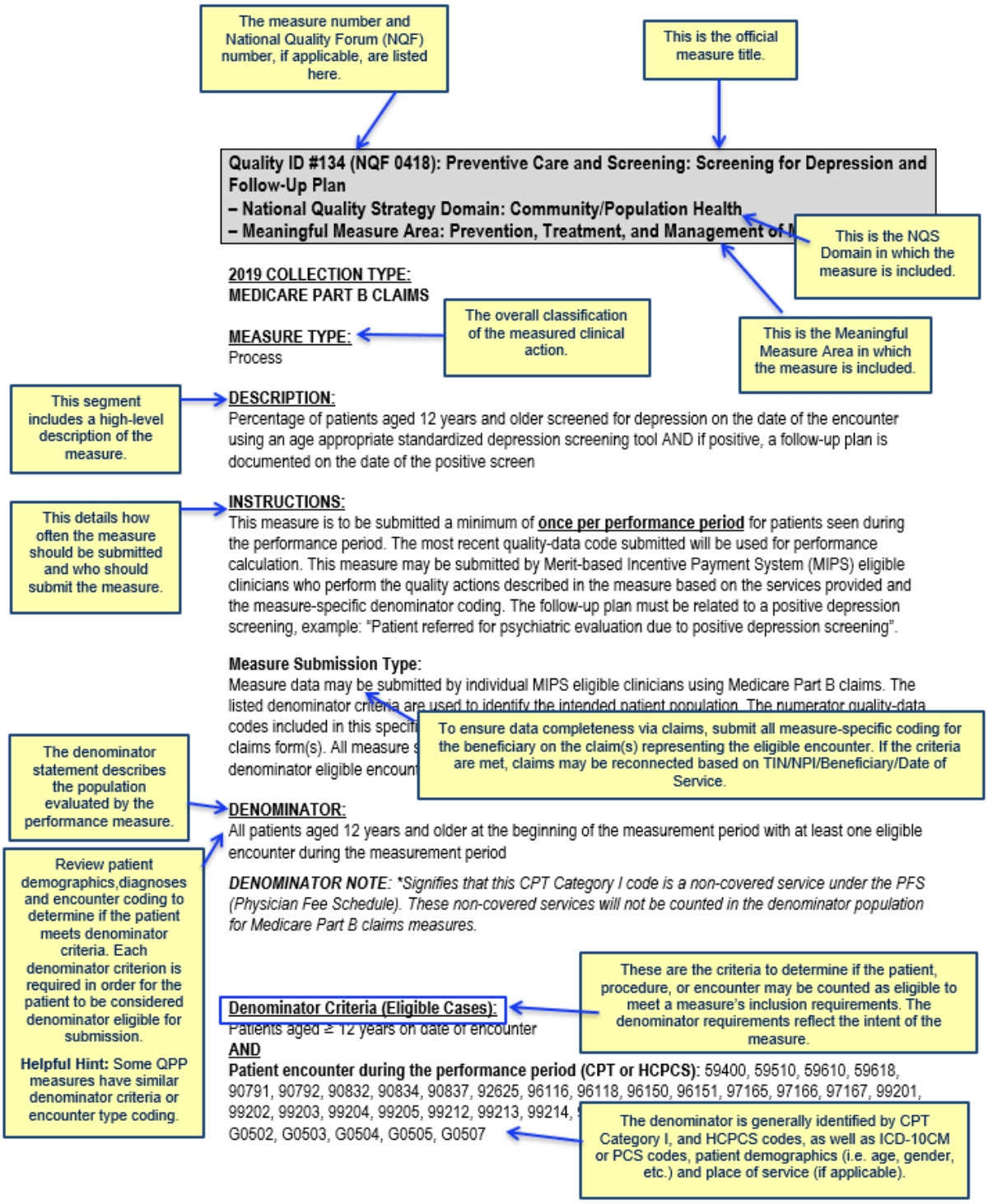
CMS recommends review of any measures that an individual MIPS eligible clinician intends to submit. Below is an example measure specification that will assist with data completeness for a measure. For additional assistance, please contact the Service Now help desk at **1-866-288-8292** (Monday – Friday 8:00AM – 8:00PM Eastern Time) or email via qpp@cms.hhs.gov.

Medicare Part B claims Measure Specification Format (Refer to the Example Measure Specification Below)
Quality ID number, National Quality Forum (NQF) number (if applicable), measure title, National Quality Strategy Domain, and Meaningful Measure Area
Collection Type
Measure type
Measure description
Instructions on submitting including frequency, timeframes, and applicability
Denominator statement, denominator criteria and coding

Numerator statement and coding options (denominator exclusion, performance met, denominator exception, performance not met)
Definition(s) of terms where applicable
Rationale
Clinical recommendations statement or clinical evidence supporting the measure intent

The Rationale and Clinical Recommendation Statements sections provide limited clinical guidelines and supporting clinical references regarding the quality actions described in the measure. Please contact the Measure Steward for section references and further information regarding the clinical rationale and recommendations for the described quality action. Measure Steward contact information is located on the last page of the Measures List document, which can be accessed at: https://qpp.cms.gov/measures/quality.

Example Medicare Part B claims Measure Specification:



NUMERATOR:
Patients screened for dep
AND, if 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., patient who received a particular clinical service or obtained a particular outcome that is being measured).

Definitions provide further information on the intent of key concepts to assist with measure submission.

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

This is an example of a complex Numerator. Review the Numerator section carefully to submit the quality-data codes (QDCs) necessary to meet data completeness and performance.

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 for Depression in Dementia (CSDD),PRIME MD-PHQ2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD)
- **Perinatal Screening Tools**
  Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale

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

- Additional evaluation or assessment 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

Examples of a follow-up plan include but are not limited to:
* Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder
* Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale
* Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as

family or group therapy, support group, depression management program, or other service for treatment of depression
* Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options
* Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

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

- Patient has an active diagnosis of depression prior to any encounter during the measurement period- F01.51, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345
  Patient has a diagnosed bipolar disorder prior to any encounter during the measurement period- F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9

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

- 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 Instructions:

A depression screen is completed on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression a follow-up plan is documented on the date of the positive screen. Depression screening is required once per measurement period, not at all encounters; this is patient based and not an encounter based measure. 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 and the screening should occur during a qualified encounter.

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.

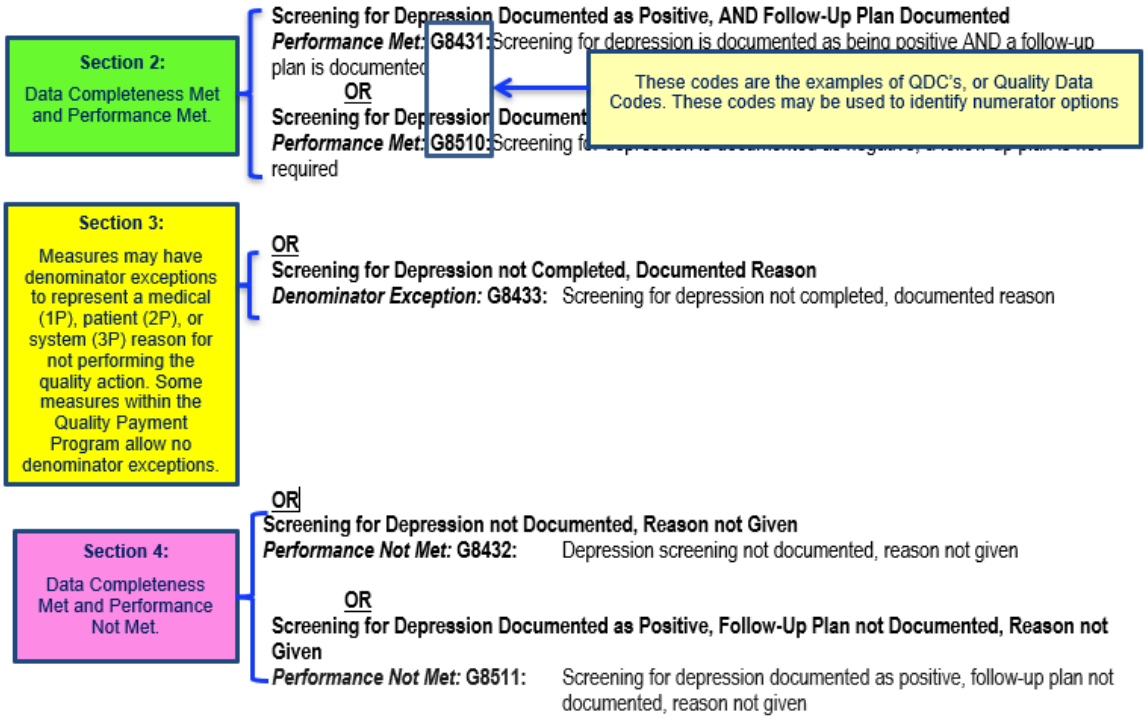
Helpful Hint: For Medicare Part B claims collection type, even though a denominator exclusion is applied before determining the quality actions, this encoded concept needs to be submitted to CMS so the claims data will be accurately calculated.

Numerator Quality-Data Coding Options:

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



RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease increased health care utilization, and impaired functioning (Pratt, Brody 2014). 2014 U.S. survey data indicate that 2.8 million (11.4 percent) adolescents aged 12 to 17 had a major depressive episode (MDE) in the past year and that 15.7 million (6.6 percent) adults aged 18 or older had at least one MDE in the past year, with 10.2 million adults (4.3 percent) having one MDE with severe impairment in the past year (Center for Behavioral Health Statistics and Quality, 2015). Data indicate that severity of depressive symptoms factor into having difficulty with work, home, or social activities. For example, as the severity of depressive symptoms increased, rates of having difficulty with work, home, or social activities related to depressive symptoms increased. For those twelve and older with mild depressive symptoms, 45.7% reported difficulty with activities and those with severe depressive symptoms, 88.0% reported difficulty (Pratt & Brody, 2014). Children and teens with major depressive disorder (MDD) has been found to have difficulty carrying out their daily activities, relating to others, and growing up healthy with an increased risk of suicide (Siu and USPSTF, 2016). Additionally, among pregnant women, especially during the perinatal period, depression and other mood disorders, such as bipolar disorder and anxiety disorders, can have devastating effects on women, infants, and families. Maternal suicide rates rise over hemorrhage and hypertensive disorders as a cause of maternal mortality (American College of Obstetricians and Gynecologists, 2015).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. 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 (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). "In nationally representative U.S. surveys, about 8% of adolescents reported having major depression in the past year. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated" (Sui, A. and USPSTF, 2016). Evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women.

If preventing negative patient outcomes is not enough, the substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. Depression imposes economic burden through direct and indirect costs. "In the United States, an estimated $22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated $23 billion in 2011" (Sui, A. and USPSTF, 2016).

This measure seeks to align with clinical guideline recommendations as well as 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) and makes an important contribution to the quality domain of community and population health.

CLINICAL RECOMMENDATION STATEMENTS:

This is the summary of the Clinical recommendations based on best practices.

Adolescent Recommendation (12-18 years):

"The USPSTF recommends screening for MDD in adolescents implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui, A. and USPSTF, 2016, p. 360).

"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 for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui, A. and USPSTF, 2016, p. 380).

The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations:

1. "Clinicians should routinely screen all adults for depression using a standardized instrument."

2. "Clinicians should establish and maintain follow-up with patients."

3. "Clinicians should screen and monitor depression in pregnant and post-partum women." (Trangle, 2016 p.p. 9 – 10)

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

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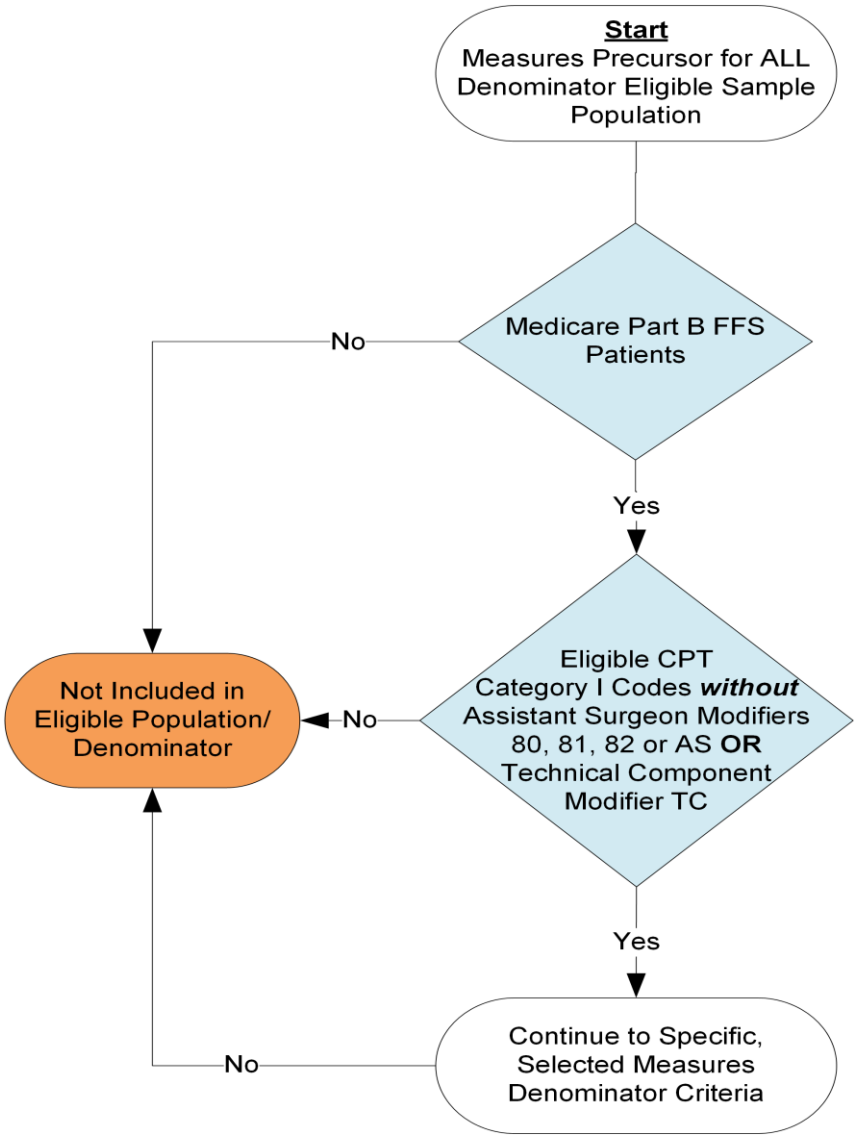
Interpretation of Medicare Part B claims Measure Flows

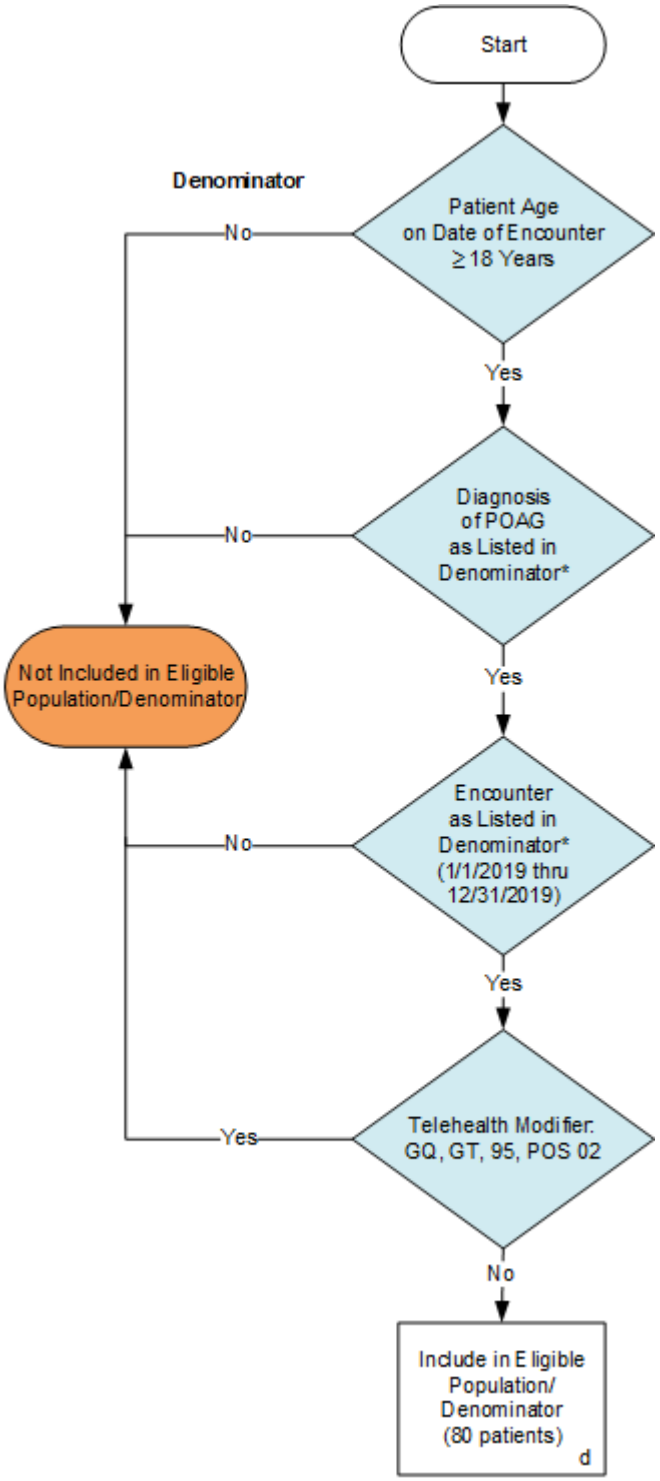
Denominator

The Medicare Part B claims Measure Flows are designed to provide interpretation of the measure logic and calculation methodology for data completeness and performance rates. The flows start with the identification of the patient population (denominator) for the applicable measure's quality action (numerator). When determining the denominator for all measures, please remember to include only Medicare Part B FFS (Fee for Service) patients and CPT I Categories **without** modifiers 80, 81, 82, AS or TC.

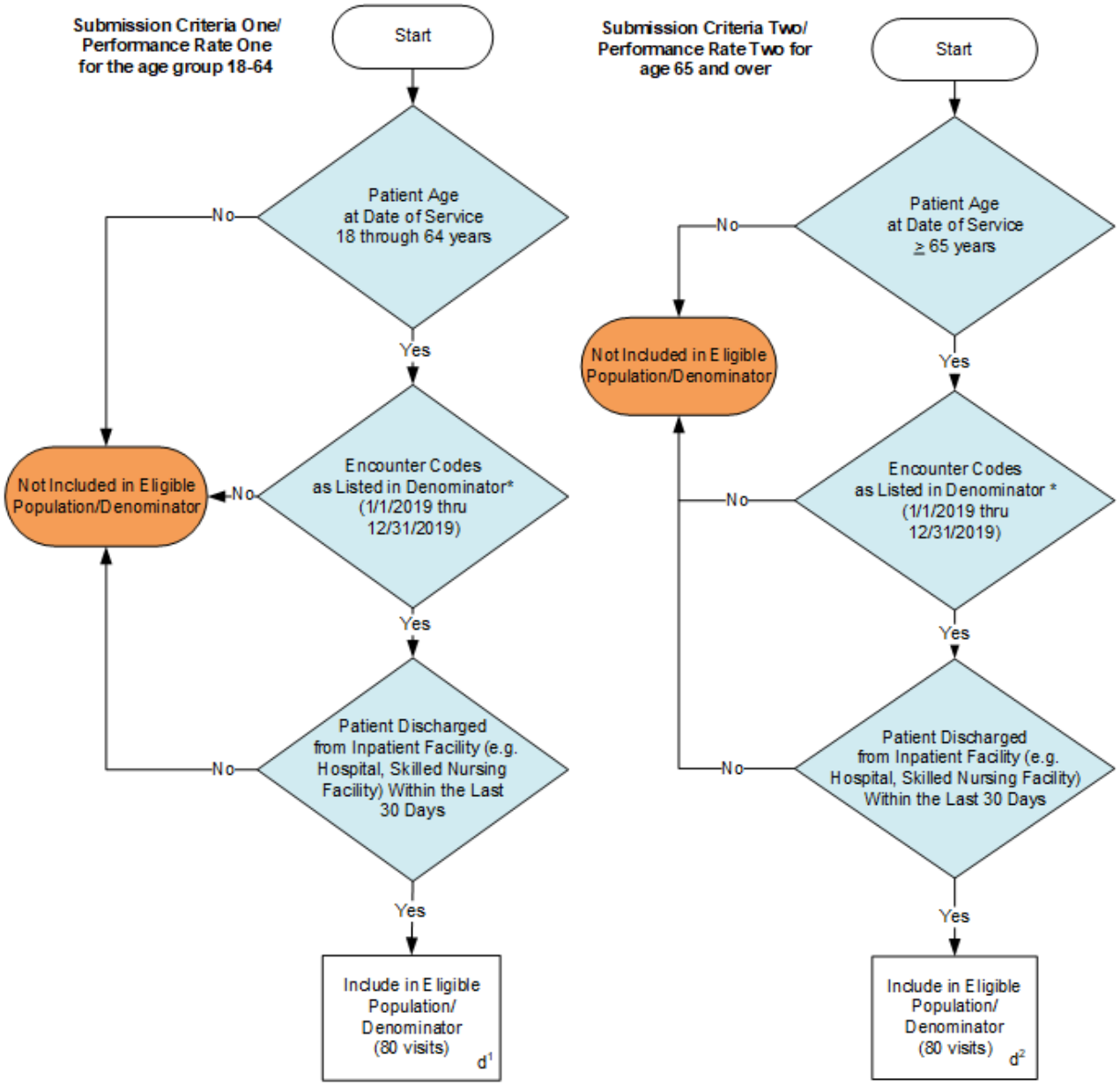
Below is an illustration of additional prerequisite denominator criteria to obtain the patient sample for all 2019 Medicare Part B claims Measures:



The Medicare Part B claims 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 Quality ID #12 NQF # 0086: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation:

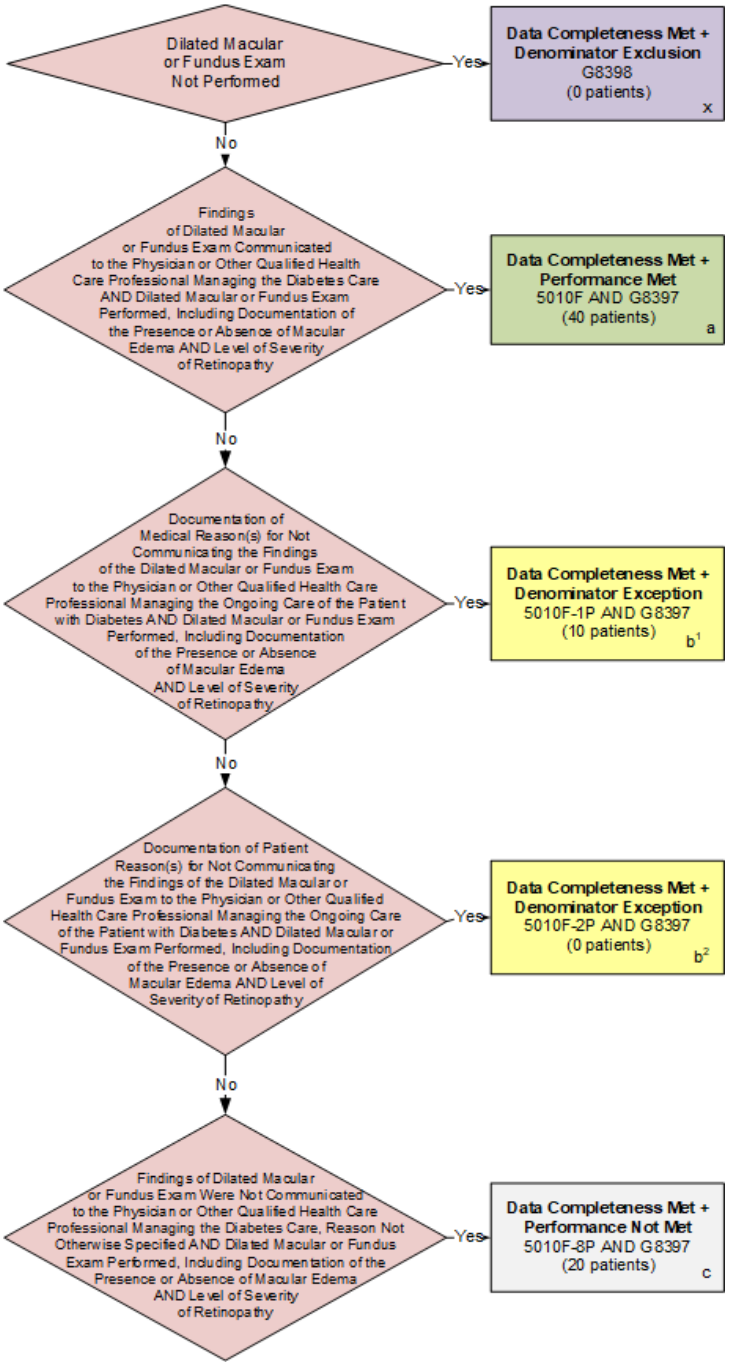


Some Medicare Part B claims measures, such as Quality ID #46 NQF #0097: Medication Reconciliation Post-Discharge have multiple submission criteria to determine the measure denominator. In the example below, the denominator also represents multiple performance rates. Patients meeting the submission criteria for either denominator option are included as part of the eligible population. Review the Medicare Part B claims measures specification to determine if multiple performance rates are required for each submission criteria.



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 Quality ID #19 NQF # 0089: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care:



Denominator/Numerator Variation of Medicare Part B claims vs. CQM Collection Types

For measures submitted via Medicare Part B claims or CQM, there are separate Measure Specifications, Flows, and Narratives. The denominator for the CQM measure may differ slightly from the denominator as outlined in the Medicare Part B claims measure specification. Some measures, such as Quality ID 19 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, have a clarifying code and/or language (e.g. G-code G8397 for Quality ID #19) in the numerator to identify eligible patients when no CPT or ICD-10 diagnosis code exists. In the case of Quality ID #19, an applicable CPT code does not exist for dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy. In Medicare Part B claims collection type, a MIPS eligible clinician would submit the numerator code G8397 to identify patients who had a dilated macular or fundus exam with documentation of the results. To comply with the Measure Steward's intent of the measures and since Qualified Registries or QCDRs may not necessarily be reliant on Medicare Part B claims data; the measure specification and flow show these QDCs or clinical concepts in the denominator. Therefore, the numerator quality-data code options for CQM specifications and flow may vary from the Medicare Part-B claims measure specification and flow.

Algorithms

Data Completeness Algorithm

The Data Completeness Algorithm is based on the eligible population and sample outcomes of the possible quality actions as described in the flow of the measure. The Data Completeness Algorithm provides the calculation logic for patients who have been submitted in the MIPS eligible clinicians' appropriate denominator. Data completeness for a measure may include the following categories provided in the numerator: Denominator Exclusion, Performance Met, Denominator Exception, and Performance Not Met. Below is a sample data completeness algorithm for Quality ID #19 NQF #0089. In the example, 80 patients met the denominator criteria for eligibility, where 0 patients were considered a denominator exclusion, 40 patients had the quality action performed (Performance Met), 10 patients did not receive the quality action for a documented reason (Denominator Exception), and 20 patients were reported as not receiving the quality action (Performance Not Met). **Note**: In the example, 10 patients were eligible for the measure but were not reported (Data Completeness Not Met).

Data Completeness =

Performance Met (a=40 patients) + Denominator Exception ($b^1+b^2+b^3$=10 patients) + Performance Not Met (c=20 patients) = 70 patients = **87.50%**

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

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 submitting with Denominator Exclusions or Denominator Exceptions are subtracted from the performance denominator when calculating the performance rate percentage. Below is a sample performance rate algorithm that represents this calculation for Quality ID #19. In this scenario, the patient sample equals 70 patients where 40 of these patients had the quality action performed (Performance Met), zero patients was submitted as a Denominator Exclusion, and 10 patients were submitted as having a Denominator Exception.

Performance Rate=

Performance Met (a=40 patients) =40 patients = **66.67%**

Data Completeness Numerator (70 patients) – Denominator Exclusion (x=0 patients) -Denominator Exception (b^1+b^2=10 patients) = 60 patients

For measures with inverse performance rates, such as Quality ID #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 Medicare Part B claims measure will provide guidance if the measure is indeed a multiple performance type. The Medicare Part B claims measure flow for these measures includes algorithm examples to understand the different data completeness and performance rates required for the measure. The system will calculate the performance rates for the measure based on the submission of claims data by the MIPS eligible clinician.