MIPS

Quality Measures Guide

Quality Measures Guide

Quality Category Requirements and Scoring Methodologies

The Quality performance category is worth 30% of the MIPS final score for 2024. In certain situations (for example, with a special status or with an insufficient number of attributed cost measures), 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.

There are five collection types for MIPS quality measures:

- Electronic Clinical Quality measures (eCQMs);
- MIPS Clinical Quality measures (CQMs);
- Qualified Clinical Data Registry (QCDR) measures;
- Medicare Part B Claims measures (only available to individuals and groups in small practices – i.e. 15 or fewer eligible clinicians); and
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey.

Depending on the measures selected, there are multiple ways you can submit quality measure data to CMS:

- On your own if using Part B Claims measures, CQMs, or eCQMs;
- Through a third party intermediary, such as a Qualified Registry (QR), Qualified Clinical Data Registry (QCDR), or Health IT Vendor; and
- Through a CMS-approved survey vendor if reporting the 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 2024, clinicians and groups must report on at least six quality measures, including at least one outcome or high-priority measure, unless they are reporting via an MVP.

CMS has 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. For 2024, the Physical Medicine Specialty Set[1] includes 11 quality measures that CMS has identified as most relevant to the specialty. As discussed later in this document, there are other measures outside of the Physical Medicine specialty set, which also might be relevant to your practice and could help you satisfy the six measure requirement.

In addition to measures reported by the clinician or practice, CMS will automatically calculate performance on the following additional administrative claims-based measures, if applicable:

- **Hospital-Wide All-Cause Readmission** measure. CMS will only score this measure if the reporting entity has at least 16 NPIs and at least 200 attributed cases.
- **Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions** measure. CMS will only score this measure if the reporting entity has at least 16 clinicians and at least 18 attributed cases.
- **Hip Arthroplasty and Knee Arthroplasty Complication** measure. CMS will only score a reporting entity if there are at least 25 attributed cases.
- **Risk-Standardized Acute Cardiovascular-Related Hospital Admissions Rates for Patients with Heart Failure** measure. CMS will only score this measure if the reporting entity has at least 1 cardiologist and at least 21 attributed cases.

These measures do not require additional data submission on the part of clinicians.

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, which can have a substantial negative impact on your final performance score. More information about this 2024 MIPS Eligible Measures Applicability (EMA) process will be available through the QPP Resource Library.

Under the EMA process, there are certain situatations where CMS will permit the reporting of less than 6 measures. For example, if a specialty set has fewer than six Part B claims measures, and a small practice clinician or group chooses to collect data via Part B claims measures from the set, they are only accountable for the Part B claims measures available through the set, even if that results in less than 6 measures. In the

[1] To view the Physical Medicine specialty set, please use the filters in the Quality Measure search tool. Quality measures included in the Physical Medicine specialty set are also indicated in the measure table at the end of this document.

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case of the Physicial Medicine specialty set, there are only four Part B claims measures in the set. If a small practice physiatrist opts to use Part B claims measures from the specialty set, they would only be required to report on those four measures. This accommodation only applies to Part B claims measures and CQMs. It does not apply to eCQMs. If a specialty set has less than 6 eCQMs, the clinician or group would have to identify additional measures available through different data collection methods (e.g., CQMs or QCDR measures) to satisfy the 6 measure requirement.

Clinicians and groups may generally earn between 1 and 10 performance achievement points for each quality measure submitted during the 2024 performance period that has a historical or performance year **benchmark**.

- CMS uses national benchmarks to score clinicians and groups on each quality measure. Each benchmark is presented in terms of deciles, with each decile identifying the range of points generally available for the measure. For example, if your performance on a measure falls within decile 5 of the benchmark, you can earn anywhere between 5 and 5.9 points on the measure depending on your performance.
- At the start of each performance year, CMS releases an historical benchmark file (based on performance data from two years prior) so that clinicians have a performance target to aim for throughout the year. The 2024 Quality Benchmark files can be found here, but MIPS participants are encouraged to check this webpage periodically since the benchmark files are often updated throughout the year.
- Note that some measures in the historical benchmark file do not have a benchmark. If CMS cannot calculate an historical benchmark for a measure due to insufficient data reported two years prior, CMS will attempt to calculate a performance year benchmark following the close of the performance year. If there are a sufficient number of reporters to develop a valid and reliable performance year benchmark, CMS will use that benchmark. However, with performance year benchmarks, clinicians will not have access to a benchmark during the performance year.
- If a clinician or group reports on a quality measure that does not have an historical or performance year benchmark, they will earn 0 out of 10 points on that measure. However, small practice clinicians will continue to receive 3 out of 10 points for such measures.

There also are multiple scenarios where CMS will restrict the number of points available for a specific measure:

- A clinician or group will earn 0 points on a measure if they do not meet the case minimum or the data completeness threshold, except that small practices will continue to receive 3 points.
  - » **Case minimum**: The quality measure is reported on for at least 20 cases (note that the administrative claims measures listed above have separate case minimums and are only calculated automatically by CMS if the clinician or group achieves that case minimum).
  - » **Data completeness threshold**: The measure is reported on for at least 75% of applicable Medicare patients (for Part B claims reporting only) or 75% of applicable patients across all payers (when reporting through a QR, QCDR, or EHR) (*note that this percentage increased from 70% in 2023).
- 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.
  - » Similarly, performance rates for some measure benchmarks are not distributed across all deciles if a large proportion of clinicians achieved the maximum performance rate. In these scenarios, anything less than a perfect score may fall into a lower decile than expected (e.g., a 99% performance rate may translate into a score of 5.9 instead of 9.9).
- CMS also recently adopted a new policy to incentivize the use of measures that are new to the program. New measures are now subject to a 7-point scoring floor in the measure's first year, and a 5-point scoring floor in the measure's second year, as long as data completeness and case minimum requirements are met.

In light of all of these scoring policies, it is important to carefully review the benchmark file throughout the year to determine the best measure selection strategy.

Clinicians and groups also may earn bonus points in the quality performance category for the following:

- **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 automatically added to the numerator of the Quality performance category score for those in small practices.

In addition, up to 10 complex 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 (generally 60 Quality points, unless the clinician or group is eligible to report on less than six measures) may earn only 30 points toward their overall MIPS final score (since the Quality category comprises 30% of a participant's MIPS final score in 2024, and MIPS final scores are assigned based on a scale of 0-100 points).[2] Since the MIPS performance threshold for 2024 (the minimum number of overall MIPS points needed to avoid a penalty in 2026) is 75 points, clinicians and groups will need to rely more heavily on points from the other performance categories to avoid a penalty than they did in the early years of MIPS.

2024 MIPS Quality Measure Guides for PM&R Physicians

For 2024 reporting, measures may be selected from either the MIPS clinical quality measure inventory (which includes 199 measures) or measures offered by specialty-specific Qualified Clinical Data Registries (QCDRs). Each year, CMS makes changes to the available inventory of measures, as well as individual measure specifications and reporting options so it is important to review the most current version of your selected measures each year.

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 eligible clinicians 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 following pages is intended to help you identify individual quality measures that you can report on for 2024. Keep in mind that the following measures previously included on this table for earlier performance periods have been removed from MIPS starting with the 2024 performance period:

- 128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan *(*note this measure was maintained for select MVPs, but cannot be reported under traditional MIPS)*
- 402: Tobacco Use and Help with Quitting Among Adolescents

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

[2] Note that in certain situations, a clinician or group may qualify for reweighting of a performance category, which may result in the Quality category contributing more weight towards the MIPS final score. For example, if CMS determines that a physiatrist is hospital-based, he/she is automatically exempt from the Promoting Interoperability (PI) category. CMS will re-weight the PI category to 0% and generally redistribute its weight (25%) to the Quality category so that it comprises 55% of the clinician's final MIPS score.

MIPS QUALITY MEASURE NUMBER	MEASURE DESCRIPTION	MEASURE TYPE	HIGH-PRIORITY	REPORTING OPTIONS	TOPPED OUT SCORING CAP (7 PTS)*	HISTORIC BENCHMARK?*
9	Anti-Depressant Medication Management	Process	N	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	Y	Claims, Registry	N	N - Claims Y – Registry
39	Screening for Osteoporosis for Women Aged 65-85 Years of Age	Process	N	Claims, Registry	N	Y
47+	Advance Care Plan	Process	Y	Claims, Registry	Y – Claims N – Registry	Y
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Process	Y	Registry	N	Y
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy— Neurological Evaluation	Process	N	Registry	Y	Y
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention— Evaluation of Footwear	Process	N	Registry	Y	Y
130+	Documentation of Current Medications in the Medical Record	Process	Y	EHR, Registry	Y	Y
134^	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Process	N	Claims, EHR, Registry	Y – Claims, Registry N – EHR	Y – Claims, Registry N – EHR
145	Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy	Process	Y	Claims, Registry	N	N
155+	Falls: Plan of Care	Process	Y	Claims, Registry	Y	Y
178	Rheumatoid Arthritis (RA): Functional Status Assessment	Process	N	Registry	Y	Y
181	Elder Maltreatment Screen and Follow-Up Plan	Process	Y	Claims, Registry	Y	Y
182^+	Functional Outcome Assessment	Process	Y	Registry	Y	Y

^ Measures have substantive changes to measure specifications relative to 2023.

\+ Measure included in 2024 Physiatry Specialty Measure Set

* Information based on benchmarks released on 2/02/2024, which may be updated over the course of the year. To check for the most recent benchmark data, click here.

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226^+	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process	N	Claims, EHR, Registry	Y – Claims N – Registry, EHR	Y
236^	Controlling High Blood Pressure	Intermediate Outcome	Y	Claims, EHR, Registry	N	Y – Claims, Registry N – EHR
238^	Use of High-Risk Medications in the Elderly	Process	Y	Registry, EHR	N	N
281	Dementia: Cognitive Assessment	Process	N	EHR	N	N
317^+	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Process	N	Claims, EHR, Registry	Y – Claims N – Registry, EHR	Y
318	Falls: Screening for Future Fall Risk	Process	Y	EHR	N	Y
370^	Depression Remission at 12 Months	Outcome	Y	EHR, Registry	N	N – Registry Y – EHR
374+	Closing the Referral Loop: Receipt of Specialist Report	Process	Y	Registry, EHR	N	N – Registry Y – EHR
376^	Functional Status Assessment for Total Hip Replacement	Process	Y	EHR	N	Y
418^	Osteoporosis Management in Women Who Had a Fracture	Process	N	Claims, Registry	N	N – Claims Y – Registry
419	Overuse of Neuroimaging for Patients with Primary Headache and a Normal Neurological Examination	Process	Y	Registry	Y	Y
431^+	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	Process	N	Registry	N	N
459	Average Change in Back Pain following Lumbar Discectomy/Laminotomy	Outcome	Y	Registry	N	N
461	Average Change in Leg Pain following Lumbar Discectomy/Laminotomy	Outcome	Y	Registry	N	N
468+	Continuity of Pharmacotherapy for Opioid Use Disorder	Process	Y	Registry	N	N

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MIPS QUALITY MEASURE NUMBER	MEASURE DESCRIPTION	MEASURE TYPE	HIGH-PRIORITY	REPORTING OPTIONS	TOPPED OUT SCORING CAP (7 PTS)*	HISTORIC BENCHMARK?*
470^	Average Change in Functional Status Following Total Knee Replacement Surgery	Outcome	Y	Registry	N	N
471	Average Change in Functional Status Following Lumbar Discectomy Laminotomy Surgery	Outcome	Y	Registry	N	N
477	Multimodal Pain Management	Process	Y	Registry	Y	Y
478	Functional Status Change for Patients with Neck Impairment	Outcome	Y	Registry	N	Y
483	Person-Centered Primary Care Measure PRO-PM	Outcome	Y	Registry	N	N
487^+ (NEW for 2024)	Screening for Social Drivers of Health	Process	Y	Registry	N	N
498+ (NEW for 2024)	Connection to Community Service Provider	Process	Y	Registry	N	N
503 (NEW for 2024)	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	PRO-PM	Y	Registry	N	N

^ Measures have substantive changes to measure specifications relative to 2023.

\+ Measure included in 2024 Physiatry Specialty Measure Set

* Information based on benchmarks released on 2/02/2024, which may be updated over the course of the year. To check for the most recent benchmark data, click here.

Where Can I Find Additional Information?

Additional information about the PI category can be found here, as well as through the QPP Resource Library.

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