MIPS

Quality Measures Guide

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Quality Category Requirements and Scoring Methodologies

The Quality performance category is worth 30 percent of the MIPS final score for 2022, which is ten percentage points lower than in 2021. 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 (only available to groups of 25 or more, and not expected to be available in future years)
- 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 2022, clinicians and groups must report on at least six quality measures, including at least one outcome or high-priority measure. Additionally, CMS will automatically calculate performance on two additional administrative claims-based measures, if applicable:

- a **Hospital-Wide All-Cause Readmission** measure. CMS will only score a group practice on this measure if the group has at least 16 NPIs and at least 200 cases are attributed to the group based on the measure specifications.
- a **Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions** measure. CMS will only score a group practice, virtual group, or APM Entity on this measure if it has at least 16 clinicians and at least 18 cases attributed to the group or entity.

Neither measure requires additional data submission on the part of the 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 2022 MIPS Eligible Measures Applicability (EMA) process will be 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 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 2022 Quality Benchmark file is available for download through the CMS QPP Resource Library, but is often updated throughout the year so it is important to periodically check for updates. You'll note that some measures in this 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 sufficient data exists). However, in these cases, clinicians will not have access to a performance target during the performance year.

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There also are multiple scenarios where CMS will restrict 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.
- CMS has also recently adopted a new policy to incentivize the use of measures that are new to the program. Starting with the 2022 performance year, new measures will be 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.

For some measures, where a large percentage of clinicians in the historical benchmark data set have the maximum achievable performance rate, the benchmark does not include a range of performance rates for every decile. This means that 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). 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.

At the same time, clinicians and groups 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 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.

Notably, starting with the 2022 performance year, CMS has terminated two avenues for earning bonus points: bonus points awarded for reporting additional outcome or high priority measures, and bonus points awarded for end-to-end electronic reporting.

Keep in mind that clinicians and groups who earn the maximum score in the Quality category (60 Quality points) may earn only 30 points towards their overall MIPS final score (since the Quality category comprises 30% of a participant's MIPS final score in 2022, and MIPS final scores are assigned based on a scale of 0-100 points).[1] Since the MIPS performance threshold for 2022 (the minimum number of overall MIPS points needed to avoid a penalty in 2024) 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 have in the past.

2022 MIPS Quality Measure Guides for PM&R Physicians

For 2022 reporting, CMS has approved 200 quality measures that MIPS eligible clinicians can be scored 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 2022 Quality Payment Program website prior to finalizing your reporting strategy to review reporting options and measure specifications for available measures for 2022.

[1] **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 redistribute its weight (25%) to the Quality category so that it comprises 55% of the clinician's final MIPS score.**

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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 below is intended to help you identify individual quality measures that you can report on for 2022. 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."[2]

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

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	N–Claims Y–Registry
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	Y–Claims N–Registry	Y
50^	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Process	Yes	Registry	Once/year	N	Y
107	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	No	EHR		N	Y

^ Measures have substantive changes to measure specifications relative to 2021.

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

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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	Y–Claims N–EHR, Registry	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	Y–Claims N–EHR, Registry	Y
145	Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy	Process	Yes	Claims, Registry	Each time	Y	Y
155	Falls: Plan of Care	Process	Yes	Claims, Registry	Once/year	Y	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	Y–Claims N–Registry	Y
182^	Functional Outcome Assessment	Process	Yes	Registry	Each eligible visit	Y	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

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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
370^	Depression Remission at 12 Months	Outcome	Yes	EHR, CMS Web Interface, Registry	Once/year	N	Y–HER N–Registry
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
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–Claims Y–Registry
419	Overuse of Neuroimaging for Patients with Primary Headache and a Normal Neurological Examination	Efficiency	Yes	Registry	Each visit	Y	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

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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	Y
478^	Functional Status Change for Patients with Neck Impairment	Outcome	Yes	Registry	Each treatment episode	N	N
483 (New)	Person-Centered Primary Care Measure PRO-PM	Outcome	Yes	Registry	Once/year	N	N

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Note that the following two measures previously included on this table for earlier performance periods have been removed from MIPS starting with the 2022 performance period:

- 154: Falls Risk Assessment
- 342: Pain Brought Under Control Within 48 Hours