CMS Measure ID 374: Closing the Referral Loop: Receipt of Specialist Report (CMS50v10)

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You can easily enter data in DrChrono to sync with Healthmonix MIPSpro. You can enter some data in multiple places. Please see our article on all the areas in DrChrono where you can enter data for reporting with Healthmonix MIPSpro.

Your Healthmonix MIPSpro dashboard contains a comprehensive description of the codes and criteria for each measure. Click on the **View Details** to see more.

My Measures

Select, review, and change the measures you will be reporting.

0	tifications You have met the measure selection requirements You may now proceed with entering patient visits Checklist Select Measures
Selec	Closing the Referral Loop: Receipt of Specialist Report
#374	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred View details

Description

Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

Instructions

This measure is to be submitted a minimum of once per performance period for all patients with a referral during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure for the patients for whom a referral was made during the performance period based on the services provided and the measure-specific denominator coding. The provider who refers the patient to another provider is the provider who should be held accountable for the performance of this measure. All MIPS-eligible professionals or eligible clinicians reporting on this measure should note that all data for the reporting year is to be submitted by the deadline established by CMS. Therefore, all MIPS eligible professionals or eligible professionals or eligible clinicians code (i.e.,

November - December), should request that providers to whom they referred their patients share their consult reports as soon as possible in order for those patients to be counted in the measure numerator during the performance period. When providers to whom patients are referred communicate the consult report as soon as possible with the referring providers, it ensures that the communication loop is closed in a timely manner and that the data is included in the submission to CMS.

NOTE: Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.

Measurement Submission Type

Measure data may be submitted by individual MIPS eligible clinicians, groups, or third-party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS-eligible clinicians, groups, or third-party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third-party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

Denominator

The number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.

DENOMINATOR NOTE: If there are multiple referrals for a patient during the performance period, use the first referral.

AND

Patient encounter during the performance period (CPT or HCPCS): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99381*, 99382*, 99383*, 99384*, 99385*, 99386*, 99387*, 99391*, 99392*, 99393*, 99393*, 99394*, 99395*, 99396*, 99397*

*Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.

AND

The patient was referred to another provider or specialist during the performance period: G9968

Schedule Appoin	tment											
Appointment	Billing	Eligibility	Vitals		Growthcharts	Flags	Log Comm.	Revision	s Custom Data	MU Helper		
								Pa	tient SuperBill	Clinical Note	Billing Details	Other Forms 🕶
2 Billi	ng Status				~		HCFA Box 10 -	Is patient's	condition relate	d to:		
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Numerator

The number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.

Definitions:

Referral: A request from one physician or other eligible providers to another practitioner for evaluation, treatment, or co-management of a patient's condition. This term encompasses referral and consultation as defined by the Centers for Medicare and Medicaid Services.

Report: A written document prepared by the eligible clinician (and staff) to whom the patient was referred and that accounts for his or her findings, provide a summary of care information about findings, diagnostics, assessments, and/or plans of care, and is provided to the referring eligible clinician.

NUMERATOR NOTE: The consultant report that will fulfill the referral should be completed after the referral and should be related to the referral for which it is attributed. If there are multiple consultant reports received by the referring provider which pertain to a particular referral, use the first consultant report to satisfy the measure.

The provider to whom the patient was referred should be the same provider that sends the report.

Numerator Options: The following codes can be entered in the HCPCS code section for the visit.

Performance Met:

The provider who referred the patient to another provider received a report from the provider to whom the patient

was referred (G9969)

Schedule Appointment										
Appointment Billing	Eligibility V	/itals	Growthcharts	Flags	Log Comm.	Revisions	Custom Data	MU Helpe	r	
						Patie	nt SuperBill 🔻	Clinical Not	e Billing Details	Other Forms -
I Billing Status			~		HCFA Box 10 -	s patient's co	ondition related	to:		
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Referral #							Onset of Currer	t Circulture		
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Credit Card Payment	Process Credit C	ard								
Claim Billed: \$0.00 Adjustm	ent: \$0.00 Insure	er Paid: \$0.00	Patient Paid: \$	0.00						
ICD-10 Codes		Find Dia	ignosis codes		CPT Co	des		F	ind CPT Procedu	re codes 🛛 🐥
# Code	Description				Code	Desc	ription		Price (\$)	
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<u>OR</u>

Performance Not Met:

The provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred **(G9970)**

Schedule App	ointment												
Appointment	Billing	Eligibility	Vitals	Growthcharts	Flags	Log Comm.	Revisions	Custom Data	MU Helper				
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NDC Codes				DC Codes	+		Modifie	ers: 🛛 🖌	• [•	*			
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				Den l		Di	agnosis Pointe	ers: 1:0:0:0					
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