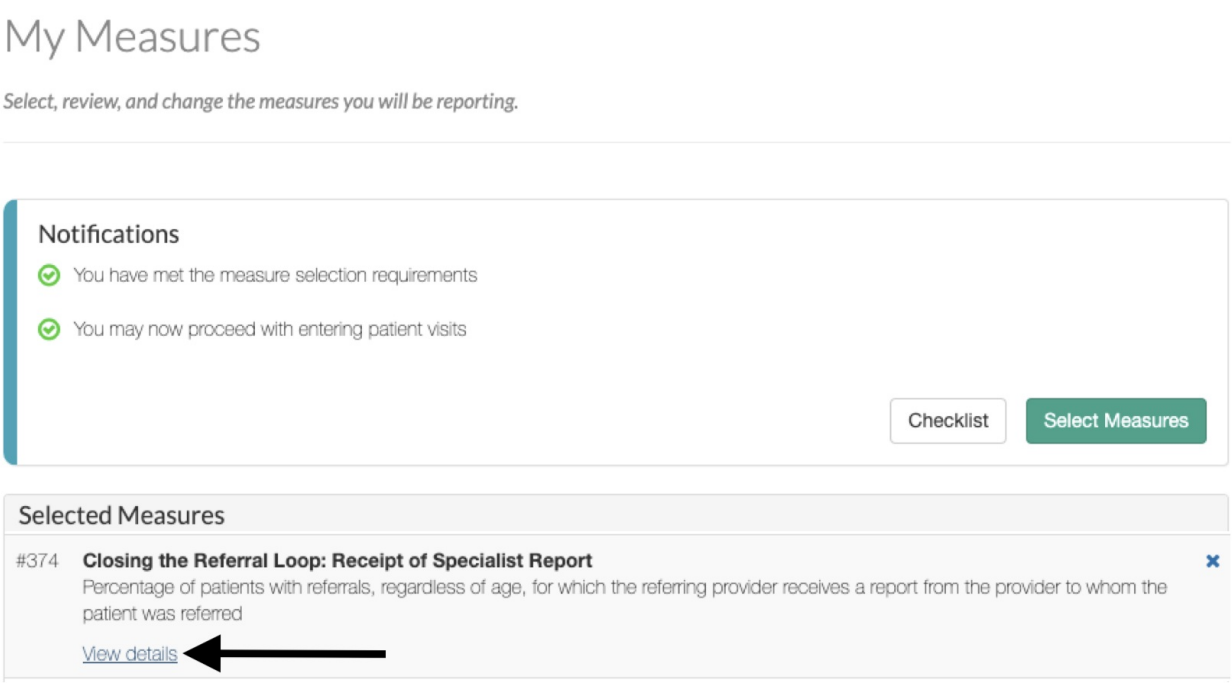
CMS Measure ID 374: Closing the Referral Loop: Receipt of Specialist Report (CMS50v10)

07/08/2024 7:56 pm EDT

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.



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 clinicians who refer patients towards the end of the performance period (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

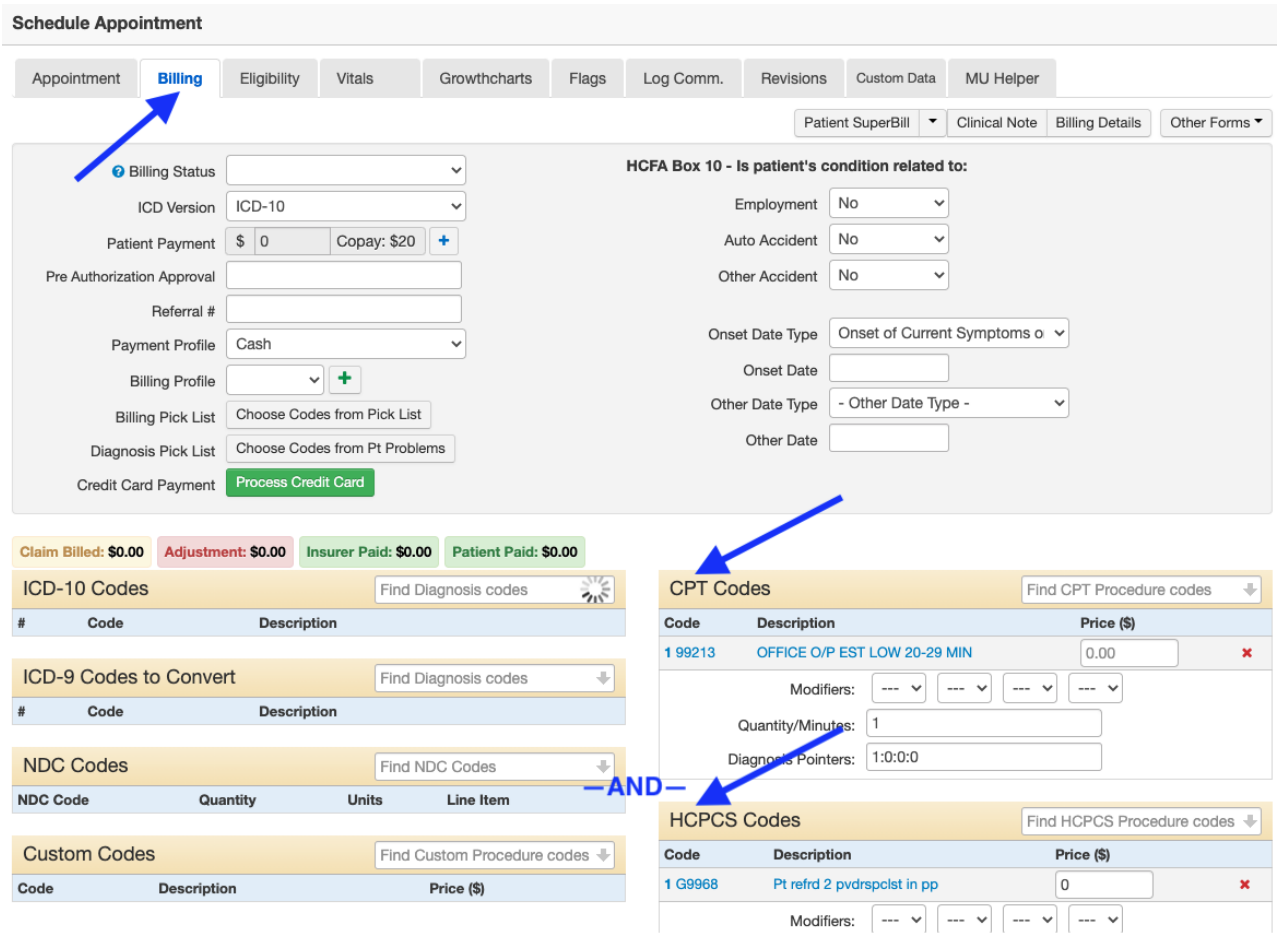
The number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.
DENOMINATOR NOTE: If there are multiple referrals for a patient during the performance period, use the first referral.

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*, 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**



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.

<u>Definitions:</u>

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.

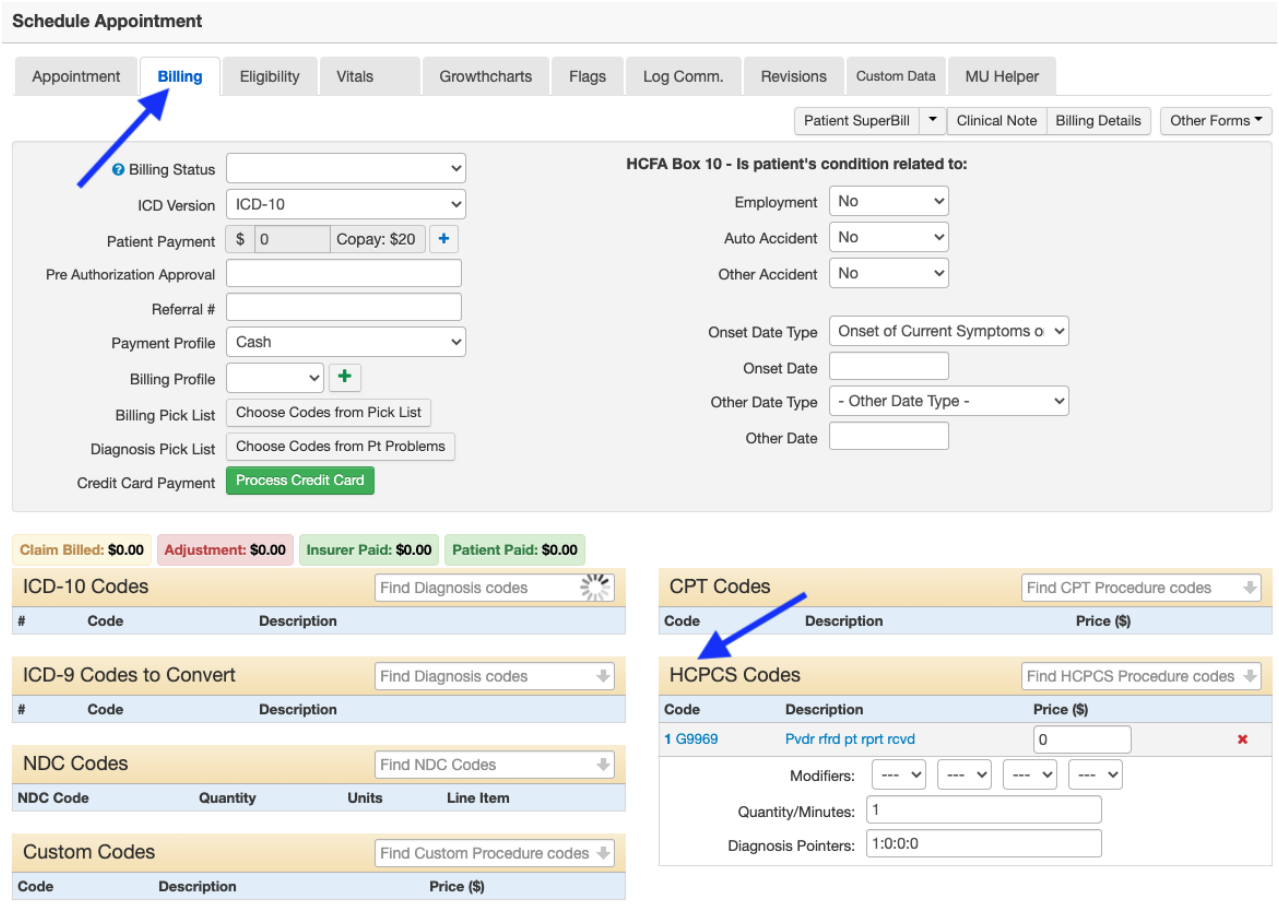
The provider to whom the patient was referred should be the same provider that sends the report.

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

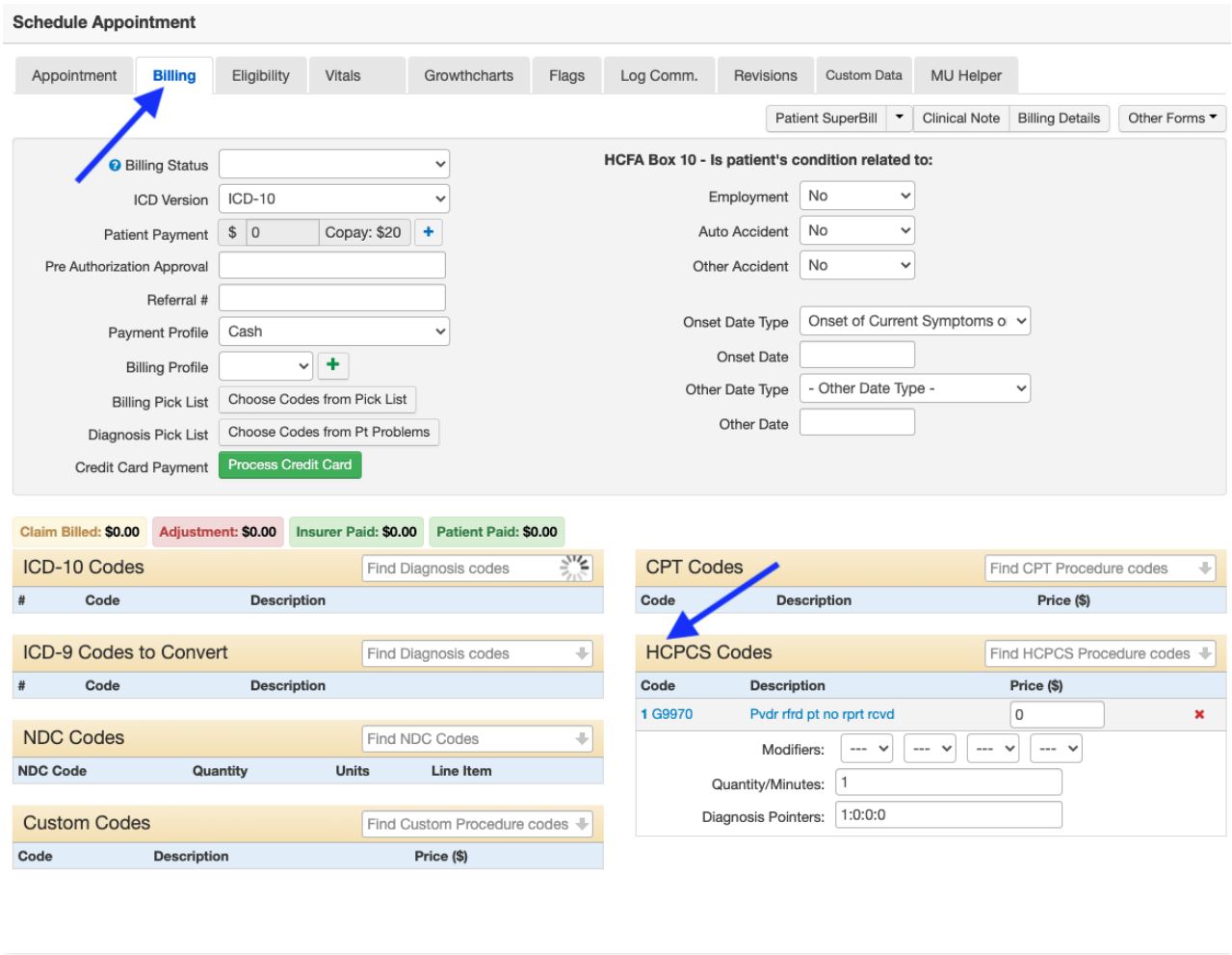
was referred **(G9969)**



OR

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 Appointment
Appointment
Billing
Eligibility
Vitals
Growthcharts
Flags
Log Comm.
Revisions
Custom Data
MU Helper
Patient SuperBill
Clinical Note
Billing Details
Other Forms
Billing Status
ICD Version
ICD-10
Patient Payment
$ 0
Copay: $20
Pre Authorization Approval
Referral #
Payment Profile
Cash
Billing Profile
Billing Pick List
Choose Codes from Pick List
Diagnosis Pick List
Choose Codes from Pt Problems
Credit Card Payment
Process Credit Card
HCFA Box 10 - Is patient's condition related to:
Employment
No
Auto Accident
No
Other Accident
No
Onset Date Type
Onset of Current Symptoms o
Onset Date
Other Date Type
- Other Date Type -
Other Date
Claim Billed: $0.00
Adjustment: $0.00
Insurer Paid: $0.00
Patient Paid: $0.00
ICD-10 Codes
Find Diagnosis codes
Code Description
ICD-9 Codes to Convert
Find Diagnosis codes
Code Description
NDC Codes
Find NDC Codes
NDC Code Quantity Units Line Item
Custom Codes
Find Custom Procedure codes
Code Description Price ($)
CPT Codes
Find CPT Procedure codes
Code Description Price ($)
HCPCS Codes
Find HCPCS Procedure codes
Code Description Price ($)
1 G9970
Pvdr rfrd pt no rprt rcvd
0
Modifiers:
Quantity/Minutes:
1
Diagnosis Pointers:
1:0:0:0