<table>
<thead>
<tr>
<th><strong>eMeasure Title</strong></th>
<th>Closing the Referral Loop: Receipt of Specialist Report</th>
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</thead>
<tbody>
<tr>
<td><strong>eMeasure Identifier</strong> (Measure Authoring Tool)</td>
<td>50</td>
</tr>
<tr>
<td><strong>eMeasure Version number</strong></td>
<td>5.0.000</td>
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<tr>
<td><strong>NQF Number</strong></td>
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<td><strong>GUID</strong></td>
<td>f58fc0d6-edf5-416a-8d29-79afbd24dea</td>
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<tr>
<td><strong>Measurement Period</strong></td>
<td>January 1, 20XX through December 31, 20XX</td>
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<tr>
<td><strong>Measure Steward</strong></td>
<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
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<tr>
<td><strong>Measure Developer</strong></td>
<td>National Committee for Quality Assurance</td>
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<tr>
<td><strong>Endorsed By</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>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</td>
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<tr>
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<td><strong>Measure Scoring</strong></td>
<td>Proportion</td>
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<td>Process</td>
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<tr>
<td><strong>Stratification</strong></td>
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<td><strong>Risk Adjustment</strong></td>
<td>None</td>
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<tr>
<td><strong>Rate Aggregation</strong></td>
<td>None</td>
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<tr>
<td><strong>Rationale</strong></td>
<td>Problems in the outpatient referral and consultation process have been documented, including lack of timeliness of information and inadequate provision of information between the specialist and the requesting physician (Gandhi, 2000; Forrest, 2000; Stille, 2005). In a study of physician satisfaction with the outpatient referral process, Gandhi et al. (2000) found that 68% of specialists reported receiving no information from the primary care provider prior to referral visits, and 25% of primary care providers had still not received any information from specialists 4 weeks after referral visits. In another study of 963 referrals (Forrest, 2000), pediatricians scheduled appointments with specialists for only 39% and sent patient information to the specialist in only 51% of the time. In a 2006 report to Congress, MedPAC found that care coordination programs improved quality of care for patients, reduced hospitalizations, and improved adherence to evidence-based care guidelines, especially among patients with diabetes and CHD. Associations with cost-savings were less clear; this was attributed to how well the intervention group was chosen and defined, as well as the intervention put in place. Additionally, cost-savings were usually calculated in the short-term, while some argue that the greatest cost-savings accrue over time (MedPAC, 2006). Improved mechanisms for information exchange could facilitate communication between providers, whether for time-limited referrals or consultations, on-going co-management, or during care transitions. For example, a study by Branger et al. (1999) found that an electronic communication network that linked the computer-based patient records of physicians who had shared care of patients with diabetes significantly increased frequency of communications between physicians and availability of important clinical data. There was a 3-fold increase in the likelihood that the specialist provided written communication of results if the primary care physician scheduled appointments and sent patient information to the specialist (Forrest, 2000). Care coordination is a focal point in the current health care reform and our nation's ambulatory health information technology (HIT) framework. The National Priorities Partnership recently highlighted care coordination as one of the most critical areas for development of quality measurement and improvement (NPP, 2008).</td>
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<tr>
<td><strong>Clinical Recommendation Statement</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Improvement Notation</strong></td>
<td>A higher score indicates better quality</td>
</tr>
</tbody>
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**Reference**

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

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

If there are multiple referrals for a patient during the measurement period, use the first referral.

The consultant report that will fulfill the referral should be completed after the referral. Eligible professionals reporting on this measure should note that all data for the reporting year is to be submitted by the deadline established by CMS. Therefore, eligible professionals who see patients towards the end of the reporting period (ie, December in particular), should communicate the consultant report as soon as possible in order for those patients to be counted in the measure numerator. Communicating the report as soon as possible will ensure the data is included in the submission to CMS.

**Transmission Format**
TBD

**Initial Population**
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**
Equals Initial Population

**Denominator Exclusions**
None

**Numerator**
Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred

**Numerator Exclusions**
Not Applicable

**Denominator Exceptions**
None

**Supplemental Data Elements**
For every patient evaluated by this measure also identify payer, race, ethnicity and sex

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**Table of Contents**

- Population Criteria
- Data Criteria (QDM Variables)
- Data Criteria (QDM Data Elements)
- Supplemental Data Elements
- Risk Adjustment Variables

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**Population Criteria**

- **Initial Population** =
  - AND: First: "Occurrence A of Intervention, Performed: Referral" during "Measurement Period"
  - AND: Union of:
    - "Encounter, Performed: Preventive Care- Initial Office Visit, 0 to 17"
    - "Encounter, Performed: Preventive Care - Established Office Visit, 0 to 17"
    - "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up"
    - "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up"
    - "Encounter, Performed: Office Visit"
    - "Encounter, Performed: Face-to-Face Interaction"
    - "Encounter, Performed: Ophthalmological Services"
  - during "Measurement Period"

- **Denominator** =

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Closing the Referral Loop: Receipt of Specialist Report

- **AND: Initial Population**

  - **Denominator Exclusions** = None
  
  - **Numerator** =
    - AND: "Communication: From Provider to Provider: Consultant Report" satisfies all:
      - fulfills "Occurrence A of Intervention, Performed: Referral"
      - starts after start of "Occurrence A of Intervention, Performed: Referral"
  
  - **Numerator Exclusions** = None
  - **Denominator Exceptions** = None
  - **Stratification** = None

**Data Criteria (QDM Variables)**

- None

**Data Criteria (QDM Data Elements)**


- "Encounter, Performed: Face-to-Face Interaction" using "Face-to-Face Interaction Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1048)"

- "Encounter, Performed: Office Visit" using "Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)"

- "Encounter, Performed: Ophthalmological Services" using "Ophthalmological Services Grouping Value Set (2.16.840.1.113883.3.526.3.1285)"

- "Encounter, Performed: Preventive Care - Established Office Visit, 0 to 17" using "Preventive Care - Established Office Visit, 0 to 17 Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1024)"

- "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up" using "Preventive Care Services - Established Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1025)"

- "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up" using "Preventive Care Services-Initial Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1023)"

- "Encounter, Performed: Preventive Care- Initial Office Visit, 0 to 17" using "Preventive Care- Initial Office Visit, 0 to 17 Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1022)"

- "Intervention, Performed: Referral" using "Referral Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1046)"

**Supplemental Data Elements**

- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity CDCREC Value Set (2.16.840.1.114222.4.11.837)"

- "Patient Characteristic Payer: Payer" using "Payer SOP Value Set (2.16.840.1.114222.4.11.3591)"

- "Patient Characteristic Race: Race" using "Race CDCREC Value Set (2.16.840.1.114222.4.11.836)"

- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex AdministrativeGender Value Set (2.16.840.1.113762.1.4.1)"

**Risk Adjustment Variables**

- None

| Measure Set | Not Applicable |