AMERICAN ACADEMY
OF OPHTHALMOLOGY®

2023 IRIS® Registry
Preparation Kit

Protecting Sight. Empowering Lives.®

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2023 IRIS® Registry (Intelligent Research in Sight) Preparation Kit

Protecting Sight. Empowering Lives.®

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IRIS Registry Terms of Use

Requirements for IRIS Registry practices are as follows:

- Ophthalmic or medical practice must have at least one active, practicing ophthalmologist who is an Academy member and
- All ophthalmologists affiliated with the practice are Academy members in a "practicing ophthalmologist" (active fellow, active member, active member in training) category

In addition to Academy membership, integrated EHR users may need to meet certain technical requirements (https://www.aao.org/iris-registry/ehr-systems)

- Check your Academy membership status through www.aao.org/membership
- Optometrists can use the IRIS Registry only if they are employed by an ophthalmologist or an ophthalmic practice

Membership

To use the IRIS Registry, all ophthalmologists in the practice must be Academy members in good standing (i.e., have paid their current year's member dues – this is the reporting year for MIPS).

- If even one ophthalmologist- including a part-time ophthalmologist – does not have a current Academy membership, no one in the practice can use the IRIS Registry for the practice. The only exceptions are neurologists who are certified by the American Board of Neurology, and not the American Board of Ophthalmology.
- An active Academy member who works part time at another practice with all member ophthalmologists may be able to use the IRIS Registry for that practice ifthe practice has registered to use the IRIS Registry.
- How to check that all ophthalmologists are active Academy members:
    - If you have each ophthalmologist's AAO.org login email and password, you can individually check each person's membership on the website. Note that members who have been lapsed by more than one year may not show a current dues bill when you log in.
    - If you don't have everyone's login, contact Academy member services (member_services@aao.org) or 415 561-8581. You will need the name of each ophthalmologist who works for the practice, both full and part time.

Introduction:

More than a dozen years, the Board of Trustees and the then Chief Executive Officer of the American Academy of Ophthalmology seized the initiative to lead in eye care by creating the IRIS® Registry (Intelligent Research in Sight) for the purposes of quality improvement, providing the abilityfor practices to quantify their performance and to compare with others in the country. For the first time, practices could benchmark their performance and have current, actionable feedback to be able to spot areas needing improvement, to make changes in process and documentation, and then to re-measure their performance to see differences. The uptake from the Academy membership was quite rapid, with 3,000 practices signing up in the firstyear. Currently, as of January 2023, there are 17,994 ophthalmologists and their eligible clinicians in practice with them participating in the IRIS Registry.

Another important objective of the IRIS Registry was to help practices with their quality reporting to the Centers for Medicare & Medicaid Services (CMS) and other payers, first with the Physician Quality Reporting System, and then with the Merit-Based Incentive Payment System (MIPS). The MIPS program moves eligible clinicians to a performance-based paymentsystem. It would be difficult for ophthalmologists on their own to be able to collate their electronic health record data for quality measures over the entire year. The Academy staff, both in San Francisco and in Washington D.C., have a wealth of expertise about the MIPS program and quality reporting. The IRIS Registry is a CMS-approved Qualified Clinical Data Registry, with eye care measures and other general medical measures, many of which have been created by the Academy. Over the 5 years of MIPS reporting, ophthalmologists participating in the IRIS Registry have saved a little over $1.2 billion in avoided penalties. In addition, a majority of ophthalmologists participating in the IRIS Registry have earned smallbonuses each year.

Another benefit of the IRIS Registry are the scientific advancements afforded by the accumulation of de-identified data. As of January 1, 2023, 70 articles have been published from the IRIS Registry database, and 178 presentations, either in paper or poster format, have beenprovided at scientific meetings in the United States and around the world. The insights gleaned from the real-world evidence in the IRIS Registry database will enhance ophthalmologists' understanding of the natural history of disease, risk factors for disease progression, and improvement of patient outcomes in everyday practice. As of January 1, 2023, there are an aggregate of 78.6 million patients in the IRIS Registry database.

This is a comprehensive reference guide for your practice to utilize the IRIS Registry for quality improvement and MIPS reporting. This should be referred to for when and what to doduring the year to optimize patient outcomes and performance on quality measures, and to report MIPS in a timely and efficient manner. This can be passed on when there are staff transitions within the practice, or to remind current staff of responsibilities over the performance year.It is the Academy's sincerest hope that this guide will help you in monitoring your quality performance on a regular basis, using the feedback to learn and make any process improvements, and seeing these improvements in subsequent performance rates, and enhanced team communications and/or documentation.

IRIS Registry and MIPS 2023 Deadlines

June 15, 2023	New practices must register for EHR integration – this deadline also includes existing practices for IRIS Registry with EHR and/or practice management (PM) system changes that will require integration. No new EHR integrations will be accepted after this deadline.
July 1, 2023	Practices need to submit IRIS Registry projects to the American Board of Ophthalmology to earn Continuing Certification (MOC) MIPS credit with Improvement Project or to earn credit for both ABO Continuing Certification (MOC) and a MIPS improvement activity (IA_PSPA_2: Participation in MOC Part IV)
August 1, 2023	New practices and existing practices with EHR and/or PM system changes should be integrated.
September 1, 2023	EHR-integrated practices should update clinician and location information, and make 2023 Academy membership dues payments for ophthalmologists so that they are in good standing. Practices can contact Academy member services for invoices and dues status (member_services@aao.org; 415 561-8581 or 866 561-8558) No new clinician and location data can be integrated into dashboard performance if notification is not made by this deadline.
October 3, 2023	Last day to start 90-day reporting period for Promoting Interoperability and improvement activities
October 31, 2023	EHR-integrated practices must submit tickets for mapping refinements. No new mapping refinement tickets will be accepted after this deadline.
January 31, 2024	All practices reporting for 2023 MIPS should sign their Data Release Consent Form, select their quality measures for reporting or submit data for their quality measures for reporting, enter data for the Promoting Interoperability performance category, attest to improvement activity(ies) and click to submit all MIPS performance categories to CMS. The last date to submit to CMS is March 31, 2024 but the lateness of the reporting will not allow for any resubmissions or quality checks.

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Roadmaps

The Academy releases *Small* and *Large Practice Roadmaps* each year to help guide you through the decision-making for successful MIPS reporting. Small practices have some scoring advantages over their large practice counterparts, thus the reason for separate roadmaps. As you go through your roadmap, keep handy *EyeNet MIPS 2023: Primer and Reference* (posted online ahead of print).

In 2023, the threshold to avoid the penalty on 2025 reimbursements from Medicare Fee For Service is a MIPS final score of 75 points.

How you earn those points depends upon which performance categories make up your MIPS score. The decisions you face depend upon how high you can score in the quality performance category and whether you qualify for the cost and Promoting Interoperability (PI) categories. For example, a practice that doesn't perform cataract surgery is not subject to the cost category. Refer to this table on the next page as you look through your practice's roadmap.

Reweighting Scenario	Practice Size	Weighting in MIPS Final Score			
		Quality	PI	Improvement Activities	Cost
No Reweighting Needed					
Default weightings apply	Small or large	30%	25%	15%	30%
Reweighting One Performance Category to a Zero Weight					
No cost	Small or large	55%	30%	15%	0%
No promoting interoperability (PI)	Small	40%	0%	30%	30%
	Large	55%	0%	15%	30%
No quality	Small or large	0%	55%	15%	30%
No improvement activities	Small or large	45%	25%	0%	30%
Reweighting Two Performance Categories to a Zero Weight					
No cost, no PI	Small	50%	0%	50%	0%
	Large	85%	0%	15%	0%
No cost, no quality	Small or large	0%	85%	15%	0%
No cost, no improvement activities	Small or large	70%	30%	0%	0%
No PI, no quality	Small or large	0%	0%	50%	50%
No PI, no improvement activities	Small or large	70%	0%	0%	30%
No quality, no improvement activities	Small or large	0%	70%	0%	30%
Reweighting Three Performance Categories to a Zero Weight					
If CMS can only score you on one performance category, you would be assigned a MIPS final score of 75 points, which is enough to avoid the payment penalty.					

Source: 86 FR 65521 Table 63 and 86 FR 65524 2022 Final Rule

2023 Solo and Small-Practice Roadmap for the Merit-Based Incentive Payment System

Step 1. Are You or Your Group Required to Report MIPS?

The clinician qualifies for an automatic exemption from MIPS if they meet one or more of the following criteria:

1. New to Medicare for 2023 and hasn't previously submitted claims under Medicare
2. Less than or equal to $90,000 in Medicare Part B service allowed charges
3. Provides covered professional services to 200 or fewer Medicare Part B patients
4. Provides 200 or fewer covered professional services to Part B patients
    a. When you treat more than 200 patients you are, by definition, performing at least 200 services
5. Clinician is a qualifying participant in an Advanced Alternative Payment Model.

The low volume criteria must be met in either of the following time periods to qualify for a MIPS exemption:

1. Oct 1, 2021 – Sept 30, 2022 + 30-day claims run out, and/or
2. Oct 1, 2022 - Sept 30, 2023

Verify your status online using the *QPP Participation Status Tool* (https://qpp.cms.gov/participation-lookup) (look under 2023 tab). According to CMS, the results of the first determination period were available Dec. 2022, and the results of the second determination period should be available Nov. or Dec. 2023.

- Note: If the clinician is reporting as a part of a group, the threshold is evaluated at the group level

If the clinician is listed as a qualifying participant of an APM, they do not need to report for MIPS – although if they do, they will be covered in the event the APM does not report.

Step 2. Are You in a Small Practice?

A small practice is defined as having 15 or fewer eligible clinicians. You can verify your status as a small practice through the online *QPP Participation Status Tool*.

Step 3. Define Your Goal: Do You Want to Avoid the Penalty or Try for a Bonus?

Goal	Effect on Reimbursement	MIPS Final Score Required
Avoid the maximum 9% Penalty	Avoids the full 9% penalty on your 2025 Medicare Part B services reimbursements. (Between 18.76 and 74.99 points, the penalty is on a sliding scale, ranging from approximately 6.75% - 0.01%)	18.76 points
Avoids a Penalty	Avoids a penalty on your 2025 Medicare Part B services reimbursements	75 points
Very Small Bonus	Qualifies you for a very small bonus on your 2025 Medicare Part B services reimbursements (ex. The small bonus turned out to be about 0.1% for the 2021 performance year)	Above 75 points
Small Bonus	Qualifies you for a small bonus - there is no more exceptional performance bonus pool but if CMS predictions of greater penalties are correct, then there will be more money in the budget-neutral bonus pool, which may offset loss of the exceptional performance bonus pool (For the 2021 performance year, the exceptional performance bonus for a perfect final score of 100 points was 2.33%)	Above 75 points

Step 4. How to Achieve Your Goal for the 2023 Performance Year

The MIPS final score is the weighted sum of performance category scores. For example, if a category is weighted at 40%, it contributes up to 40 MIPS final score points to the total score of up to 100 points.

MIPS Performance Category	2023 Score Weight
Quality	30%
Promoting interoperability	25%
Improvement activities	15%
Cost	30%

❖ For those eligible for the cost performance category

You may be eligible for the cost performance category if you perform 10 or more cataract surgeries in the performance year OR 10 or more melanoma resections in the performance year OR your practice reports at the group-level and one or more colleagues are scored on cost (because, for example, they are cataract surgeons, or you are in a multispecialty practice and a non-ophthalmology cost measure applies).

To Avoid a Penalty

This requires MIPS final score of 75 points. Do *all* the following:

Improvement activities category:

- *If individual reporting*, complete 1 high-weighted or 2 medium-weighted improvement activities for 90+ consecutive days.
- *If group reporting*, at least 50% of eligible clinicians in your group must complete the same 1 high-weighted or 2 medium-weighted activities in any continuous 90-day period. The clinicians do not need to share the same 90-day period.

Quality category:

Report on at least 6 quality measures, 1 of which must be an outcome or, if no outcome measure is available, another type of high priority measure.

❖ For Small Practices *without* EHR:

- Fully report (on *at least* 70% of denominator-eligible[1] patients to meet the data completeness threshold, and providing the total eligible patient populations for the reporting period AND with *at least* 20 patients in the denominator) for all 6 quality measures
- You must average **7.75** quality measure points across all 6 measures (with the automatic PI hardship for small practices and assuming at least 10 points out of 30 points for the cost category)

❖ For Small Practices with EHR (and not taking the automatic PI hardship exception):

- Fully report (on *at least* 70% of denominator-eligible[1] patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire reporting period AND with at least 20 patients in the denominator) for all 6 quality measures
- The score you need will depend on how well you do in the EHR-based PI category

Promoting Interoperability category:

All small practices will receive an automatic PI hardship reweighting.

- If you have a 2015 Edition Cures Update certified electronic health record technology (CEHRT), complete the PI required measures[2] and try to maximize your performance where possible.

❖ For those not eligible for the cost category (the category is reweighted)

For group reporting, if you are in an ophthalmic only practice that performs fewer than 10 cost category eligible cataract surgeries, your cost category score should be reweighted to the quality and PI categories. The same applies for individual reporting if you perform fewer than 10 cost category eligible cataract surgeries. Do *all* the following:

Improvement activities category:

- *If individual reporting*, complete 1 high-weighted or 2 medium-weighted improvement activities for 90+ consecutive days within the 2023 performance year.

[1] The IRIS Registry reports on 100% of denominator-eligible patients for IRIS Registry-EHR integrated practices.
[2] www.aao.org/medicare/promoting-interoperability

- *If group reporting*, *at least* 50% of eligible clinicians in your group must complete the same 1 high-weighted or 2 medium-weighted activities in any continuous 90-day period within the 2023 performance year. The clinicians do not need to share the same 90-day period.

Quality category:

Report on at least 6 quality measures, 1 of which must be an outcome measure or, if no outcome measure is available, another type of high priority measure.

- For Small Practices without EHR:
  - Fully report (on *at least* 70% of denominator-eligible[3] patients, and providing the total eligible patient populations for the reporting period AND with *at least* 20 patients in the denominator) for all 6 quality measures
  - You must average at least **4.0** out of 10 points on all measures assuming you are approved for the PI hardship.
- For Small Practices with EHR (and not taking the automatic PI hardship exception):
  - Fully report (on *at least* 70% of denominator-eligible[3] patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire reporting period AND with at least 20 patients in the denominator) for all 6 quality measures
  - The score you need will depend on how well you do in the EHR-based PI category

Promoting Interoperability category:

All small practices will receive an automatic PI hardship reweighting.

- If you have a 2015 Edition Cures Update CEHRT, complete the PI required measures[4] and try to maximize your performance where possible.

Step 5: Choose your measures and/or activities.

- Note: Each MIPS category can be reported on the same or on different performance periods as the other MIPS categories. However, within each MIPS category, typically all measures or activities must be reported for the same period.

Improvement activities category:

Performance period: 90+ consecutive days

- To fulfill the entire improvement activities category score: complete 1 high-weighted or 2 medium-weighted improvement activities
- Each high-weighted improvement activity will count for 100% of the category score
- Each medium-weighted improvement activity will count for 50% of the category score
- Group Reporting: *At least 50%* of the group's clinicians need to perform the same IA(s) for the whole group to get credit. The clinicians performing the IA(s) do not all need to perform it on the same 90+ consecutive day period for the group to get credit.

Note: Do not report on more activities than required to fulfill the category. CMS can audit each activity you report.

The following are improvement activities that many clinicians/practices already do routinely as well as new activities added to the IRIS Registry for 2023. Read the activity specifications available on the Academy's website.[5]

[3] The IRIS Registry reports on 100% of denominator-eligible patients for IRIS Registry-EHR integrated practices.
[4] www.aao.org/medicare/promoting-interoperability
[5] www.aao.org/medicare/improvement-activities

High-Weighted

- IA_EPA_1: Provide 24/7 Access
  - Evidence of urgent patients being seen in the practice on the same or next day
  - No EHR required
- IA_AHE_1: Enhance Engagement of Medicaid and Other Underserved Populations
  - Evidence of an analysis of trends in inequities in time to treat data
  - Documentation of implementation of plans of activities to address inadequacies in time to treat performance and outcomes of these activities
  - No EHR required
- IA_AHE_6: Provide Education Opportunities for New Clinicians
  - Documentation of participation as a preceptor for clinicians-in-training and clinical rotation assignments in community practices in small, underserved, or rural areas
  - No EHR required
- IA_ERP_3: COVID-19 Clinical Trials
  - Evidence of treatment of patients diagnosed with COVID-19 and reporting their data to a QCDR, such as the IRIS Registry
  - EHR required
- IA_AHE_8: Create and Implement an Anti-Racism Plan – NEW
  - Evidence of a practice-wide review and implementation of an anti-racism plan
  - No EHR required
- IA_AHE_11: Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender and Queer Patients – NEW
  - Evidence of a practice-wide review and implementation of a plan to improve care for LGBTQ+ patients
  - No EHR required
- IA_BE_25: Drug Cost Transparency – NEW
  - Evidence of use of the Real-Time Benefit Tool and discussion of alternative medications and assistance programs
  - No EHR required
- IA_EPA_6: Create and Implement a Language Access Plan - NEW
  - Review of existing tools and practice, creation of a gap analysis memo, a plan to improve language access and a report with results of plan implementation
  - No EHR required

Medium-Weighted

- IA_CC_1: Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close the Referral Loop
  - Evidence that consultant sends report to referring clinician or that referring clinician has a process for capturing referral information in medical records
  - No EHR required

- IA_CC_2: Implementation of Improvements That Contribute to More Timely Communication of Test Results
    - Evidence of a process that reduces time before communicating test results that includes the population identified, method of communication and benchmark for timeliness and strategies for improvement
    - No EHR required
- IA_AHE_7: Comprehensive Eye Exams
    - Evidence of promotion of comprehensive eye exams and caring for underserved patients at no cost (e.g., through the Academy's EyeCare America)
    - Promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment
    - No EHR required
- IA_PSPA_2: Participation in MOC Part IV
    - Evidence of participation in MOC Part IV
    - No EHR required
- IA_PSPA_7: Use of QCDR Data for Ongoing Practice Assessments and Improvements
    - Feedback reports and documentation of how QCDR data is used for quality improvement or improvements in patient safety
    - EHR required
- IA_AHE_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols - NEW
    - Documentation of screening tools for identifying at-risk patients and an implementation plan to advance support to patients and results achieved
    - No EHR required
- IA_AHE_10: Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data - NEW
    - Documentation of implementation of technology meeting security tags criteria in practice systems and clinical workflows
    - EHR required
- IA_ERP-4: Implementation of a Personal Protective Equipment (PPE) Plan - NEW
    - Documentation of a PPE plan, including plans for conventional, contingency and crisis capacity, staff training materials and procurement or existing inventory
    - No EHR required
- IA_ERP-6: COVID-19 Vaccine Achievement for Practice Staff - NEW
    - Evidence showing that COVID-19 vaccinations are up to date for staff according to current CDC guidelines, including standardized approach to document vaccine status, employee education and process for vaccine administration
    - EHR required

- IA_PM_18: Provide Clinical-Community Linkages - NEW
  - Documentation of engagement with community health workers, and coordination with primary care, and use of quality measurement and improvement processes
  - No EHR required
- IA_PSPA_15: Implementation of an ASP - NEW
  - Evidence of leadership of an Antimicrobial Stewardship Program (ASP) that measures appropriate use of antibiotics for several different conditions
  - No EHR required

Quality category:

Performance period: Full calendar year

- Reminder: Unless you receive a hardship exception for the quality performance category, it is not possible to ensure a MIPS final score of 75 points without fully reporting on 6 quality measures

General Quality Category Information:

- This category must be performed for the full calendar year on 70% of denominator-eligible patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire calendar year AND at least 20 patients in the denominator for each measure AND a performance rate >0 (or <100 if an inverse measure).[6] CMS emphasizes that 100% of eligible patients is desired for MIPS reporting.
- Report on at least 6 quality measures, 1 of which must be an outcome measure or, if no outcome measure is available, another type of high priority measure
- Review the measure achievement point benchmark table to make sure your choices maximize your point potential
- Bonus points: Small Practice Bonus (6 bonus points for the category)
  - All small practices that report on at least one quality measure will receive 6 bonus points within the quality category

Promoting Interoperability category:

This requires the use of 2015 Edition Cures Update CEHRT.

Performance period: 90+ consecutive days

- Note: You can only report data that is captured by 2015 Edition Cures Update CEHRT for this category. If you report as a group, you will not be downgraded if not all your clinicians use 2015 Edition Cures Update CEHRT.

How CMS Scores the Category

- Four PI objectives are required[7]
- To receive any credit for the category, you must meet the reporting requirements--or, where available, claim an exclusion--for all the required measures
- Some of these measures will be scored based on your performance rate
- Some measures are optional bonus measures

[6] Note: CMS emphasizes that 100% of eligible patients is desired for MIPS

[7] The number depends on whether you report the new HIE Bi-Directional Exchange measure or the two Support Electronic Referral Loops measures

- Four critical attestations - To score more than 0% for PI, you must submit “Yes” for:
  - The Security Risk Analysis attestation
  - The SAFER Guides attestation
  - The Prevention of Information Blocking attestation
  - The ONC Direct Review attestation

How to Report Measures

- You must submit all required measures to get *any* PI credit.
- For each performance rate-based measure, you must have at least *one* patient in the numerator
- Exclusion for Query of Prescription Drug Monitoring Program (PDMP)

  A clinician is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs, OR writes fewer than 100 permissible prescriptions during the performance period, OR querying a PDMP would impose an excessive workflow or cost burden prior to start of performance period
- Exclusion for Support Electronic Referral Loops by Sending Health Information measure:

  A clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period
- Exclusion for Support Electronic Referral Loops by Receiving and Reconciling Health Information measure:

  A clinician who receives transitions of care or referrals or has patient encounters in which the clinician has never before encountered the patient fewer than 100 times during the performance period
- Exclusion for Immunization Registry Reporting measure:

  A clinician does not administer any immunizations to any of the populations for which data is collected by their jurisdiction, OR operates in a jurisdiction where no immunization registry is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no immunization registry has declared readiness to receive immunization data
- Exclusion for Electronic Case Reporting measure:

  A clinician does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction, OR operates in a jurisdiction where no public health agency is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data

Objective	Measures	Reporting requirement	Maximum points
e-Prescribing	e-Prescribing** Query of Prescription Drug Monitoring Program**	Numerator/denominator Yes/No	10 points 10 points
Health-information exchange	Support electronic referral loops by sending health information** Support electronic referral loops by receiving and reconciling health information** OR HIE Bi-Directional Exchange OR Enabling Exchange under TEFCA	Numerator/denominator Numerator/denominator OR Yes/No OR Yes/No	15 points 15points OR 30 points OR 30 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Numerator/denominator	25 points
Public Health and Clinical Data Exchange	Report the following two measures: Immunization Registry Reporting** Electronic Case Reporting** Optional measures: Clinical data registry reporting, OR Public health registry reporting, OR Syndromic surveillance reporting	Yes/No	25 points 5 points bonus (maximum, even if more than 1 registry)

IRIS Registry EHR-integrated practices qualify for the Clinical Data Registry reporting bonus measure.

**Exclusions are available for the Registry measures. Check the exclusions on the measure specifications to see if you qualify.[8]

Measures that depend upon your performance rate will be scored by multiplying the performance rate (calculated from the numerator and denominator you submit) by the available points for the measure.

[8] www.aao.org/medicare/promoting-interoperability/measures and *EyeNet's* MIPS 2023: A Primer and Reference

STEP 6: Submission

The January after the end of the performance year is when the submission function is activated in the IRIS Registry. You must press the submit button for your information to go to CMS. Watch for announcements from the Academy.

Academy Resources:

Eye on Advocacy[9]: This news page is updated every Thursday evening and new stories are sent to Members by the *Washington Report Express* email. It is the first place you will see any changes discussed and explained.

Academy MIPS Webpages:	www.aao.org/medicare/mips.
EyeNet's MIPS 2023: A Primer and Reference:	www.aao.org/eyenet/mips-manual-2023
Email IRIS Registry questions to:	irisregistry@aao.org
Email MIPS questions to:	mips@aao.org
AAOE e-Talk	For AAOE Members: https://aao.mobilize.io/users/sign_in

[9] www.aao.org/advocacy/eye-on-advocacy

2023 Large Practice Roadmap for the Merit-Based Incentive Payment System

Step 1. Are You or Your Group Required to Report MIPS?

A clinician qualifies for an automatic exemption from MIPS if they meet one or more of the following:

1. New to Medicare for 2023 and hasn't previously submitted claims under Medicare
2. Less than or equal to $90,000 in Medicare Part B service allowed charges, and/or
3. Provides covered professional services to 200 or fewer Medicare Part B patients, and/or
4. Provides 200 or fewer covered professional services to Part B patients
    a. When you treat more than 200 patients you are, by definition, performing at least 200 services
5. Clinician is a Qualified Participant in an Advanced Alternative Payment Model

The low volume criteria must be met in *either* of the following time periods to qualify for a MIPS exemption:

1. Oct 1, 2021 – Sept 30, 2022 + 30-day claims run out, and/or
2. Oct 1, 2022 - Sept 30, 2023

Verify your status online using the *QPP Participation Status Tool* (https://qpp.cms.gov/participation-lookup) (look under 2023 tab). According to CMS, the results of the first determination period were available Dec. 2022, and the results of the second determination period should be available Nov. or Dec. 2023.

- Note: If the clinician is reporting as a part of a group, the threshold is evaluated at the group level

If the clinician is listed as a qualified participant of an APM, they do not need to report for MIPS although if they do, they'll be covered in the event the APM does not report.

Step 2. Are You in a Large Practice?

A large practice is defined as 16 or more eligible clinicians.

If you are in a small practice, please refer to the *Small Practice Roadmap*.

Step 3. Define Your Goal: Do You Want to Avoid the Penalty or Try for a Bonus?

Goal	Effect on Reimbursement	MIPS Final Score Required
Avoid the maximum 9% Penalty	Avoids the full 9% penalty on your 2025 Medicare Part B services reimbursements. (Between 18.76 and 74.99 points, the penalty is on a sliding scale, ranging from approximately 6.75% - 0.01%)	18.76 points
Avoids a Penalty	Avoids a penalty on your 2025 Medicare Part B services reimbursements	75 points
Very Small Bonus	Qualifies you for a very small bonus on your 2025 Medicare Part B services reimbursements (ex. The small bonus turned out to be about 0.1% for the 2021 performance year)	Above 75 points
Small Bonus	Qualifies you for a small bonus - there is no more exceptional performance bonus pool but if CMS predictions of greater penalties are correct, then there will be more money in the budget-neutral bonus pool, which may offset loss of the exceptional performance bonus pool (For the 2021 performance year, the exceptional performance bonus for a perfect final score of 100 points was 2.33%.)	Above 75 points

Step 4. How to Achieve Your Goal for the 2023 Performance Year

The MIPS final score is the weighted sum of performance category scores. For example, if a category is weighted at 40%, it contributes up to 40 MIPS final score points to the total score of up to 100 points.

MIPS Performance Category	2023 Score Weight
Quality	30%
Promoting interoperability	25%
Improvement activities	15%
Cost	30%

To Avoid a Penalty

This requires MIPS final score of 75 points. Do *all* the following:

Improvement activities category:

- Complete 2 high-weighted OR 4 medium-weighted OR 1 high-weighted and 2 medium-weighted improvement activities for 90+ consecutive days.
- *If group reporting*, at least 50% of eligible clinicians in your group must Complete 2 high-weighted OR 4 medium-weighted OR 1 high-weighted and 2 medium-weighted improvement activities in any continuous 90-day period. The clinicians do not need to share the same 90-day period.

Quality category:

Report on at least 6 quality measures, 1 of which must be an outcome or, if no outcome measure is available, another type of high priority measure.

Report each quality measure:

- For the full calendar year[10]; and
- On *at least* 70% of denominator-eligible patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire reporting period; and
- With *at least* 20 patients in the denominator

Promoting interoperability category:

- With 2015 Edition Cures Update CEHRT, complete the PI required measures and try to maximize your performance where possible

Step 5: Choose your measures and/or activities.

- Note: Each MIPS category can be reported on the same or on different performance periods as the other MIPS categories. However, within each MIPS category, typically all measures or activities must be reported for the same period.

Improvement activities category:

Performance period: 90+ consecutive days

- To fulfill the entire improvement activities category score: complete 1 high-weighted or 2 medium-weighted improvement activities
- Each high-weighted improvement activity will count for 100% of the category score
- Each medium-weighted improvement activity will count for 50% of the category score
- Group Reporting: *At least 50%* of the group's clinicians need to perform the same IA(s) for the whole group to get credit. The clinicians performing the IA(s) do not all need to perform it on the same 90+ consecutive day period for the group to get credit.

Note: Do not report on more activities than required to fulfill the category. CMS can audit each activity you report.

The following are improvement activities that many clinicians/practices already do routinely as well as new activities added to the IRIS Registry for 2023. Read the activity specifications available on the Academy's website.[11]

High-Weighted

- IA_EPA_1: Provide 24/7 Access
  - Evidence of urgent patientsA being seen in the practice on the same or next day

[10] The IRIS Registry allows you to report from the beginning of the year.
[11] www.aao.org/medicare/improvement-activities

    - No EHR required
- IA_AHE_1: Enhance Engagement of Medicaid and Other Underserved Populations
    - Evidence of an analysis of trends in inequities in time to treat data
    - Documentation of implementation of plans of activities to address inadequacies in time to treat performance and outcomes of these activities
    - No EHR required
- IA_AHE_6: Provide Education Opportunities for New Clinicians
    - Documentation of participation as a preceptor for clinicians-in-training and clinical rotation assignments in community practices in small, underserved, or rural areas
    - No EHR required
- IA_ERP_3: COVID-19 Clinical Trials
    - Evidence of treatment of patients diagnosed with COVID-19 and reporting their data to a QCDR, such as the IRIS Registry
    - EHR required
- IA_AHE_8: Create and Implement an Anti-Racism Plan – NEW
    - Evidence of a practice-wide review and implementation of an anti-racism plan
    - No EHR required
- IA_AHE_11: Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender and Queer Patients – NEW
    - Evidence of a practice-wide review and implementation of a plan to improve care for LGBTQ+ patients
    - No EHR required
- IA_BE_25: Drug Cost Transparency – NEW
    - Evidence of use of the Real-Time Benefit Tool and discussion of alternative medications and assistance programs
    - No EHR required
- IA_EPA_6: Create and Implement a Language Access Plan - NEW
    - Review of existing tools and practice, creation of a gap analysis memo, a plan to improve language access and a report with results of plan implementation
    - No EHR required

Medium-Weighted

- IA_CC_1: Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close the Referral Loop
    - Evidence that consultant sends report to referring clinician or that referring clinician has a process for capturing referral information in medical records
    - No EHR required

- IA_CC_2: Implementation of Improvements That Contribute to More Timely Communication of Test Results
    - Evidence of a process that reduces time before communicating test results that includes the population identified, method of communication and benchmark for timeliness and strategies for improvement
    - No EHR required
- IA_AHE_7: Comprehensive Eye Exams
    - Evidence of promotion of comprehensive eye exams and caring for underserved patients at no cost (e.g., through the Academy's EyeCare America)
    - Promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment
    - No EHR required
- IA_PSPA_2: Participation in MOC Part IV
    - Evidence of participation in MOC Part IV
    - No EHR required
- IA_PSPA_7: Use of QCDR Data for Ongoing Practice Assessments and Improvements
    - Feedback reports and documentation of how QCDR data is used for quality improvement or improvements in patient safety
    - EHR required
- IA_AHE_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols - NEW
    - Documentation of screening tools for identifying at-risk patients and an implementation plan to advance support to patients and results achieved
    - No EHR required
- IA_AHE_10: Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data - NEW
    - Documentation of implementation of technology meeting security tags criteria in practice systems and clinical workflows
    - EHR required
- IA_ERP-4: Implementation of a Personal Protective Equipment (PPE) Plan - NEW
    - Documentation of a PPE plan, including plans for conventional, contingency and crisis capacity, staff training materials and procurement or existing inventory
    - No EHR required
- IA_ERP-6: COVID-19 Vaccine Achievement for Practice Staff - NEW
    - Evidence showing that COVID-19 vaccinations are up to date for staff according to current CDC guidelines, including standardized approach to document vaccine status, employee education and process for vaccine administration
    - EHR required

- IA_PM_18: Provide Clinical-Community Linkages - NEW
  - Documentation of engagement with community health workers, and coordination with primary care, and use of quality measurement and improvement processes
  - No EHR required
- IA_PSPA_15: Implementation of an ASP - NEW
  - Evidence of leadership of an Antimicrobial Stewardship Program (ASP) that measures appropriate use of antibiotics for several different conditions
  - No EHR required

Quality category:

Performance period: Full calendar year

- Reminder: Unless you receive a hardship exception for the quality performance category, it is not possible to ensure a MIPS final score of 75 points without fully reporting on 6 quality measures

General Quality Category Information:

- This category must be performed for the full calendar year on 70% of denominator-eligible patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire calendar year AND at least 20 patients in the denominator for each measure AND a performance rate >0 (or <100 if an inverse measure).[12] CMS emphasizes that 100% of eligible patients is desired for MIPS reporting.
- Report on at least 6 quality measures, 1 of which must be an outcome measure or, if no outcome measure is available, another type of high priority measure
- Review the measure achievement point benchmark table to make sure your choices maximize your point potential

Promoting interoperability category:

This requires the use of 2015 Edition Cures Update CEHRT.

Performance period: 90+ consecutive days

- Note: You can only report data that is captured by 2015 Edition Cures Update CEHRT for this category. If you report as a group, you will not be downgraded if not all your clinicians use 2015 Edition Cures Update CEHRT.

How CMS Scores the Category

- Four PI objectives are required[13]
- To receive any credit for the category, you must meet the reporting requirements--or, where available, claim an exclusion--for all the required measures
- Some of these measures will be scored based on your performance rate
- Some measures are optional bonus measures
- Four critical attestations - To score more than 0% for PI, you must submit "Yes" for:
  - The Security Risk Analysis attestation

[12] Note: CMS emphasizes that 100% of eligible patients is desired for MIPS

[13] The number depends on whether you report the new HIE Bi-Directional Exchange measure or the two Support Electronic Referral Loops measures

- The SAFER Guides attestation
- The Prevention of Information Blocking attestation
- The ONC Direct Review attestation

How to Report Measures

- You must submit all required measures to get *any* PI credit.
- For each performance rate-based measure, you must have at least *one* patient in the numerator
- Exclusion for Query of Prescription Drug Monitoring Program (PDMP)

  A clinician is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs, OR writes fewer than 100 permissible prescriptions during the performance period, OR querying a PDMP would impose an excessive workflow or cost burden prior to start of performance period
- Exclusion for Support Electronic Referral Loops by Sending Health Information measure:

  A clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period
- Exclusion for Support Electronic Referral Loops by Receiving and Reconciling Health Information measure:

  A clinician who receives transitions of care or referrals or has patient encounters in which the clinician has never before encountered the patient fewer than 100 times during the performance period
- Exclusion for Immunization Registry Reporting measure:

  A clinician does not administer any immunizations to any of the populations for which data is collected by their jurisdiction, OR operates in a jurisdiction where no immunization registry is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no immunization registry has declared readiness to receive immunization data
- Exclusion for Electronic Case Reporting measure:

  A clinician does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction, OR operates in a jurisdiction where no public health agency is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data

Objective	Measures	Reporting requirement	Maximum points
e-Prescribing	e-Prescribing** Query of Prescription Drug Monitoring Program**	Numerator/denominator Yes/No	10 points 10 points
Health-information exchange	Support electronic referral loops by sending health information** Support electronic referral loops by receiving and reconciling health information** OR HIE Bi-Directional Exchange OR Enabling Exchange under TEFCA	Numerator/denominator Numerator/denominator OR Yes/No OR Yes/No	15 points 15points OR 30 points OR 30 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Numerator/denominator	25 points
Public Health and Clinical Data Exchange	Report the following two measures: Immunization Registry Reporting** Electronic Case Reporting** Optional measures: Clinical data registry reporting, OR Public health registry reporting, OR Syndromic surveillance reporting	Yes/No	25 points 5 points bonus (maximum, even if more than 1 registry)

IRIS Registry EHR-integrated practices qualify for the Clinical Data Registry reporting bonus measure.

**Exclusions are available for the Registry measures. Check the exclusions on the measure specifications to see if you qualify.[14]

Measures that depend upon your performance rate will be scored by multiplying the performance rate (calculated from the numerator and denominator you submit) by the available points for the measure.

[14] www.aao.org/medicare/promoting-interoperability/measures and *EyeNet's* MIPS 2023: A Primer and Reference

STEP 6: Submission

The January after the end of the performance year is when the submission function is activated in the IRIS Registry. You must press the submit button for your information to go to CMS. Watch for announcements from the Academy.

Academy Resources:

Eye on Advocacy[15]: This news page is updated every Thursday evening and new stories are sent to Members by the *Washington Report Express* email. It is the first place you will see any changes discussed and explained.

Academy MIPS Webpages:	www.aao.org/medicare/mips.
EyeNet's MIPS 2023: A Primer and Reference:	www.aao.org/eyenet/mips-manual-2023
Email IRIS Registry questions to:	irisregistry@aao.org
Email MIPS questions to:	mips@aao.org
AAOE e-Talk	For AAOE Members: https://aao.mobilize.io/users/sign_in

[15] www.aao.org/advocacy/eye-on-advocacy

2015-Edition Cures Update CEHRT for Integrated Practices: Roles, Responsibilities, and Schedule

Read this section if you are an EHR integrated practice with the IRIS Registry.

Integration Benefits

- The IRIS Registry remains the best option for ophthalmology practices to comply with MIPS requirements. Integrating your practice's EHR with the IRIS Registry simplifies the most burdensome part of MIPS reporting: the quality performance category.

Your Role

- The Academy hears repeatedly from practices that they thought "the IRIS Registry took care of everything." It's important to emphasize that the only automated aspect of integration is bringing over the patient quality measure performance information. A practice must still regularly monitor the data as it appears in the IRIS Registry against what is appearing in the EHR. Discrepancies found during monitoring usually have four possible causes:
    1. *Mapping Issue*: If the IRIS Registry shows a patient does not meet a particular measure, but the EHR system shows they do, that is a mapping issue. A request or ticket should be entered in the Zendesk for Verana Support to report the discrepancy.
    2. *Data Entry Error*: It is possible that the IRIS Registry and the EHR show the same outcome for a patient, but you suspect the outcome to be different. If you verify that suspicion, then there may have been a data entry error in the EHR and additional training of staff may be required. When caught early, the EHR entry can be corrected and the data repulled for the IRIS Registry.
    3. *Lack of Clinician Awareness:* It is also possible that you may need to review with the clinician which quality measures are being reported and what information is needed to ensure the correct outcome is recorded correctly in the EHR.
    4. *Failing to Add New Clinicians:* Have you notified the IRIS Registry through your datalink@veranahealth.com and your *Practice Portal* of any new clinicians joining the practice? If not, then it will not know to pull data for them. The performance you see would not be representative of the entire practice.
- Regardless of the cause, nothing can be done unless you catch it early. The Academy believes the data should be checked *no less* than quarterly.
- Integration does not take care of the Promoting Interoperability (PI) nor the improvement activity (IA) reporting. These require you to perform some (minimal) manual data entry - outlined later in this guide – in addition to the tasks necessary to report the quality category's measures.

- "Housekeeping" tasks are performed by you each year on the *Verana Quality Measures (VQM) Dashboard*. These consist of:
    - Verifying your tax ID number (TIN) (Q1 2023)
    - Confirming Academy Member ID numbers for each ophthalmologist (Q1-Q2 2023)
    - Signing the Data Release Consent Form (DRCF) (January 2024)
    - Answering the "Validation" questions (January 2024)
    - Submitting your data to CMS after the performance period ends (before 3/31/2024)

Selecting Your Quality Measures

- Note: Using the data from your EHR to record the quality measure performance of your clinicians in the IRIS Registry requires *mapping*. It cannot happen without your involvement. You must check the accuracy of the mapping, and communicate performance to the clinicians for continued improvement over the year.

The first thing to do at the beginning of the reporting period is look at your quality measures and select the quality measures you would like to improve upon or focus on.

- Each year it is prudent to review your group of quality measures. Some reasons are:
    - A quality measure may no longer be offered for the reporting method that you use
    - A quality measure may now offer fewer achievement points towards your MIPS score
    - Other measures may offer a better opportunity to earn more points
    - Adding measures without benchmarks offers a hedge against capped and stalled measures for the future and even for the same reporting year if at least 20 practices submit eligible data.
- Benchmark Resources:
    - A benchmark table shows how many measure achievement points are possible for the performance rate you reach on that measure. Each measure will have its own benchmarks for performance.
    - Check out the benchmark table in this prep kit.
    - There is also a comprehensive list of the measures by reporting pathway in this prep kit.
- Considerations in Making Your Selection for MIPS Submission:
    - You should pick at least six quality measures to submit for MIPS. These are the measures you expect will give you the highest score. Let's call them your core quality measures.
        - At least one of the six should be classified as an outcome or, if none are available, another type of high priority measure.
    - The Academy encourages you to report on more than six measures with special emphasis on the IRIS Registry QCDR measures. Remember, you need to monitor the mapping on all measures you'd like to report on regularly throughout the reporting year. More measures equal more monitoring.
    - There may be a restriction on the number of achievement points you can earn due to the measure's benchmarks (e.g. a 7-point cap).
    - Some are not benchmarked. (This means there is typically no guarantee of earning achievement points when the 20-patient case minimum and 70% patient data completeness thresholds are met, except for small practices are guaranteed at least 3 achievement points). See Some Benchmarks are Subject to Scoring Limitations in *EyeNet's MIPS 2023: A Primer and Reference* for a full explanation.

- In 2023, there is one measure (QPP130) that is capped at 7.0 achievement points – meaning, even with a perfect performance, you can earn only 7.0 and not 10.0 achievement points. QPP128 does not have a 2023 benchmark because of changes in the specifications or insufficient data, though CMS could add benchmarks later if there is sufficient data submitted for the performance period. Two other measures, QPP14 and QPP384, can also be reported by EHR-integrated practices, and these are capped at 7.0 achievement points.
- Five measures are stalled (QPP238, QPP141, QPP384, QPP389 and IRIS54), meaning some range of points from 7.9 through 9.9 are not available. See Some Benchmarks are Subject to Scoring Limitations of *EyeNet*'s *MIPS 2023: A Primer and Reference* for a full explanation.
- For 2023, 11 IRIS Registry QCDR measures (only available through the IRIS Registry) have a full range of achievement points: IRIS2, IRIS13, IRIS17, IRIS23, IRIS43, IRIS44, IRIS46, IRIS51, IRIS53, IRIS55, and IRIS59. IRIS54 stalls at the 8th decile, but otherwise has a fairly large range of achievement points. CMS could add benchmarks later for the other IRIS Registry QCDR measures if there is sufficient data submitted for the performance period.
- Look at the benchmark table for those that are of interest
  - On your first pass, pick measures that allow you to earn between up to 10.0 achievement points without any gaps (no stalled measures and no capped measures).
    - Note: Make sure at least one of them is classified as an outcome measure or, if none are available, another type of high priority measure.

- Consider reporting IRIS Registry QCDR measures that are without benchmarks in addition to your core selection. If you choose to report them, you will be assisting with the benchmarking for future years. This will give ophthalmic practices a greater selection of measures that reflect their everyday practice and can provide potentially more points than many other MIPS measures that are subject to scoring restrictions.
    - Note: If enough practices report on the IRIS Registry QCDR measures then CMS may benchmark them before your final score is released. It is possible that these could end up raising your score. *You have nothing to lose in reporting them in addition to your six core measures.*
- Enter a request or ticket in the Zendesk of Verana Support if you think that there are missing patients in the numerator or denominator of the measures you wish to use for the current MIPS reporting period. The vendor administering the IRIS Registry, Verana Health, will then proceed to refine the measure calculations. Remember:
  - Do it early rather than late in the year – the deadline to submit requests or tickets is October 31, 2023
  - It's always prudent to watch the status of your service requests or tickets
  - It's your responsibility to check the mapping after each data pull and investigate

Staying on Schedule:

- Once you've picked your measures, it's time to plan your schedule of events for the reporting period
- Staffing changes – *after* you've submitted MIPS IRIS Registry data for the previous year:
  - Make sure your clinicians list is up to date in the IRIS Registry. This means making sure that new clinicians are added and ones who departed during the prior reporting year are inactivated for the current year. If clinicians leave during the current reporting period, you want to keep them active in the IRIS Registry since their patients are included in the group's performance for the year (assuming you are reporting as a group). The vendor overseeing the IRIS Registry has the deadline of September 1, 2023 to add any new clinicians in your for mapping. You can update this information by emailing datalink@veranahealth.com and in your *Practice Portal*.

- Have there been changes to the administrative staff? If more people need IRIS Registry access, you can take care of that in the *Practice Portal* section. If staff need to be inactivated, you can do that as well. You can also add additional practice locations or inactivate those that were closed the prior year.

January of the Current Reporting Year:

- Choose your quality measures for MIPS submission. You should remain vigilant in checking the accuracy of your *VQM Dashboard*.
- Make sure all your clinicians are reported through the integration. If someone just joined your practice, now is the time to submit a request or ticket in Zendesk of *Verana Support* asking that they be added or email irisdatalink@veranahealth.com. Provide the individual NPI number. You will need to include whether the individual is an ophthalmologist. If so, then include their Academy Member ID number in the request or ticket.
    - Note: Adding clinicians to the *Practice Portal* section of the *VQM Dashboard*, while necessary, is not sufficient. You must still enter a request or ticket or email datalink@veranahealth.com to add them to the *VQM Dashboard*.
- Check to make sure your EHR is configured so your PI performance is optimized. Make sure to review the PI measure requirements with the staff inputting the data into the EHR.
    - Providing patients electronic access to their health information is a key measure in the PI category. For specific steps on maximizing your score read the corresponding MIPS Tip[1].
- One way to improve your PI score is to make sure your electronic contact information is recorded with CMS.
    - The Centers for Medicare & Medicaid Services asks you to add your secure electronic contact information, also known as an electronic end point or "Direct address"[2] to your National Plan and Provider Enumeration System (NPPES) profile.
        - If you do not know your exact electronic end point or Direct email address, contact your electronic health record (EHR) vendor for this information. Go to the NPPES[3] website and update your provider profile. You can add your electronic address under the “Health Information Exchange” section. A CMS' *Medicare Learn Network Matters*[4] newsletter from April 16, 2019 (page four) provides more information on the necessary steps.
        - Taking this step will help you and your colleagues succeed at PI health information exchange (HIE) measures by ensuring you, and physicians referring to you, can send referral information electronically.
        - Completing this update connects the unique Direct address to a specific physician NPI number. It will help ophthalmologists succeed in the PI HIE measures that are worth 30% of the overall PI score.
        - Along with entering your Direct addresses in NPPES, your practice may want to proactively request Direct addresses from their referring physicians and update their EHR/PM system with that information. Review PI reports for HIE sending referrals and confirm Direct addresses are entered for all referring (out) physicians as well.

[1] www.aao.org/practice-management/article/mips-tips-provide-patients-electronic-access
[2] www.healthit.gov/sites/default/files/directbasicsforprovidersqa_05092014.pdf
[3] nppes.cms.hhs.gov/#/
[4] www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11003.pdf

- Pick your IAs[5] and make sure your clinicians know that they are participating. Ensure that the documentation outlined on the IA specification is collected in the event you are audited.

End of First Quarter:

- Review your quality measure mapping:
- If you find a mapping issue, enter a request or ticket as soon as possible
- If you find a data entry issue, address the training issue
- If the quality measure performance is correct, then engage your clinicians
- Print out their individual *VQM Dashboard* reports on each measure for the first quarter. Let them see how their work is contributing to the group's performance.
- Begin the housekeeping tasks. These are necessary as they tell the IRIS Registry how to estimate your MIPS score.
    - Hint: You will need your EHR's Certified IT Product List (CHPL) number. The easiest way to obtain this number is to contact your EHR.
- Run your PI report from your EHR and review the results. The PI reporting period is 90 consecutive days, so you have time to improve your score. Of course, as soon as you get a great score in a 90-day period, then you can consider yourself done with the performance category that much earlier.
    - Hint: Plug your PI measure performance report data into the *VQM Dashboard* PI screen and you can see what your estimated MIPS score will be for that 90-day period. You're not committing to what you've entered and can key in values for a different 90-day period later.[6]
- It's time to check the status of the IA(s) your practice has been doing. If you've not made the selection, then now is the time to do it. If reporting as a group, at least half of your clinicians must have performed the agreed upon activities during a minimum 90 consecutive day period. Each clinician participating should have the appropriate documentation recorded or accessible. For example: *Measure IA_AHE_1: Engagement of New Medicaid Patients and Follow-Up* states that the documentation should:
    - Report analysis of trends in inequities in time to treat data
    - Document plans of activities to address inadequacies in time to treat performance and the outcomes of these activities[7]
    - In other words, doing the activity successfully means you can prove you not only analyzed time to treat data in terms of Medicaid patients and other underserved populations, but also you've documented the practice's analysis of its performance, identified steps to improve it, and implemented and monitored the success of those steps. Demonstrating that you see new patients in 10 days is not sufficient to prove you completed the activity.

End of Second Quarter:

- Review your *VQM Dashboard*.
- Does the measure performance match your expectation?

[5] https://www.aao.org/medicare/improvement-activities

[6] Under no circumstances do you report PI through more than one mechanism (e.g. the IRIS Registry and CMS portal) because you will be assigned zero points in the category.

[7] In 2021 this "And" was changed to "Or" per the 2021 Data Validation Spreadsheet released by CMS. The reason for this change isn't known, so it is prudent to consider both requirements still necessary.

- Do a spot check to make sure the mapping remains in order. Enter a request or ticket if needed. The final deadline for requesting mapping changes is October 31, 2023. Make sure your request or ticket is entered by then.
- If the quality measure performance is correct, then engage your clinicians
- Print out their individual *VQM Dashboard* reports on each measure for the second quarter. Let them see how their work is contributing to the group's performance.
- Have you added any clinicians?
    - Add them to your list of clinicians in your Practice Portal area of the *VQM Dashboard*.
    - Put in a request or ticket to have them mapped – otherwise their data will not be included. You'll need their NPI and, if an ophthalmologist, the Academy Member ID Number. Verana Health has the deadline of September 1, 2023 to add any new clinicians for mapping. Your request or ticket must be entered by then.
- Run your PI reports from your EHR
    - Are you seeing an improvement? If not, there's time to take corrective action.
- Check that the documentation for the selected IAs is adequate for at least half your clinicians (if reporting as a group).
    - If so, you can attest to the completion in the IRIS Registry
    - If not, implement changes for the third Quarter

End of Third Quarter:

- If you have not yet completed your housekeeping tasks, go ahead and do so. You will need your CHPL number.
- Review your VQM Dashboard
    - Does the measure performance look good?
    - Do a spot check to make sure the mapping remains in order. Enter a request or ticket if needed.
- Run your PI reports
    - You are beginning the fourth quarter which is the last chance to get the PI measures to their highest performance.
- Check that the documentation for the selected IAs is adequate for your clinicians – if you are attesting to this activity during all or part of the quarter.
- Have you checked the status of any requests or tickets you've entered? You will want to be sure the issue reported is resolved.

End of Fourth Quarter:

- The final quality measure data pull may not happen right away in the new year. Since you've been reviewing your *VQM Dashboard* regularly throughout the year, your quality measure performance should be accurate, once your final pull is completed. Double check one last time as soon as you can.
    - Do a spot check to make sure the mapping remains in order. If you find an issue reported in an earlier request or ticket, contact Verana Health at datalink@veranahealth.com.
- If the quality measure performance is correct, then engage your clinicians.
    - Print out their individual *VQM Dashboard* reports on each measure for the year. Let them see how their work is contributing to the group's performance.

- Since the performance year is over, it is time to finalize your data in each of the performance categories. These tasks are done in the *VQM Dashboard* MIPS Submission tab.
- Select which quality measures you wish to submit
    - ➢ Hint: Select all measures you have good performance data on. The IRIS Registry will calculate the quality score as you add and subtract measures.
    - In the PI area, enter which 90 consecutive day period gives you the best results and enter the PI values for the measures
    - In the IA section, enter the date range of the performance period, which can range in length from 90 consecutive days to the full calendar year, then select the activities.
- Once the submit button is active, you should proceed through that process

Common Pitfalls:

Here are some of the reasons why practices find themselves with a lower MIPS score than anticipated.

- Not checking their junk folder for communications from Verana Health – the vendor that is the Academy's end to end partner for the IRIS Registry
- Not watching their quality measure performance regularly
- Not reviewing and updating their quality measure choices each year, if needed
- Not notifying the IRIS Registry if:
    - EHR/PMS vendor change or upgrade
    - EHR network server upgrade, or transition to cloud-based
    - Server changes.
    - IT personnel or MIPS administrator change at the practice
    - Physician has joined or left the group
- Not acting when there are changes to their EHR. Remember:
    - Notify the IRIS Registry immediately of changes to your EHR
    - Monitor the *VQM Dashboard* and keep following up on unresolved requests or tickets
    - Resolve any mapping issues with Verana Health
    - Update internal workflows related to measure reporting (quality, PI and IA)
    - Test workflows and confirm reporting appropriately (ex. PI Health Information Exchange)
    - Train employees on any new MIPS protocols
- Not submitting in the IA category
- Submitting the PI performance category data to CMS through more than one pathway that differs (which results in a score of zero in the PI category)
- Not knowing this information on a PI measure: www.aao.org/practice-management/article/mips-tips-provide-patients-electronic-access
- Assuming that there aren't any IAs suited to ophthalmology (there are lots!)
- Answering the *VQM Dashboard* Validation questions incorrectly (thus preventing the submission of data in some performance categories)
- Not checking all the applicable performance category boxes during the submission process

Web Portal Manually Reporting Practices: Roles, Responsibilities, and Schedule

What the Future Holds

While the Academy can't foresee what will happen with MIPS in the next few years, it can certainly point to some trends. The number of MIPS points necessary to avoid the penalty will probably increase. More of the quality measures that are reported manually will be topped out, capped at 7 measure achievement points, or become stalled in the achievement points available. The cost category could begin to apply to non-cataract surgeons. The exceptional performance bonus was discontinued after the 2022 performance year. Because CMS made the small practice promoting interoperability (PI) hardship exception automatic, avoiding the penalty is easier than originally thought for small practices without an EHR or not reporting PI. However, CMS has stated that they expect only to accept electronic reporting (via EHRs) in the future for the MIPS program.

To make a long story short, practices that do not transition to EHRs soon will find themselves subject to a penalty, according to CMS' statement (see above). With that being said, it's time for your practice to re-examine the benefits, risks and costs of moving to an EHR, if you haven't already.[35]

Benefits of Manual Reporting via the IRIS Registry vs Claims-Based Reporting.

Reporting manually through the IRIS Registry for those not on a 2015-edition CURES Update certified EHR, allows you to score higher than reporting through claims. Not only are the stalled and capped quality measures less frequent, but the number of available measures relevant to ophthalmology is greater. The Academy develops its own QCDR measures that are ophthalmology specific. These measures are only available to those reporting through the IRIS Registry. A copy of the Academy's quality measure benchmark table is included in this *Preparation Kit*.

IRIS Registry manual web portal reporting offers seven times the number of ophthalmology relevant measures than claims-based reporting. IRIS Registry manual reporting has twelve times the number of measures available that allow achievement scores above 7.0 without requiring a perfect performance. And claims-based reporting has 4 out of 7 total measures that stalled measures at 6.9 or lower achievement points. Simply put, manual web portal reporting through the IRIS Registry, and even more so, IRIS Registry EHR integration offers a greater opportunity to score higher in the quality performance category than claims-based reporting.

Reporting Method	Available Measures	Advantageous Measures	Restricted PointsMeasures	Not Benchmarked Measures
Claims-Based	7	2	4	1
IRIS Registry Web Portal	50	24	10	16
IRIS Registry EHR Integration (includes QCDR and other MIPS measures that can be reported via EHR but have manual benchmarks)	44	27	1	16

Advantageous measures allow more than 7.0 achievement points without a perfect performance rate. Restricted points measures are stalled at or below 6.9 or lower achievement points without a perfect performance score.

[35] www.aao.org/practice-management/multimedia-detail/think-twice-why-you-should-implement-ehr-now

Your Role

Reporting manually through the IRIS Registry requires a significant amount of time to perform the quality measure entry on the patient level. With the minimum MIPS final score to avoid the penalty in 2023 raised to 75 MIPS points, there's no way to avoid doing large quantities of data entry. This is one reason why transitioning to an EHR integrated with the IRIS Registry should be part of the practice's strategic plan. It removes this most burdensome part of MIPS reporting.

If you are on a 2015-edition CURES Update CEHRT and you don't take advantage of the automatic PI exception for small practices, then you'll also be responsible for reporting the promoting interoperability performance category.

If your practice is reporting as a group, you'll want to ensure that at least half your clinicians complete the improvement activity category requirements in a 90 consecutive day period. In the IRIS Registry this is a simple attestation, where boxes are checked and a date range entered. You would be responsible for maintaining the documentation proving that the activities were performed in the event you are audited.[37]

Lastly, there are housekeeping tasks that must be performed in the IRIS Registry annually. Here's what you should do each quarter of the calendar year. These are performed in the *MIPS Dashboard* of the IRIS Registry.

- Verifying your tax ID number (TIN) (Q1 2023)
- Confirming Academy Member numbers for each ophthalmologist (Q1-Q2 2023)
- Signing the Data Release Consent Form (DRCF) (January 2024)
- Answering up to 8 "Settings" question (January 2024)
- Submitting your data to CMS after the performance period end (before 3/31/2024)

The first step however is to choose your quality measures.

Selecting Your Quality Measures.

- Each year it is prudent to review your selection of quality measures and update them as warranted. Some reasons are:
  - A quality measure may no longer be offered for the reporting method
  - A quality measure may now offer fewer achievement points towards your MIPS score
  - Other measures offer a better opportunity to earn more points
  - Adding un-benchmarked measures offer a hedge against capped and stalled measures
- Benchmark resources:
  - A benchmark table shows how many measure achievement points are possible for the performance rate on that measure. Each measure in the table will have its own benchmark entry or special scoring notation.
  - Reference the benchmark tables from the *EyeNet's MIPS 2023: A Primer and Reference* .

[36] *EyeNet*'s *MIPS 2023: A Primer and Reference*

[37] *EyeNet*'s *MIPS 2023: A Primer and Reference* and aao.org/medicare/improvement-activities

- There is also a benchmark table in the measure specification section of this *Preparation Kit.* The measure specifications themselves follow.

- Considerations in Making Your Selection:
  - You should pick at least six quality measures. These are the measures you expect will give you the highest score. Let's call them your core quality measures.
    - At least one of the six should be classified as an outcome or, if none are available, another type of high priority measure.
  - The Academy encourages you to report on more than six measures with special emphasis on the IRIS Registry QCDR measures.
  - There may be restrictions on the number of achievement points you can earn on measures.
    - Sixteen measures are not benchmarked. This means there is no guarantee of earning more than 3.0 achievement points when case minimum and data completeness are met.See "Some Benchmarks Are Subject to Scoring Limitations" in *EyeNet's MIPS 2023: A Primer and Reference* for a full explanation.
    - Ten measures are capped at 7 achievement points. Even with a perfect performance rate, you can't earn more than 7 measure achievement points.
    - Twenty-four measures allow you to earn more than 7.0 achievement points withouta perfect performance rate.
  - Look at the measures for those that are of interest.
    - Try to pick measures that allow you to earn between 3.0 and 10.0 achievement points without any gaps (no stalled measures and no capped measures).
      - Note: Make sure at least one of them is classified as outcome or, if none areavailable, another type of high priority measure.
    - Consider reporting IRIS Registry QCDR measures that are without benchmarks in addition to your core selection. You will be assisting with the benchmarking for future years. This will give ophthalmic practices a greater selection of measures that reflect their everyday practice and can provide potentially more points than many other MIPS measures that are topped out.
      - Note: If enough practices report on the un-benchmarked IRIS Registry QCDR measures then CMS may benchmark them before your final score is released. It is possible that these could end up raising your score. *You have nothing to lose in reporting them in addition to your six core measures*.

[38] Download the benchmark table found on aao.org/medicare/quality-reporting-measures

Staying on Schedule

At the beginning of the current reporting year:

- Choose your quality measures
- Add any new clinicians, administrators, and locations to your IRIS Registry account
- In the *Patient Visit* screen, assign the measures to each of your clinicians
- Begin your patient visit and quality measure reporting. Consider setting up a worksheet to help track the clinicians' and your colleagues' quality measure performance.[39]
    - Remember you must track the eligible population for each quality measure. Where exceptions exist on the quality measure specifications, they need to be tracked as well. [40]
- Pick the improvement activities the providers will perform for a 90 consecutive day period. Distribute the improvement activities' measure specifications to the clinicians.[41] Establish workflow that allows you to retain the suggested documentation.
- Get in the habit of checking for MIPS announcements on www.aao.org/medicare/mips.
- Make sure your spam/junk email filter does not prevent emails sent by veranahealth.com from getting through to you.
- Are your ophthalmologists' dues paid for the reporting year? Every ophthalmologist in the practice must be a member in good standing with the Academy for all the practice's clinicians to report through the IRIS Registry.
- Is an Academy Member forwarding to you the *Washington Report* emails that are sent each Thursday? MIPS-related information will more than likely be announced there first. Otherwise, as the administrator, consider joining the AAOE if you aren't a Member already. AAOE Members receive MIPS updates in the weekly *Practice Management Express* and have access to their very own ophthalmic community on www.aao.org. The AAOE community is very supportive and helpful – and that includes with MIPS. An email titled "IRIS Registry" is also sent out to the membership monthly.

Monthly

- Keep up with the quality measure reporting.
- Check your IRIS Registry account information for accuracy.
- Have there been any reorganizations at your practice? If you're using a different taxpayer ID number, you'll need to get that updated. If the practice is going to be dissolved, make sure you decide which provider will keep the IRIS Registry account and which will need to sign up new. Be aware of the deadlines listed on www.aao.org/iris-registry.

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[39] *EyeNet*'s *MIPS 2023: A Primer and Reference*

[40] *EyeNet*'s *MIPS 2023: A Primer and Reference*

[41] www.aao.org/medicare/improvement-activities

End of the First Quarter

- Review the EyeNet MIPS 2023: A Primer and Reference (aao.org/eyenet/mips-manual-2023)
- Add any new clinicians, administrators, and locations to your IRIS Registry account
- If you haven't started your quality measure reporting, don't put it off any longer. Get your workflow established, and make sure your eligible population and exception totals are captured.
- Review your Quality Performance Dashboard.
    - Does the measure performance look good?
    - Audit the data entry by pulling some charts to double check.
    - Do you still like the measures you've selected? If not, there's time to change before more of the year goes by.
        - Hint: you're not limited to six quality measures. In fact, you can help develop benchmarks for the IRIS Registry QCDR measures by reporting on them.
    - If the quality measure performance data entry is correct, then engage your clinicians. The IRIS Registry allows you to generate reports for each clinician showing how their work impacts quality performance.
- With three months behind you, check how your providers are doing with their improvement activity documentation. Make adjustments as needed. Remember, if reporting at the group level, 50% of your clinicians must perform the same activities for 90 consecutive days – and be able to show documentation in case of an audit.
- If you are on a 2015-edition CURES Update CEHRT, yet reporting quality measures manually, run your first quarter's promoting interoperability report. See how well you are doing and make changes to maximize your score.[42] Contact your vendor to iron out any discrepancies. While you're at it, get your EHR's 2015 Certified Health IT Product List (CHPL) number from your vendor. You'll need to enter it into the IRIS Registry.

End of the Second Quarter

- Add any new clinicians, administrators, and locations to your IRIS Registry account. Remember any newly arrived ophthalmologists must have Academy dues paid for the reporting year.
- Take care of the IRIS Registry's annual housekeeping tasks. These are necessary as they tell the IRIS Registry how to estimate your score.
- You should be entering your quality measure data for your patients. If you aren't, it's better to catch up now rather than wait until the last minute. Remember, to score enough

[42] *EyeNet*'s *MIPS 2023: A Primer and Reference*

[43] aao.org/medicare/promoting-interoperability/exceptions.

points in the category to avoid a penalty, you'll be reporting on at least 70% of the eligible patients, across all payors, seen in the year, for which the measure applies.[44]

- Don't forget that you'll need your eligible population totals and the totals of excepted patients (if applicable) by the end of the year.
- Review your measure performance.
    - Does the measure performance look good?
    - Audit the data entry by pulling some charts to double check
    - Do you still like the measures you've selected? If not, there's still time to change before more of the year goes by.
        - Hint: You're not limited to six quality measures. In fact, you can help develop benchmarks for the IRIS Registry QCDR Measures by reporting on them.
    - If the quality measure performance data entry is correct, then engage your clinicians. The IRIS Registry allows you to generate reports for each clinician showing how their work is contributing to the group's performance.
- If you are reporting the promoting interoperability category, run your second quarter reports. Are you seeing an improvement? There's still time to work with your EHR vendor to get things corrected.
- If your providers have met the improvement activities' requirements for 90 consecutive days (make sure there's documentation) then you can attest to that category's completion.
- If you entered any tickets into Zendesk, it's best you check their status

End of the Third Quarter

- Add any new clinicians, administrators, and locations to your IRIS Registry account
- If you've not done so, take care of your housekeeping tasks in the *MIPS Dashboard*. This includes validating NPIs, taxpayer ID numbers, Academy Member numbers, signing the Data Release Consent Form and answering the settings questions.
- Review your measure performance.
    - Does the measure performance look good?
    - Is the data entry correct? Pull some charts to double check.
    - Do you still like the measures you've selected? If not, there's still time to change before more of the year goes by.
    - Run your clinicians' individual quality performance reports and send them their copies.
- If you are reporting the promoting interoperability category, then run your third quarter report. Compare it against your other two quarters.

[44] This assumes you'll also meet the case minimum of 20. See "Meet Quality's Submission Thresholds" in *EyeNet*'s *MIPS 2023: A Primer and Reference.*

- If your providers have not yet begun their improvement activities, time is now running out
- Make sure you get any outstanding tickets resolved

End of the Fourth Quarter

Time to assemble your eligible population totals for each quality measure you're reporting. If there are exceptions on the quality measure specifications, then you'll need a total on those as well.

  - When you have these numbers, then go to the *MIPS Dashboard*, check the applicable quality measures, enter the totals and see your quality score.
  - If you question the number of measure achievement points, check the benchmark table for insight. If you think something isn't calculating correctly, enter a *Service Desk* ticket right away.

- You should attest to your practice's improvement activities in the *MIPS Dashboard* if you've not yet done it.
- You're ready to submit your data to CMS. You can do so as soon as the *Submit* button becomes available.

Common Pitfalls

Here are some of the reasons why practices get a lower score than anticipated.

- Staff turnover occurred and no one was assigned to be the practice's new MIPS administrator
- Waiting until the end of the year to begin quality measure reporting
- Not choosing the improvement activities soon enough
- Not getting access to the Academy's MIPS and IRIS Registry reference materials and communications
- Not checking your spam/junk folders for emails from Verana Health. Many are sent throughout the year.
- Waiting until the end of the performance year to ask for help from the Academy
- Not regularly sharing with the clinicians' their quality measure performance rates
- Not reporting IRIS Registry QCDR Measures to earn bonus points in the quality category
- Not submitting in the improvement activities category
- Assuming that there aren't any improvement activities suited to ophthalmology (there are lots!)
- Answering the IRIS Registry *Settings* questions incorrectly (preventing the submission in some performance categories)
- Not checking all the performance category boxes during the submission process

American Academy of Ophthalmology IRIS® Registry (Intelligent Research in Sight)
2023 Electronic Clinical Quality Measures for Reporting for MIPS and Quality Improvement

QPP #	eMeasure ID	NQF #	Measure Title	Outcome or High Priority	Domain	Meaningful Measure Area
374	CMS50v11		Closing the Referral Loop: Receipt of Specialist Report	High Priority	Communication and Care Coordination	Transfer of Health Information and Interoperability
130	CMS68v12	0419e	Documentation of Current Medications in the Medical Record	High Priority	Patient Safety	Medication Management
128	CMS69v11	0421e	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan		Community/Population Health	Preventive Care
1	CMS122v11		Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	Inter. Outcome	Effective Clinical Care	Management of Chronic Conditions
117	CMS131v11		Diabetes: Eye Exam		Effective Clinical Care	Management of Chronic Conditions
191	CMS133v11	0565e	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Outcome	Effective Clinical Care	Management of Chronic Conditions
226	CMS138v11	0028e	Preventive Care and Screening Tobacco Use: Screening and Cessation Intervention		Community/Population Health	Prevention and Treatment of Opioid and Substance Use Disorders
318	CMS139v11		Falls: Screening for Future Fall Risk	High Priority	Patient Safety	Preventable Healthcare Harm
19	CMS142v11	0089e	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	High Priority	Communication and Care Coordination	Transfer of Health Information and Interoperability
12	CMS143v11	0086e	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation		Effective Clinical Care	Management of Chronic Conditions
238	CMS156v11		Use of High-Risk Medications in the Elderly	High Priority	Patient Safety	Medication Management
236	CMS165v11		Controlling High Blood Pressure	Inter. Outcome	Effective Clinical Care	Management of Chronic Conditions

American Academy of Ophthalmology IRIS® Registry
(Intelligent Research in Sight)
Qualified Clinical Data Registry Measures for 2023 Reporting Year

Cataract: 2

IRIS54*: Complications after Cataract Surgery

IRIS59: Regaining Vision After Cataract Surgery

See also IRIS55 and IRIS60 under Glaucoma

Cornea: 2

IRIS1: Endothelial Keratoplasty- Post-operative improvement in best corrected visual acuity to 20/40 or better

IRIS38*: Endothelial Keratoplasty - Dislocation Requiring Surgical Intervention

Glaucoma: 6

IRIS2: Glaucoma - Intraocular Pressure Reduction

IRIS44*: Visual Field Progression in Glaucoma

IRIS43: Intraocular Pressure Reduction following Laser Trabeculoplasty

IRIS39: Intraocular Pressure Reduction following Trabeculectomy or an Aqueous Shunt Procedure

IRIS55: Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery

IRIS60: Visual Acuity Improvement Following Cataract Surgery Combined with a Trabeculectomy or an Aqueous Shunt Procedure

Neuro-Ophthalmology: 2

IRIS56: Adult Diplopia: Improvement of ocular deviation or absence of diplopia or functional improvement

IRIS57: Idiopathic Intracranial Hypertension: Improvement of mean deviation or stability of mean deviation

Oculoplastic: 1

IRIS6: Acquired Involutional Entropion: Normalized lid position after surgical repair

Pediatric Ophthalmology/Strabismus: 3

IRIS50: Amblyopia: Interocular visual acuity

IRIS49: Surgical Pediatric Esotropia: Postoperative alignment

IRIS48: Adult Surgical Esotropia: Postoperative alignment

Refractive Surgery: 2

IRIS23: Refractive Surgery: Patients with a postoperative improvement in uncorrected visual acuity (UCVA) of 20/20 or better within 30 days

IRIS24: Refractive Surgery: Patients with a postoperative correction within + or - 0.5 Diopter (D) of the intended correction

Retina: 4

IRIS13: Diabetic Macular Edema - Loss of visual acuity

IRIS41: Improved visual acuity after epiretinal membrane treatment within 120 days

IRIS46: Evidence of anatomic closure of macular hole within 90 days after surgery as documented by OCT

IRIS58: Improved Visual Acuity after Vitrectomy for Complications of Diabetic Retinopathy within 120 Days

Uveitis: 4

IRIS17: Acute Anterior Uveitis: Post-treatment Grade 0 anterior chamber cells

IRIS51: Acute Anterior Uveitis: Post-treatment visual acuity

IRIS53: Chronic Anterior Uveitis - Post-treatment visual acuity

IRIS35: Improvement of Macular Edema in Patients with Uveitis

Measures identified with an asterisk (*) are inverse measures, in these cases a lower performance rate is indicative of better performance.

The Measures are not clinical guidelines, do not establish a standard of medical care, and have not been tested for all potential applications.

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American Academy of Ophthalmology IRIS® Registry
(Intelligent Research in Sight)
2023 Web Portal MIPS Measures

2023 IRIS Registry Web Portal MIPS Measures			
QPP #	NQF #	Measure Title	Outcome or High Priority
1	0059	Diabetes: Hemoglobin A1c Poor Control	Intermediate Outcome
14	0087	Age-related Macular Degeneration: Dilated Macular Examination	
19	0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	High Priority
117	0055	Diabetes: Eye Exam	
128	0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan	
130	0419	Documentation of Current Medications in the Medical Record	High Priority
137	N/A	Melanoma: Continuity of Care – Recall System	High Priority
138	N/A	Melanoma: Coordination of Care	High Priority
141	0563	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	Outcome
191	0565	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Outcome
226	0028	Preventive Care and Screening Tobacco Use: Screening and Cessation Intervention	
236	0018	Controlling High Blood Pressure	Intermediate Outcome
238	0022	Use of High-Risk Medications in the Elderly	High Priority
317	N/A	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	
374	N/A	Closing the Referral Loop: Receipt of Specialist Report	High Priority

384	N/A	Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room within 90 Days of Surgery	Outcome
385	N/A	Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement within 90 Days of Surgery	Outcome
389	N/A	Cataract Surgery: Difference Between Planned and Final Refraction	Outcome
397	N/A	Melanoma Reporting	High Priority
402	N/A	Tobacco Use and Help Quitting among Adolescents	
419	N/A	Overuse of Imaging for the Evaluation of Primary Headache	High Priority
440	N/A	Skin Cancer: Biopsy Reporting Time - Pathologist to Clinician	High Priority
487	N/A	Screening for Social Drivers of Health	High Priority
493	N/A	Adult Immunization Status	

Table 4: Quality Measures Benchmarks

eCQMs, MIPS CQMs, and claims-based measures. eCQMs can be reported via IRIS Registry–EHR integration; MIPS CQMs can be reported manually via the IRIS Registry and, in some cases, via IRIS Registry–EHR integration; claims-based measures can only be reported by small practices.

Report an outcome measure. You must report at least one outcome or intermediate outcome measure—look for measures that are flagged as "Outcome" or "Interm. outcome" in the "High Priority" column below. If none are available to you, report at least one other type of high-priority measure ("Other HP") instead.

Meet two data submission thresholds. If your reporting for a quality measure satisfies both the case minimum requirement (20 patients) and the data completeness criteria (70% of denominator-eligible patients), your performance rate will be compared against a benchmark (if there is one), and you can earn the achievement points indicated below. If you are manually reporting via the IRIS Registry, you also must track your data completeness totals (see page 25). If you meet those reporting requirements, the "Points" column shows the range of points available to you for each measure. Some measures are subject to a 7-point

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
PREVENTIVE MEASURES								
Interm. outcome	**1: Diabetes: Hemoglobin A1c Poor Control (>9%)**	MIPS CQM	1*-10	**Performance rate**	99.00%-90.01%	90.00%-80.01%	80.00%-70.01%	
				Points	1	2	3	
		Claims	No benchmark					
		eCQM	1*-10	**Performance rate**	99.52%-93.34%	93.33%-75.01%	75.00%-57.61%	
				Points	1	2	3	
	117: Diabetes: Eye Exam	MIPS CQM	1*-5.9 or 7	**Performance rate**	1.30%-48.28%	48.29%-95.67%	95.68%-99.03%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		eCQM	1*-10	**Performance rate**	0.59%-5.89%	5.90%-13.81%	13.82%-22.99%	
					1.0-1.9	2.0-2.9	3.0-3.9	
	128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	MIPS CQM	1*-7.9 or 10	**Performance rate**	2.28%-31.81%	31.82%-64.93%	64.94%-85.32%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		Claims	3-4.9 or 7	**Performance rate**			95.78%-99.25%	
				Points			3.0-3.9	
		eCQM	No benchmark					
Other HP	**130: Documentation of Current Medications in the Medical Record**	MIPS CQM	3-7 points	**Performance rate**	2.60%-30.28%	30.29%-87.25%	87.26%-95.56%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	

cap and/or "score stalling" (see page 23).

Understand the measures. Detailed measure specifications can be downloaded via the IRIS Registry dashboard. Those specifications are also available as part of the *2023 IRIS Registry Preparation Kit,* which is availabe at aao.org/iris-registry/user-guide/getting-started.

Some changes to this list of measures. If you used this table to plan your quality measure reporting in 2022, you may notice some changes this year. Measures 110 and 110 have been replaced with measure 493; measures 440 and 487 have been added; measure 265 has been removed; and measures 117 and 130 are no longer available for claims-based reporting.

New for 2023: 3-point floor applies to small practices, but not large practices. In the chart below, the scoring for deciles 1 and 2 only applies to large practices. Small practices that meet the 70%–data completeness criteria and, if applicable, report data-completeness totals will score a minimum of 3 points.

Important caveat. If reporting via IRIS Registry–EHR integration, you can only report a measure if the relevant data elements are available for extraction from your EHR system. Check with staff from Verana Health to work on mapping for any of these measures.

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
PREVENTIVE MEASURES							
70.00%-60.01%	60.00%-50.01%	50.00%-40.01%	40.00%-30.01%	30.00%-20.01%	20.00%-10.01%	≤10.00%	Flat benchmark, inverse measure
4	5	6	7	8	9	10	
Because this measure was suppressed as an eCQM in 2021, CMS wasn't able to create a benchmark. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							Inverse measure
57.60%-46.16%	46.15%-38.18%	38.17%-32.27%	32.26%-27.33%	27.32%-22.51%	22.50%-17.08%	≤17.07%	Inverse measure
4	5	6	7	8	9	10	
99.04%-99.73%	99.74%-99.99%					100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9					7.0	
23.00%-33.25%	33.26%-46.03%	46.04%-80.50%	80.51%-97.64%	97.65%-99.20%	99.21%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
85.33%-94.61%	94.62%-98.34%	98.35%-99.71%	99.72%-99.99%			100%	Topped out
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9			10.0	
99.26%-99.99%						100%	Topped out, 7-point cap
4.0-4.9						7.0	
Because this measure was suppressed as an eCQM in 2021, CMS wasn't able to create a benchmark. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
95.57%-98.61%	98.62%-99.73%	99.74%-99.98%	99.99%			100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9	6.0-6.9	7.0			7.0	

Continued on page 28.

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
PREVENTIVE MEASURES								
Other HP	**130: Documentation of Current Medications in the Medical Record** (continued)	eCQM	1*-7	**Performance rate**	7.66%-66.24%	66.25%-83.07%	83.08%-89.81%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
	226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	MIPS CQM	1*-8.9 or 10	**Performance rate**	2.88%-17.29%	17.30%-34.61%	34.62%-53.73%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		Claims	3-4.9 or 10	**Performance rate**			90.20%-96.42%	
				Points			3.0-3.9	
		eCQM	1*-10	**Performance rate**	2.05%-13.94%	13.95%-24.99%	25.00%-36.10%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Interm. outcome	**236: Controlling High Blood Pressure**	MIPS CQM	1*-10	**Performance rate**	1.00%-9.99%	10.00%-19.99%	20.00%-29.99%	
				Points	1	2	3	
		Claims	3-10	**Performance rate**			20.00%-29.99%	
				Points			3	
		eCQM	1*-10	**Performance rate**	2.74%-41.95%	41.96%-51.35%	51.36%-56.60%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Other HP	**238: Use of High-Risk Medications in Older Adults**	MIPS CQM	1*-4.9 or 10	**Performance rate**	20.00%-3.74%	3.73%-0.64%	0.63%-0.06%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		eCQM	1*-7.9 or 10	**Performance rate**	21.82%-10.56%	10.55%-6.71%	6.70%-3.85%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
	317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	MIPS CQM	1*-10	**Performance rate**	0.05%-12.03%	12.04%-21.48%	21.49%-28.32%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		Claims	3-6.9 or 10	**Performance rate**			84.62%-96.65%	
				Points			3.0-3.9	

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
							PREVENTIVE MEASURES
89.82%-93.62%	93.63%-96.11%	96.12%-97.74%	97.75%-98.78%	98.79%-99.46%	99.47%-99.86%	≥99.87%	Topped out, 7-point cap
4.0-4.9	5.0-5.9	6.0-6.9	7.0	7.0	7.0	7.0	
53.74%-71.99%	72.00%-84.84%	84.85%-92.85%	92.86%-97.77%	97.78%-99.99%		100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9		10.0	
96.43%-99.99%						100%	Topped out
4.0-4.9						10.0	
36.11%-47.99%	48.00%-60.35%	60.36%-72.49%	72.50%-83.99%	84.00%-92.30%	92.31%-98.32%	≥98.33%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
30.00%-39.99%	40.00%-49.99%	50.00%-59.99%	60.00%-69.99%	70.00%-79.99%	80.00%-89.99%	≥90.00%	Flat benchmark
4	5	6	7	8	9	10	
30.00%-39.99%	40.00%-49.99%	50.00%-59.99%	60.00%-69.99%	70.00%-79.99%	80.00%-89.99%	≥90.00%	Flat benchmark
4	5	6	7	8	9	10	
56.61%-60.70%	60.71%-64.23%	64.24%-67.54%	67.55%-71.09%	71.10%-75.27%	75.28%-81.34%	>= 81.35%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
0.05%-0.01%						0%	Inverse measure, topped out
4.0-4.9						10.0	
3.84%-1.80%	1.79%-0.65%	0.64%-0.17%	0.16%-0.01%			0%	Inverse measure, topped out
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9			10.0	
28.33%-35.86%	35.87%-50.24%	50.25%-71.52%	71.53%-91.75%	91.76%-98.68%	98.69%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
96.66%-99.03%	99.04%-99.72%	99.73%-99.99%				100%	Topped out
4.0-4.9	5.0-5.9	6.0-6.9				10.0	

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
PREVENTIVE MEASURES								
Other HP	**318: Falls: Screening for Future Fall Risk**	eCQM	1*-10	**Performance rate**	0.14%-3.90%	3.91%-16.79%	16.80%-35.69%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Other HP	**374: Closing the Referral Loop: Receipt of Specialist Report**	MIPS CQM	1*-5.9 or 7	**Performance rate**	0.90%-30.42%	30.43%-66.93%	66.94%-84.37%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		eCQM	1*-10	**Performance rate**	0.50%-4.84%	4.85%-11.35%	11.36%-17.30%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
	402: Tobacco Use and Help with Quitting Among Adolescents	MIPS CQM	1*-7	**Performance rate**	37.84%-84.08%	84.09%-92.40%	92.41%-96.66%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
	493: Adult Immunization Status	MIPS CQM	No benchmark					
HEALTH EQUITY								
Other HP	**487: Screening for Social Drivers of Health**	MIPS CQM	No benchmark					
CATARACT/ANTERIOR SEGMENT								
Outcome	**191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery**	MIPS CQM	1*-6.9 or 10	**Performance rate**	23.55%-85.70%	85.71%-92.90%	92.91%-97.02%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		eCQM	1*-10	**Performance rate**	17.24%-74.47%	74.48%-88.07%	88.08%-92.66%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**389: Cataract Surgery: Difference Between Planned and Final Refraction**	MIPS CQM	1*-8.9 or 10	**Performance rate**	1.35%-14.82%	14.83%-24.10%	24.11%-33.07%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS54: Complications After Cataract Surgery**	QCDR	1*-8.9 or 10	**Performance rate**	7.50%-3.67%	3.66%-2.48%	2.47%-1.91%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS59: Regaining Vision After Cataract Surgery**	QCDR	1*-10	**Performance rate**	1.37%-16.32%	16.33%-23.66%	23.67%-28.31%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
For two additional measures, see IRIS55 and IRIS60, under "Glaucoma"								

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
PREVENTIVE MEASURES							
35.70%-52.46%	52.47%-66.86%	66.87%-79.38%	79.39%-88.68%	88.69%-95.36%	95.37%-98.91%	≥98.92%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
84.38%-95.11%	95.12%-99.99%					100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9					7.0	
17.31%-23.47%	23.48%-30.49%	30.50%-38.82%	38.83%-50.50%	50.51%-66.56%	66.57%-85.70%	≥ 85.71%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
96.67%-98.71%	98.72%-99.64%	99.65%-99.99%				100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9	6.0-6.9				7.0	
New measure incentive: If you meet the data completeness criteria and, if applicable, report data-completeness totals, you'll score a minimum of 7 points. And if CMS can create a benchmark based on 2023 performance data, you may be able to score more than 7 points.							New measure, 7-point floor
HEALTH EQUITY							
New measure incentive: If you meet the data completeness criteria and, if applicable, report data-completeness totals, you'll score a minimum of 7 points. And if CMS can create a benchmark based on 2023 performance data, you may be able to score more than 7 points.							New measure, 7-point floor
CATARACT/ANTERIOR SEGMENT							
97.03%-98.35%	98.36%-99.17%	99.18%-99.99%				100%	
4.0-4.9	5.0-5.9	6.0-6.9				10.0	
92.67%-95.13%	95.14%-96.76%	96.77%-97.85%	97.86%-98.62%	98.63%-99.26%	99.27%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
33.08%-45.00%	45.01%-64.66%	64.67%-91.12%	91.13%-97.99%	98.00%-99.99%		100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9		10.0	
1.90%-1.67%	1.66%-1.26%	1.25%-0.87%	0.86%-0.44%	0.43%-0.01%		0%	Inverse measure
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9		10.0	
28.32%-32.17%	32.18%-35.62%	35.63%-42.78%	42.79%-49.30%	49.31%-56.74%	56.75%-67.34%	≥67.35%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
CORNEA/EXTERNAL DISEASE								
Outcome	**IRIS1: Endothelial Keratoplasty: Postoperative Improvement in BCVA to 20/40 or Better**	QCDR	No benchmark					
Outcome	**IRIS38: Endothelial Keratoplasty: Dislocation Requiring Surgical Intervention**	QCDR	No benchmark					
GLAUCOMA								
	12: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	eCQM	1*-10	**Performance rate**	3.88%-68.61%	68.62%-83.12%	83.13%-88.68%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care**	MIPS CQM	1*-8.9 or 10	**Performance rate**	1.39%-52.26%	52.27%-75.16%	75.17%-86.30%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		Claims	3 or 10	**Performance rate**				
				Points				
Interm. outcome	**IRIS2: Glaucoma: Intraocular Pressure (IOP) Reduction**	QCDR	1*-10	**Performance rate**	1.80%-50.92%	50.93%-61.69%	61.70%-66.90%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS39: IOP Reduction Following Trabeculectomy or an Aqueous Shunt Procedure**	QCDR	No benchmark					
Outcome	**IRIS43: IOP Reduction Following Laser Trabeculoplasty**	QCDR	1*-10	**Performance rate**	5.00%-8.69%	8.70%-14.28%	14.29%-17.41%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS44: Visual Field Progression in Glaucoma**	QCDR	1*-10	**Performance rate**	90.00%-18.19%	18.18%-13.34%	13.33%-12.65%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS55: VA Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery**	QCDR	1*-10	**Performance rate**	3.70%-8.26%	8.27%-27.26%	27.27%-33.32%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS60: VA Improvement Following Cataract Surgery Combined with a Trabeculectomy or an Aqueous Shunt Procedure**	QCDR	No benchmark					

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
CORNEA/EXTERNAL DISEASE							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							Inverse measure
GLAUCOMA							
88.69%-91.93%	91.94%-94.16%	94.17%-96.07%	96.08%-97.65%	97.66%-98.95%	98.96%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
86.31%-93.40%	93.41%-96.25%	96.26%-98.25%	98.26%-99.37%	99.38%-99.99%		100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9		10.0	
						100%	
						10.0	
66.91%-71.08%	71.09%-74.28%	74.29%-77.60%	77.61%-80.12%	80.13%-83.49%	83.50%-87.58%	≥87.59%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
17.42%-21.61%	21.62%-24.34%	24.35%-31.66%	31.67%-36.16%	36.17%-77.58%	77.59%-93.32%	≥93.33%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
12.64%-11.64%	11.63%-11.14%	11.13%-7.15%	7.14%-5.01%	5.00%-4.06%	4.05%-1.40%	≤1.39%	Inverse measure
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
33.33%-33.69%	33.70%-36.72%	36.73%-43.89%	43.90%-46.86%	46.87%-48.88%	48.89%-65.84%	≥65.85%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
NEURO-OPHTHALMOLOGY								
Other HP	**419: Overuse of Imaging for the Evaluation of Primary Headache**	MIPS CQM	1*-7.9 or 10	**Performance rate**	68.04%-37.83%	37.82%-16.49%	16.48%-8.87%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS56: Adult Diplopia: Improvement of Ocular Deviation or Absence of Diplopia or Functional Improvement**	QCDR	No benchmark					
Outcome	**IRIS57: Idiopathic Intracranial Hypertension: Improvement of Mean Deviation or Stability of Mean Deviation**	QCDR	No benchmark					
OCULOFACIAL PLASTICS/RECONSTRUCTIVE								
Other HP	**137: Melanoma: Continuity of Care—Recall System**	MIPS CQM	1*-2.9* or 10	**Performance rate**	15.56%-92.15%	92.16%-99.99%		
				Points	1.0-1.9	2.0-2.9		
Other HP	**138: Melanoma: Coordination of Care**	MIPS CQM	1*-3.9 or 7	**Performance rate**	3.33%-60.77%	60.78%-93.01%	93.02%-99.99%	
					1.0-1.9	2.0-2.9	3.0-3.9	
Other HP	**397: Melanoma Reporting**	MIPS CQM	1*-1.9* or 7	**Performance rate**	41.33 - 99.99			
				Points	1.0-1.9			
		Claims	3-3.9 or 7	**Performance rate**			98.44%-99.99%	
							3.0-3.9	
Other HP	**440: Skin Cancer: Biopsy Reporting Time—Pathologist to Clinician**	MIPS CQM	1*-4.9 or 7	**Performance rate**	71.05%-96.73%	96.74%-98.98%	98.99%-99.73%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS6: Acquired Involutional Entropion: Normalized Lid Position After Surgical Repair**	QCDR	No benchmark					
PEDIATRIC OPHTHALMOLOGY AND STRABISMUS								
Outcome	**IRIS48: Adult Surgical Esotropia: Postoperative Alignment**	QCDR	No benchmark					

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
NEURO-OPHTHALMOLOGY							
8.86%-6.22%	6.21%-2.99%	2.98%-0.60%	0.59%-0.01%			0%	Inverse measure, topped out
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9			10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
OCULOFACIAL PLASTICS/RECONSTRUCTIVE							
						100%	
						10.0	
						100%	Topped out, 7-point cap
						7.0	
						100%	Topped out, 7-point cap
						7.0	
						100%	Topped out, 7-point cap
						7.0	
99.74%-99.99%						100%	Topped out, 7-point cap
4.0-4.9						7.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
PEDIATRIC OPHTHALMOLOGY AND STRABISMUS							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
PEDIATRIC OPHTHALMOLOGY AND STRABISMUS								
Outcome	**IRIS49: Surgical Pediatric Esotropia: Postoperative Alignment**	QCDR	No benchmark					
Outcome	**IRIS50: Amblyopia: Interocular Visual Acuity**	QCDR	No benchmark					
REFRACTIVE SURGERY								
Outcome	**IRIS23: Refractive Surgery: Patients With a Postoperative Uncorrected Visual Acuity (UCVA) of 20/20 or Better Within 30 days**	QCDR	1*-10	**Performance rate**	24.29%-43.99%	44.00%-68.54%	68.55%-77.57%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS24: Refractive Surgery: Patients With a Postoperative Correction Within + or - 0.5 Diopter (D) of the Intended Correction**	QCDR	No benchmark					
RETINA								
Age-Related Macular Degeneration (AMD)								
	14: AMD: Dilated Macular Examination	MIPS CQM	1*-7	**Performance rate**	5.91%-74.54%	74.55%-89.15%	89.16%-93.78%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Other HP	**19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care**	MIPS CQM	1*-4.9 or 7	**Performance rate**	3.33%-72.33%	72.34%-91.44%	91.45%-98.70%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		eCQM	1*-10	**Performance rate**	6.41%-52.98%	52.99%-70.17%	70.18%-80.35%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS13: DME: Loss of Visual Acuity**	QCDR	1*-10	**Performance rate**	56.86%-80.43%	80.44%-84.61%	84.62%-86.51%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS58: Improved Visual Acuity After Vitrectomy for Complications of Diabetic Retinopathy Within 120 Days**	QCDR	No benchmark					

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
PEDIATRIC OPHTHALMOLOGY AND STRABISMUS							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
REFRACTIVE SURGERY							
77.58%-81.24%	81.25%-82.34%	82.35%-84.20%	84.21%-89.19%	89.20%-94.28%	94.29%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
RETINA							
Age-Related Macular Degeneration (AMD)							
93.79%-96.30%	96.31%-98.07%	98.08%-99.13%	99.14%-99.76%	99.77%-99.99%		100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9	6.0-6.9	7.0	7.0		7.0	
98.71%-99.99%						100%	Topped out, 7-point cap
4.0-4.9						7.0	
80.36%-86.31%	86.32%-90.90%	90.91%-93.74%	93.75%-96.04%	96.05%-97.99%	98.00%-99.54%	≥99.55%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
86.52%-88.01%	88.02%-89.41%	89.42%-90.36%	90.37%-92.05%	92.06%-93.82%	93.83%-96.35%	≥96.36%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
RETINA								
Epiretinal Membrane								
Out-come	**IRIS41: Improved visual acuity after epiretinal membrane treatment within 120 days**	QCDR	No benchmark					
Macular Hole								
Out-come	**IRIS46: Evidence of Anatomic Closure of Macular Hole Within 90 Days after Surgery as Documented by OCT**	QCDR	1*-10	**Performance rate**	4.17%-24.13%	24.14%-39.99%	40.00%-53.05%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Retinal Detachment								
Out-come	**384: Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery**	MIPS CQM	1*-5.9 or 7	**Performance rate**	75.76%-89.13%	89.14%-95.09%	95.10%-96.76%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Out-come	**385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery**	MIPS CQM	1*-10	**Performance rate**	6.52%-16.80%	16.81%-21.89%	21.90%-34.77%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
UVEITIS/IMMUNOLOGY								
Out-come	**IRIS17: Acute Anterior Uveitis: Post-Treatment Grade 0 Anterior Chamber Cells**	QCDR	1*-10	**Performance rate**	13.33%-32.19%	32.20%-49.99%	50.00%-60.74%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Out-come	**IRIS35: Improvement of Macular Edema in Patients With Uveitis**	QCDR	No benchmark					
Out-come	**IRIS51: Acute Anterior Uveitis: Post-Treatment Visual Acuity**	QCDR	1*-10	**Performance rate**	60.00%-84.43%	84.44%-87.90%	87.91%-91.29%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Out-come	**IRIS53: Chronic Anterior Uveitis: Post-Treatment Visual Acuity**	QCDR	1*-10	**Performance rate**	53.12%-78.68%	78.69%-83.99%	84.00%-86.35%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	

Key: EHR = Electronic health record; **Interm. outcome** = Intermediate outcome measure; **Other HP** = Other high priority measure.
* There is 3-point floor for small practices, provided that they report on at least one patient and, depending on their collection type, submit submit data-completeness totals (see page 25). Note: You may be able to report measures 14, 141, 384, 385, 389, and 493 via IRIS Registry–EHR integration. Although CMS didn't create electronic specifications for these six measures, the IRIS Regis-

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
RETINA							
Epiretinal Membrane							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
Macular Hole							
53.06%-56.51%	56.52%-63.30%	63.31%-66.66%	66.67%-71.90%	71.91%-81.57%	81.58%-95.23%	≥95.24%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Retinal Detachment							
96.77%-98.25%	98.26%-99.99%					100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9					7.0	
34.78%-38.77%	38.78%-56.93%	56.94%-62.27%	62.28%-64.70%	64.71%-77.28%	77.29%-81.47%	≥81.48%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
UVEITIS/IMMUNOLOGY							
60.75%-67.85%	67.86%-71.36%	71.37%-74.01%	74.02%-77.77%	77.78%-82.13%	82.14%-87.17%	≥87.18%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
91.30%-93.78%	93.79%-95.44%	95.45%-95.91%	95.92%-97.25%	97.26%-99.25%	99.26%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
86.36%-88.23%	88.24%-90.17%	90.18%-92.85%	92.86%-95.23%	95.24%-97.77%	97.78%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	

try was able to extract the necessary data for the first five of those measures from EHR systems in the past. Similarly, the Academy expects that the IRIS Registry will be able to extract data for measure 493, which is a new measure, from most EHR systems.

Look out for CMS corrections. Some years, CMS has published corrections to the benchmark data part way through the performance year. Stay alert for CMS corrections (see "Empower Your MIPS Team," page 7).

Verana Health

IRIS Registry

Zendesk for Verana Support User Guide

2023v1

Table of Contents

Zendesk for Verana Support

Access Zendesk for Verana Support

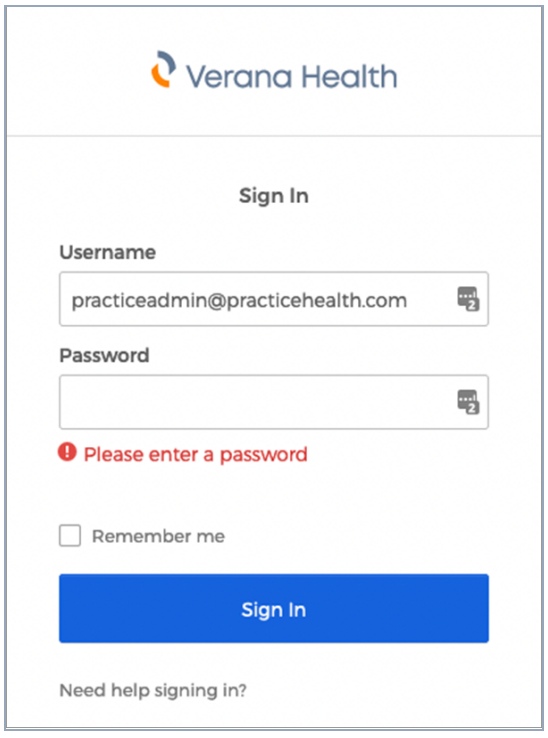
Verana Health recently implemented a practice support and help center via Zendesk for your Verana Quality Measures Dashboard. You can access Zendesk for Verana Support via okta.

Log In to Zendesk

To log in to Zendesk for Verana Support, follow these steps:

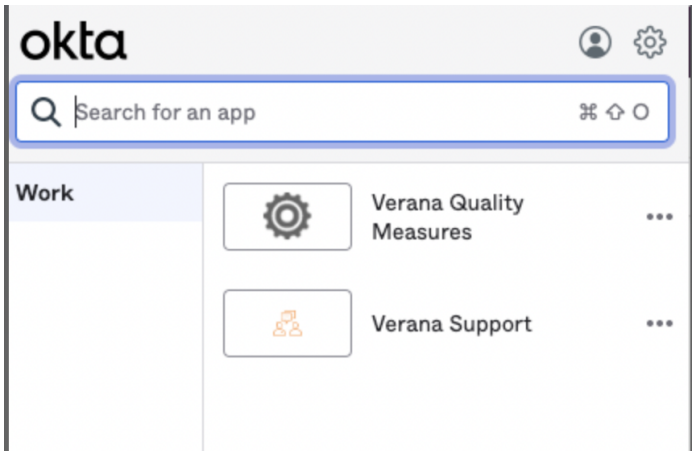
1. Go to https://vqm.veranahealth.com.
2. On the **Sign In** page, enter your **Username** and **Password**.

   Note: Use the credentials that were provided for your Verana Quality Measures Dashboard.



3. Click **Sign In**.

4. Click **Verana Support**.

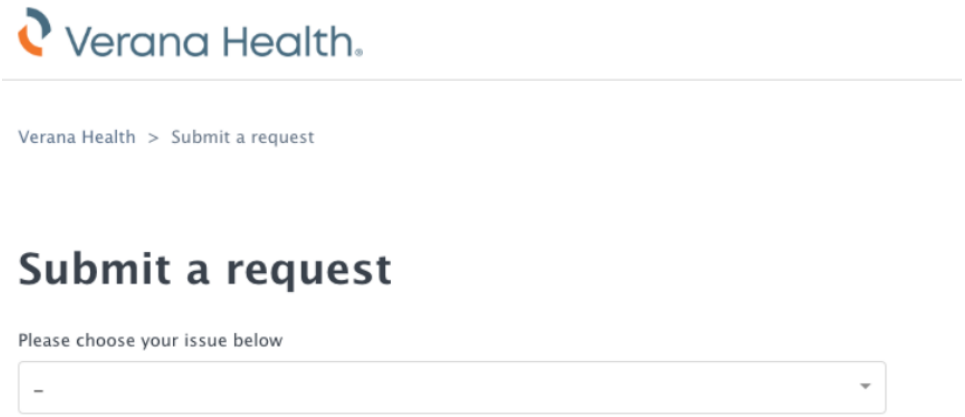


Submit a Request

To submit a request for support, follow these steps:

1. Click **Submit a request**.

2. In the **Submit a request** page, select your issue from the dropdown menu.



Submit a request dropdown menu

The submit a request dropdown menu has 6 issue categories to choose from. Use the following guidelines to determine which option to select for your support request.

- **User Access Form**
  (Accessing your Verana Quality Measures Dashboard)
  - **Request Type**:
    (Choose from the dropdown menu)
    - Password Reset
    - Add User
    - Remove User
    - User Role Change
    - Other

- **Quality Measure Support and Refinements**
  (Issues with the data on your Verana Quality Measures Dashboard)
  - **Request Type**:
    (Choose from the dropdown menu)
    - **Patient(s) in the Incorrect Section**
      (Refinements to the data showing on your Verana Quality Measures Dashboard)
      - Screenshots of each component of measure are encouraged
        - ICD-10 Code
        - CPT Code
        - Numerator requirement documentation
    - **Add a New Measure**
      (Add a measure that currently is not populated on your Verana Quality Measures Dashboard but should be available to the Registry)
    - **Keyword/Code Request**
      (Add a keyword or code to the mapping of measures)
      - The request is reviewed internally for acceptance
    - **Remove Test Patient**
      (Remove a "test" patient[s] on your Verana Quality Measures Dashboard that you found during review of your data)
    - **Other**
      (Use when none of the above **Request Types** are appropriate)
  - **Registry Membership**:
    (Choose from the dropdown menu)
    - **IRIS Registry**
    - **AXON**
    - **AQUA**

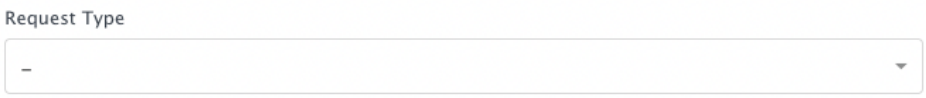
- **Provider Issue**
  - **Request Type:**
    (Choose from the dropdown menu)
    - **Add Provider**
      (Add a new clinician that joined your group)
    - **Remove Provider**
      (Remove an incorrect practice association)
    - **Deactivate Provider**
      (Deactivate a clinician that left your group. Deactivate only if you are not required to report data for this clinician)
    - **Reactivate Provider**
      (Reactivate a previously deactivated clinician who needs to be active)
    - **Other**
      (Use when none of the above **Provider Issues** are appropriate)

- **Location Issue**
  - **Request Type**:
    (Choose from the dropdown menu)
    - Add Location
    - Remove Location
    - Deactivate Location
    - Reactivate Location
    - Other

- **Data Connection Support**
  (Lost connectivity to your EHR, Server Migration or hosting change, or have Data Connection questions)

- **General**
  (None of the above issues apply to your request)

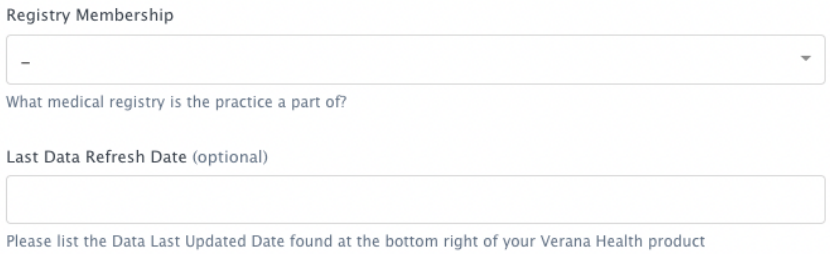
3. For **Data Connection Support** and **General**, continue to step 5. For all other issue categories, choose **Request Type** from the dropdown menu, see **Submit a request dropdown menu** for guidelines.



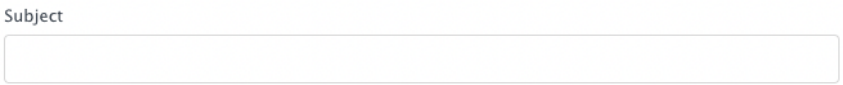
4. If the request is for **Quality Measure Support and Refinements**, complete the following. For all other issue categories, continue to step 5.

    a. Choose **Registry Membership** from the dropdown menu.

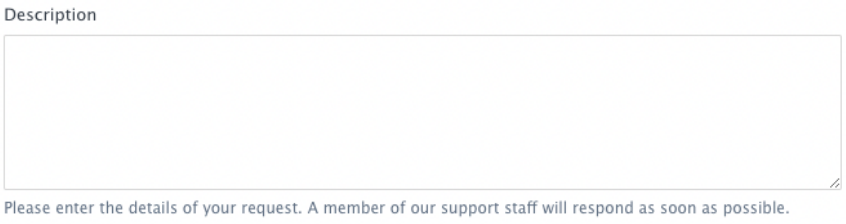
    b. Enter **Last Data Refresh Date** (optional).



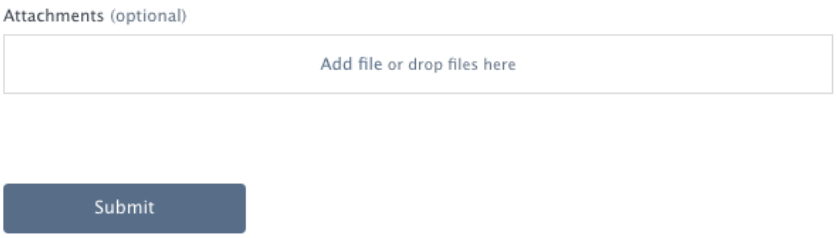
5. In the **Subject** field, enter a brief title for your request.



6. In the **Description** field, enter a detailed description of the request.



7. In the **Attachments** field (optional), add or drop files that provide additional information that relates to your request.



8. Click **Submit**.

Recent Activity

The Recent Activity section shows your submitted tickets. You can click on the tickets to view your submissions.

Verana Health

IRIS Registry

Verana Quality Measures Dashboard User Guide

March 2023

Table of Contents

Introduction

This user guide provides society registry administrators, practice administrators, and clinicians information for using the Verana Quality Measures Dashboard to track quality improvement and access quality performance measure data for Merit-based Incentive Payment System (MIPS) reporting.

The Verana Quality Measures Dashboard is accurate, up to date, easy to use, and fully supported.

- It uses high quality VeraQ® data and a scoring algorithm that maximizes the accuracy of quality measures and MIPS scores.
- It provides regular data updates from practice Electronic Health Records (EHR) systems.
- It supports the enhancement of patient care by clearly pinpointing opportunities for improvement and areas of excellence.
- It provides full support from Verana Health's experienced and knowledgeable team of Practice Experience Managers.

Practices that participate in the American Academy of Ophthalmology IRIS® Registry (Intelligent Research in Sight) or the American Academy of Neurology's Axon Registry® and have completed their EHR integration via Verana Health are eligible to receive the Verana Quality Measures Dashboard.

Recommended Browsers

- Google Chrome™ browser/85.0.4158.0 and higher
- Safari®

Practice Support

Contact Verana Health Practice Experience at datalink@veranahealth.com or call 877-353-0304.

- Help with your dashboard
- Help with logging in
- Reset password
- Modify practice clinicians

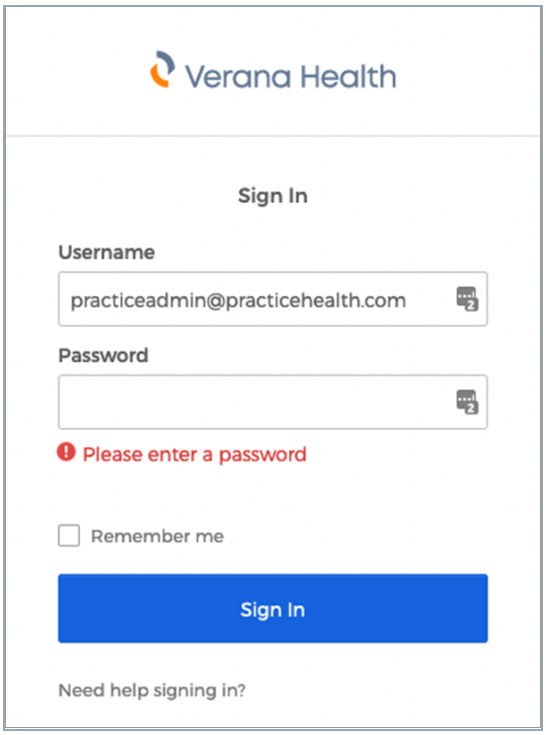
Your Verana Quality Measures Dashboard Account

Access your Verana Quality Measures Dashboard

You will receive an email from our Practice Experience Team when your dashboard is available with data. That email will provide instructions on how to activate your account, and how to log in for the first time and access your dashboard.

Log In

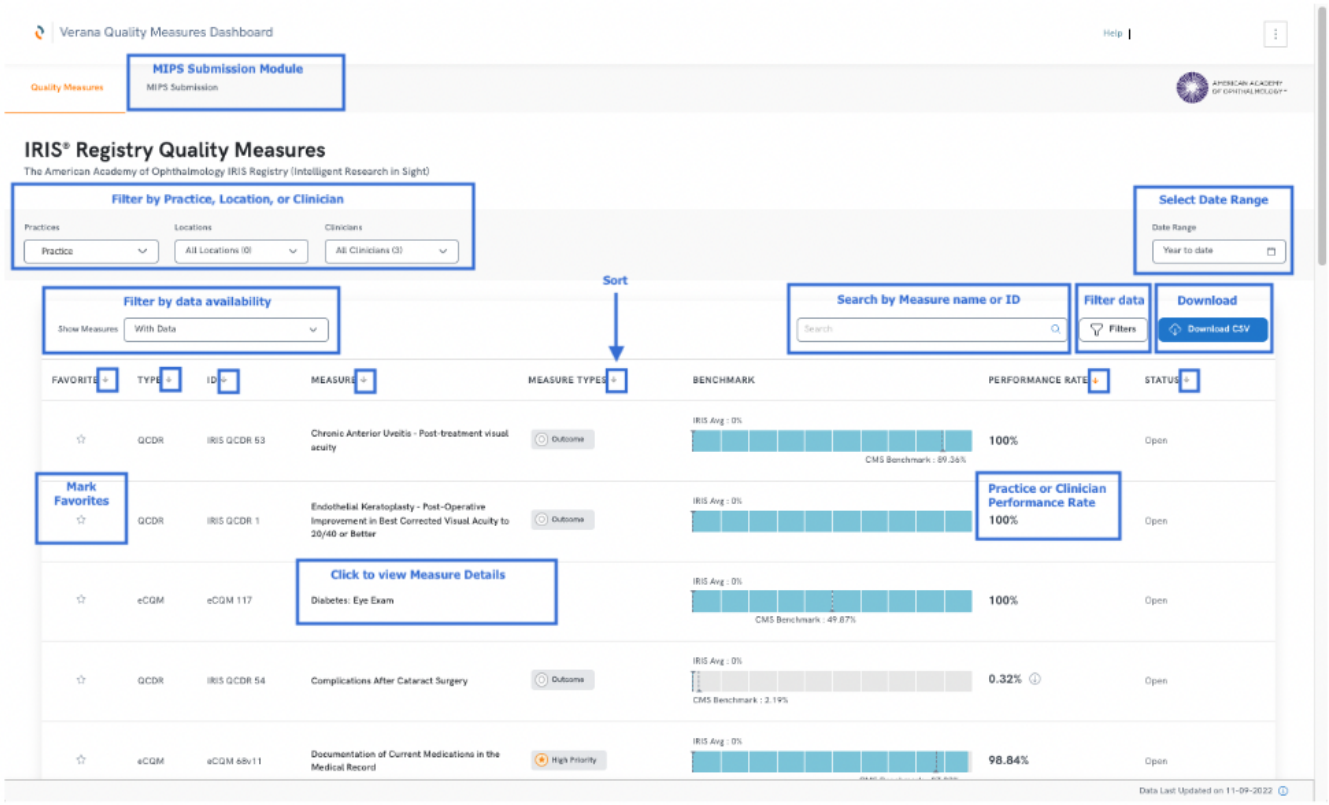
To log in to Verana Quality Measures Dashboard, go to https://vqm.veranahealth.com



From the sign in page:

1. Enter your username and password
2. Click **Sign In**

Quick Start Guide



Improvements in January 2023

Key Updates

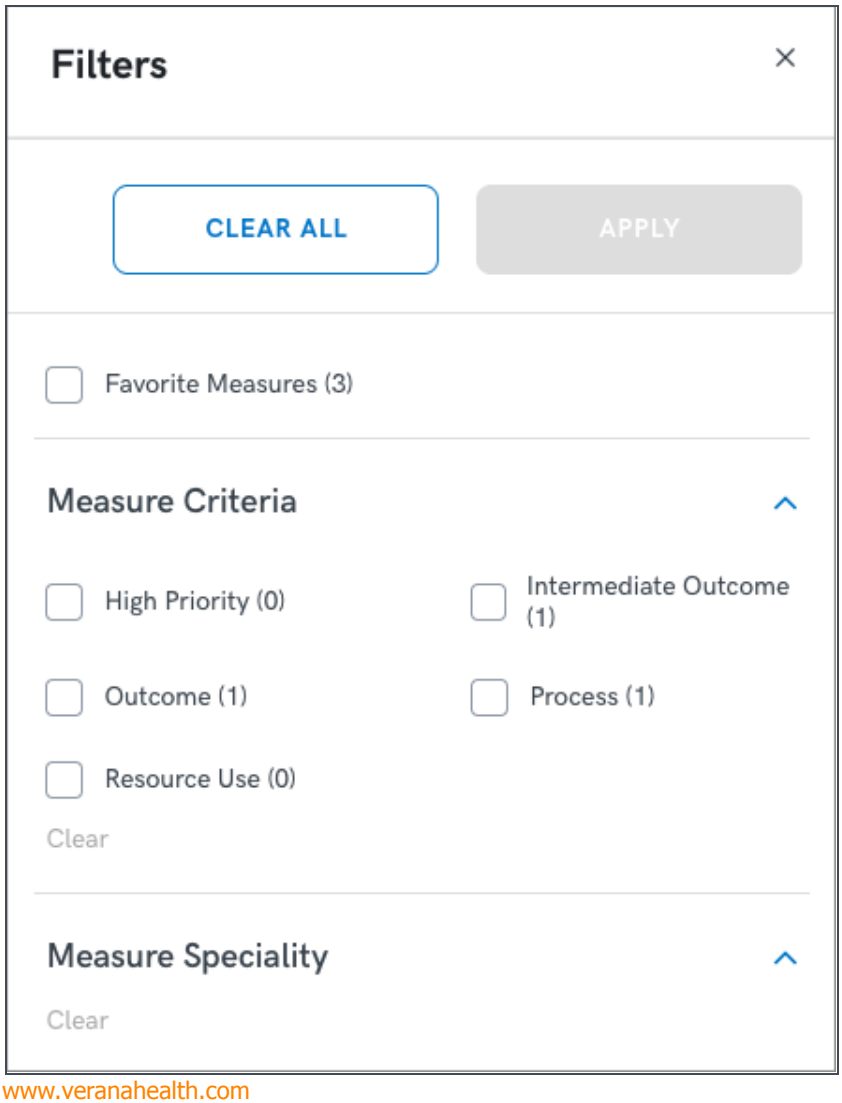
- DRCF Signing
    - Axon DRCF User Guide 2022
    - IRIS DRCF User Guide 2022

Dashboard Features and Functions

Customize Your Quality Performance Measures View

Pick which lens through which you want to view your quality performance measures data. If you want to focus on measure type, filter by **Measure Criteria**. If you identify favorites for tracking, make sure to "favorite" them by clicking the star (the star will turn yellow when selected).

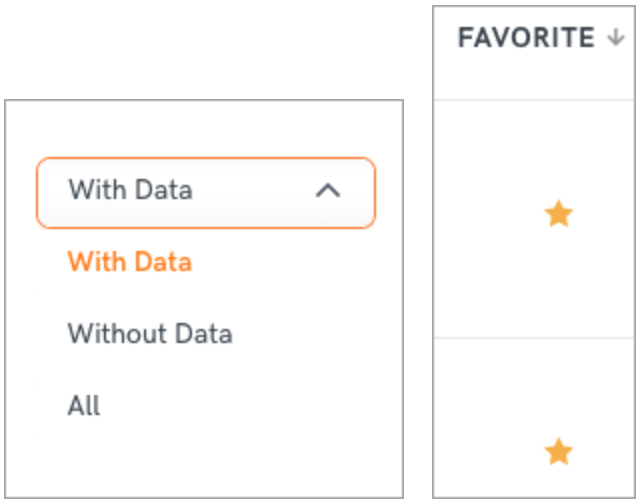
If you want to see which measures don't have data, which means they are being tested and validated by your Registry for your specialty, then use the filter **Without Data**. The Without Data filter will also help identify gaps in data coming from your EHR so we may together engage your EHR vendor to provide the data necessary to compute these quality performance measures.



Filter your measures based on measure type and specialty to quickly locate the Registry measures most applicable to your practice.

Filter for measures with and without data. Measures without data are those most likely to be in Test or Implementation mode by your Registry. Your society and the Verana Health Practice Experience Team will need your help to map and refine data for these specialty measures.

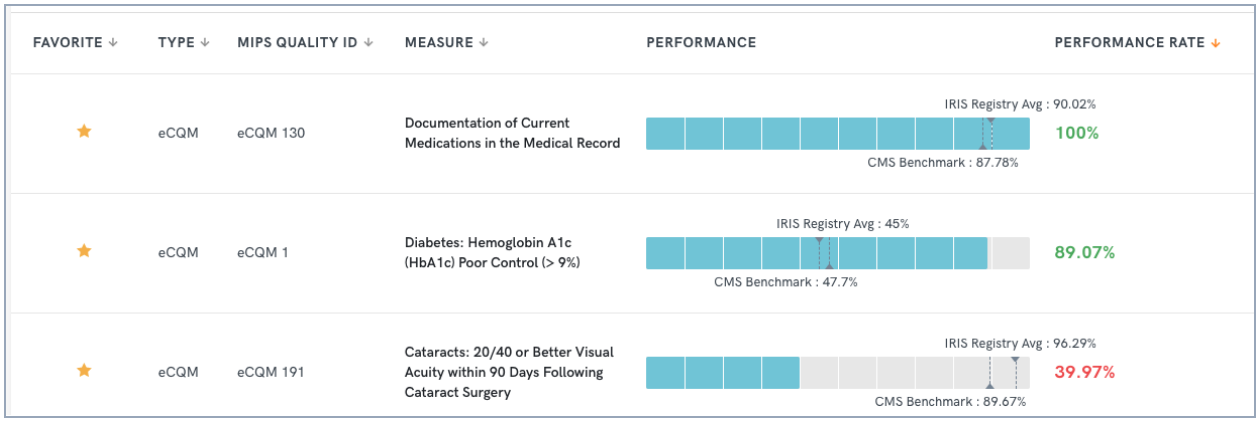
Or, pick your favorite measures for tracking.



Monitor Your Performance

Track your performance on quality measures and benchmark yourself to your peers and other clinicians nationwide. Sort by Favorite, Measure Type, Measure ID, Measure Title or Performance Rate.

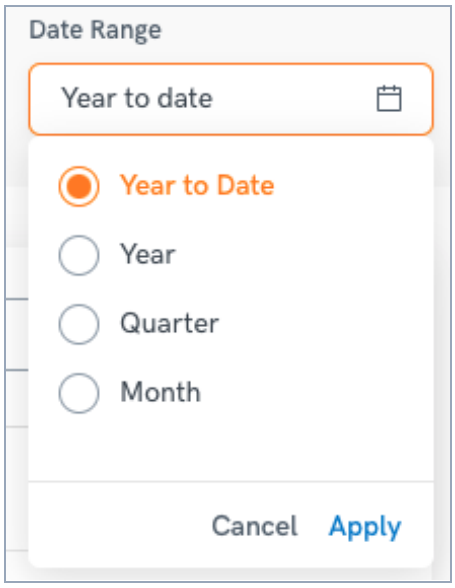
When you engage with your dashboard you have the opportunity to uncover gaps in care and/or documentation that could be impacting your quality performance scores. Use your dashboard tools to further understand why performance appears to be lower than it should be.



Use your drill-down functions to identify potential causes for low performance.

Review Data

View your quality performance data at the practice, location or clinician levels in order to identify gaps in care or gaps in documentation that impact quality performance scores.

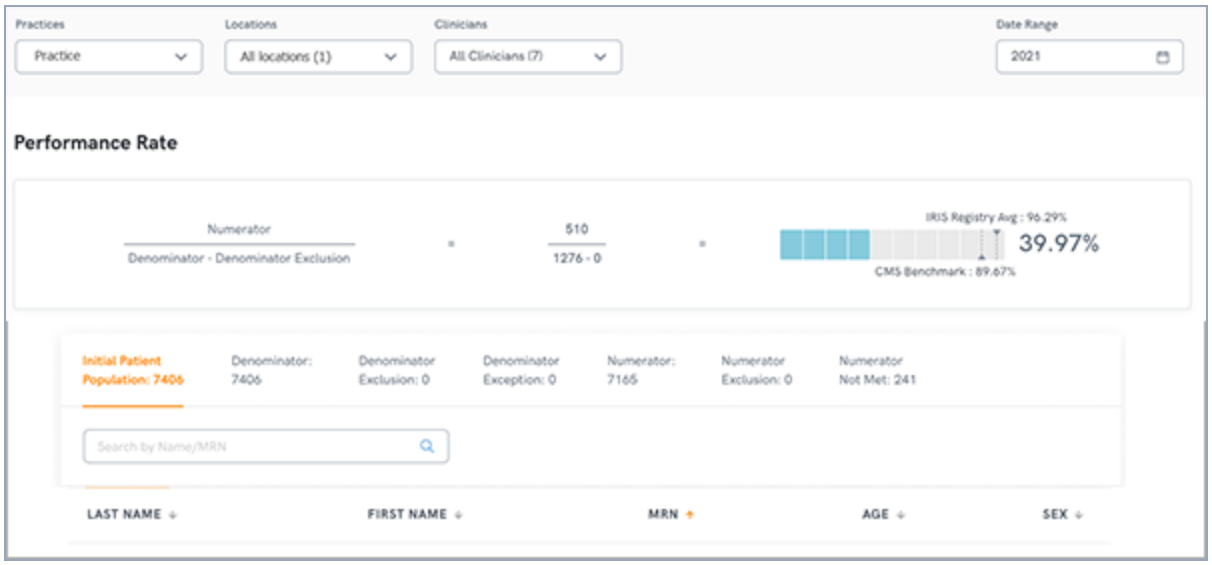


View your quality performance data by year. Select your target year or customize your quality performance date to facilitate quality improvement.

Use these tools to research low performance and identify gaps in documentation and/or care.

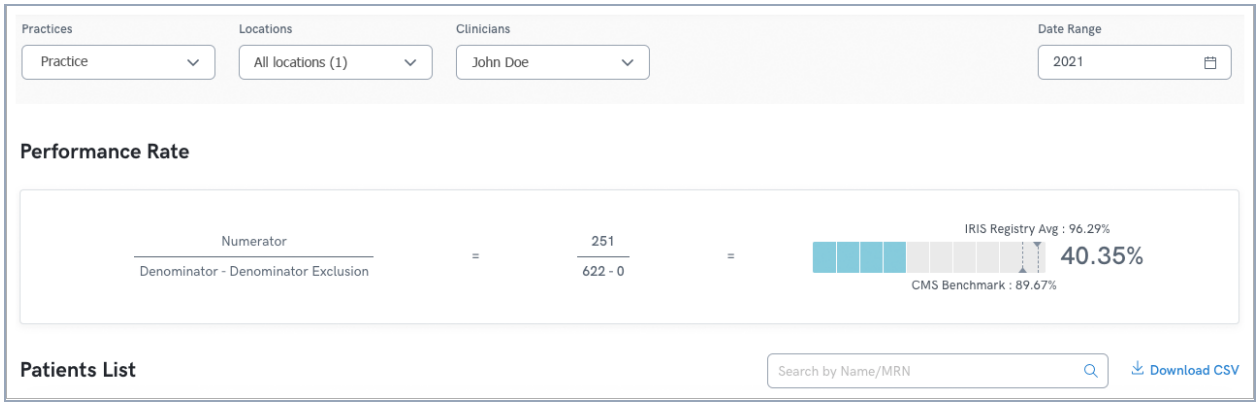
Performance Rate Review: Practice, Location, Clinician

Further understand measure performance by filtering data at the practice, location and clinician levels and review patient data based on your filters.



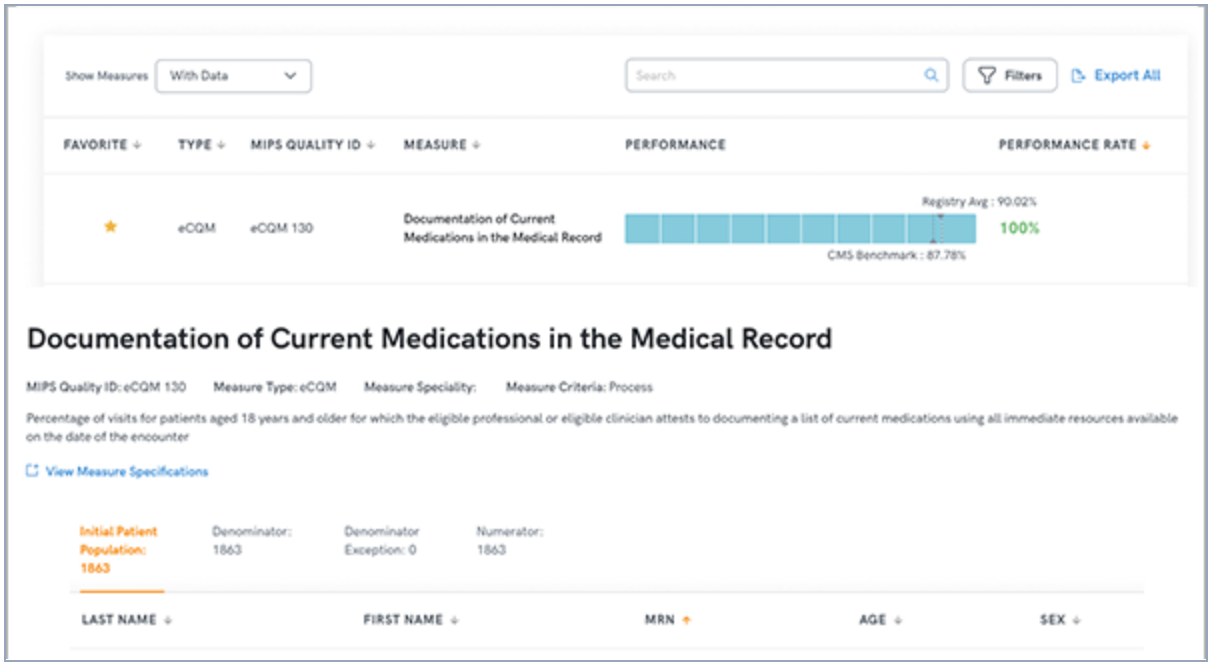
Review Clinicians and Location Performance

You may further review performance data by downloading patient data using the **Download .CSV** function to review individual patient-level data. This feature allows for offline review of patient level details to determine if performance is due to actual performance or documentation practices. Use the Clinician drop-down to review other clinicians at the practice. Then use your customized date range views on your dashboard to track your quality improvement or system interventions and improvements to your performance rates and quality measure scores.



Review and Refine Quality Performance Measures Data

One of your practice favorites has a performance rate of 100%. Is this correct? Assess if you and your practice are performing at 100%. Click on the measure title to view details on the measure and scroll down to confirm the patients in the measure. Double-check the patient population counts and measure component counts to determine if the numerator patients and denominator population are indeed correct. Confirm by reviewing a random sample of patients that appear in your measures details screen and confirm they are indeed eligible for the measure. Then you will know whether or not your performance rate really is 100%.



Quality Performance Measures Data

Mapping, Validation, and Refreshes

It is a shared responsibility to assure that quality performance measures data is accurate, true and complete prior to submission to Centers for Medicare & Medicaid Services (CMS).

Quality Performance Measures Mapping:

- Assures that quality performance measures components are validated and verified, that you agree to the accuracy of the data, and that there are no errors in measures calculation or performance rates prior to MIPS submission.
- Helps the registry in which you participate to identify measures that may require rewriting (no data available) or that point to poor quality care (low performance rates) or that need further testing and refinement to produce data.

Data Validation:

- Tests data quality on all ingested data.
- Validates quality performance measures data prior to presentation in registry dashboards.
- Validates quarterly quality performance measures data.
- Audits CMS-mandated pre-submission randomized data validation.
- Assures accuracy in quality performance measures data submitted to CMS.

Verana Quality Measures Dashboard Data Refreshes:

- Take into account refinements discovered on practice mapping calls.
- Assure currency of data on a monthly basis

Appendix

Common Terms

1. **Verana Quality Measures Dashboard:** Verana Health's quality platform offers practices and clinicians participating in their society registries access to registry-specific quality performance measures that may be used for Merit-based Incentive Payment System (MIPS) reporting and for quality improvement.

2. **MIPS:** Merit-based Incentive Payment System, a regulatory reporting requirement from the Centers for Medicare and Medicaid Services (CMS) that includes reporting data from all payers and includes four categories: Quality Performance, Promoting Interoperability, Improvement Activities and Cost.

3. **MIPS Submission Module:** Available from the Verana Quality Measures Dashboard. It is used to report Quality Performance, Promoting Interoperability and Improvement Activities categories of MIPS to CMS.

4. **Quality Performance Measures:** Quality measures are standards for measuring the performance of healthcare clinicians in their care for patients and populations.

5. **QCDR:** Qualified Clinical Data Registry – **QR:** Qualified Registry

6. **Benchmarks and Deciles:** Measurement of clinical performance. Facilitates comparison of individual and practice quality and scoring within MIPS.

7. **Registry Average:** Simple average of clinical performance across practices within each registry.

8. **Performance Rate:** Measure performance based on measure calculation. Higher scores indicate higher-quality care, unless you are working with an inverse measure where lower performance equates to higher-quality care.

9. **CEHRT:** Certified EHR Technology 2015 Edition Cures. Verana Health's quality platform is also CEHRT.

Verana Quality Measures Dashboard User Roles and Permissions

User Role	**Role Description**
Registry Administrator	Responsible for oversight and management of the registry to include management of all the practices and clinicians, as well as locations within the registry. • Read-only access to the Verana Quality Measures Dashboard and individual practice Quality Performance Dashboards. • Read-only access to Quality Performance, Promoting Interoperability, and Improvement Activities Dashboards within the MIPS Submission Module.
Multi-Practice Administrator	Master user role/class responsible for oversight and management of practices, clinicians, and practice locations within their scope. Access is enabled for protected health information (PHI) in a table view in order to map and refine measure data.
Single Practice Administrator	Responsible for managing a single practice and may be an administrator or a clinician administrator. Access is enabled for protected health information (PHI) in a table view in order to map and refine measure data.
General Clinician	Users can access their own quality measures but cannot see other practice or clinician's performance data.

Past Improvements

December 2022

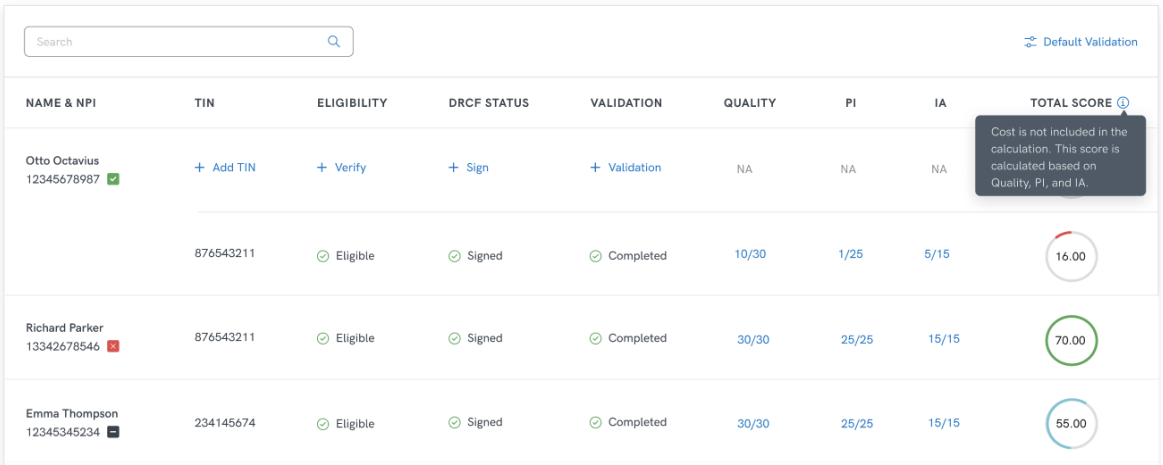
Key Updates

- MIPS Quality Scoring
- TIN Details
- Verana Quality Measures Dashboard Enhancements
- Additional Changes

MIPS Quality Scoring

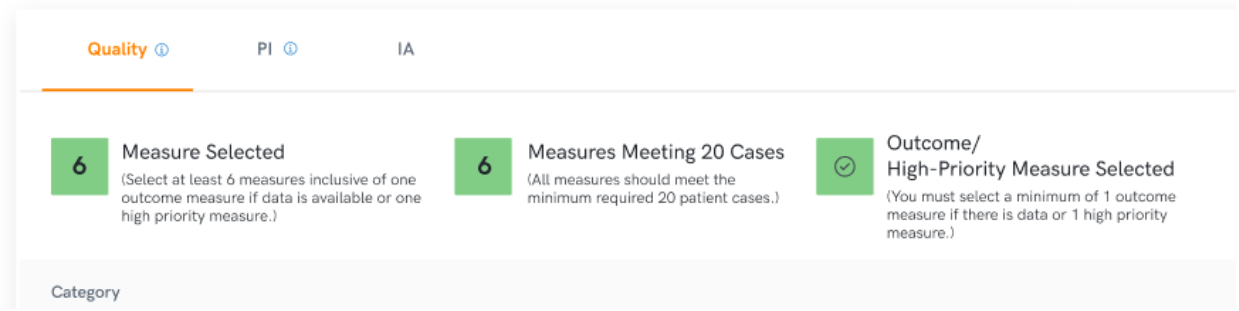
Quality Scoring

- Class 1, 2, and 4 measure scoring. Axon and IRIS do not have any Class 3 measures.
- MIPS Summary will score Quality Measures up to 30 possible points for the Quality category.
    - Green: 60.00-70
    - Blue: 45.00-59.00
    - Red: 44.99 and under
- Available once TIN, Eligibility, and Validations are entered.



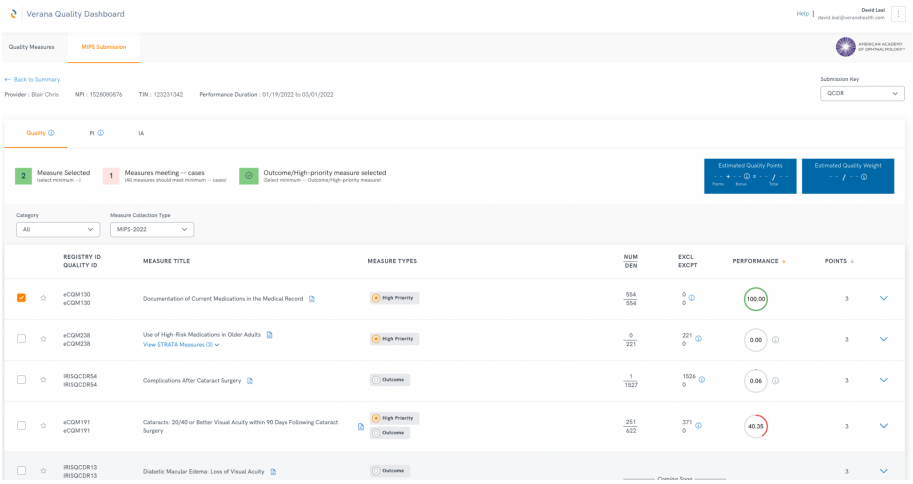
Measure Tracker

- Measure Selected: Provides measure count status.
- Measures Meeting 20 Cases: Provides case minimum status.
- Outcome/High-Priority Measure Selected: Provides Outcome/High-Priority measure status.



Measure Selection

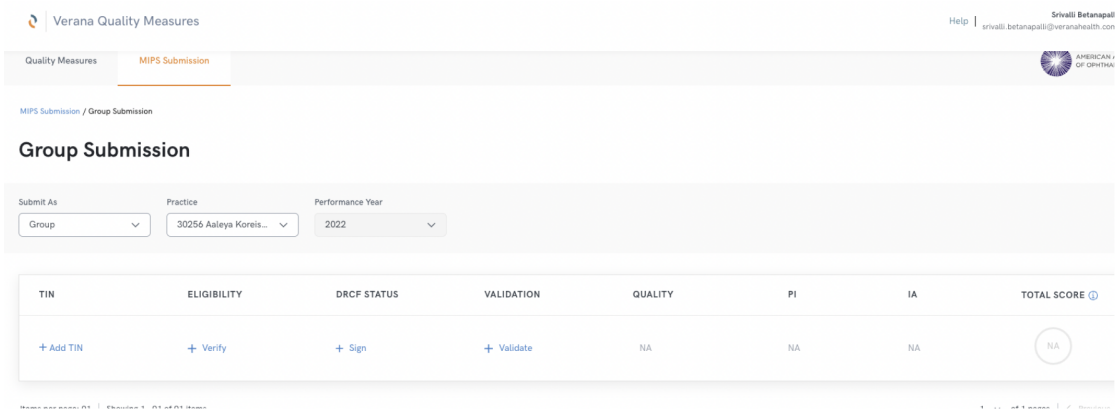
- Select Verified Measures from the Quality Dashboard.
- Score will take top 6 measures:
    - Small practices will receive 6 point bonus.
    - If more than six measures are selected, we will calculate top 6 measures with 1 being High Priority/Outcome.
- MIPS Quality Weight will be calculated in relation to score.



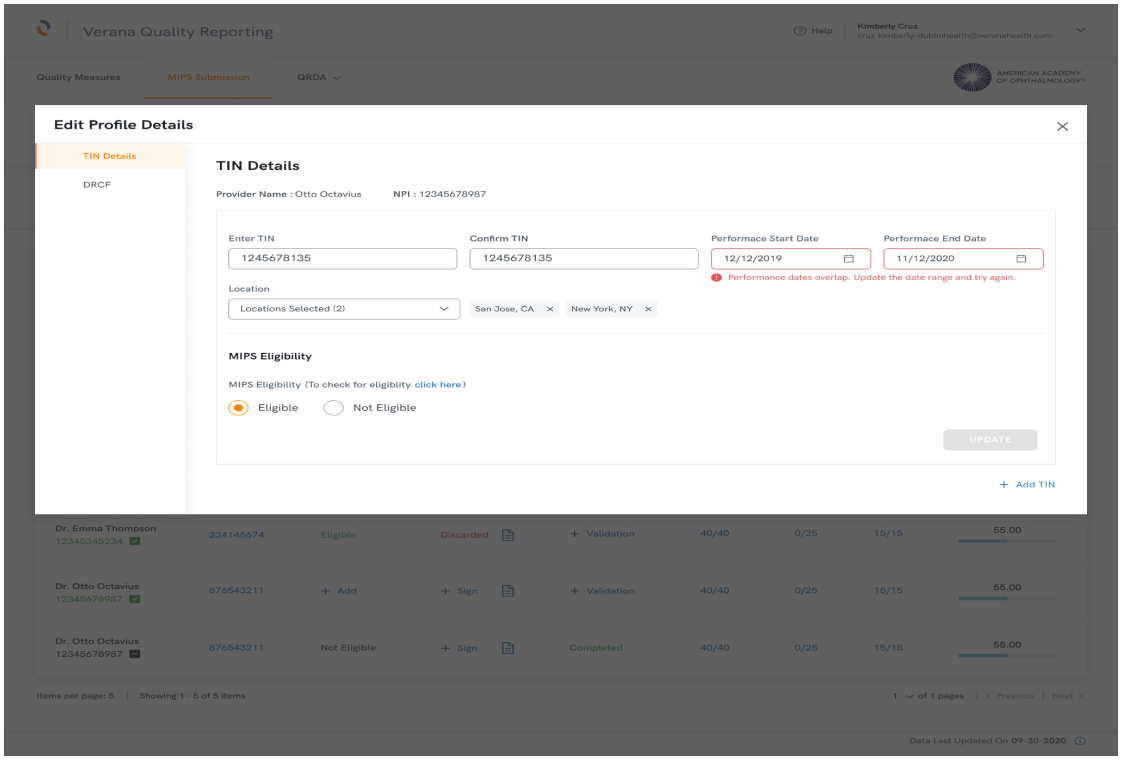
TIN Details

Key Features

- Adding TIN when one does not exist for Group Submission.



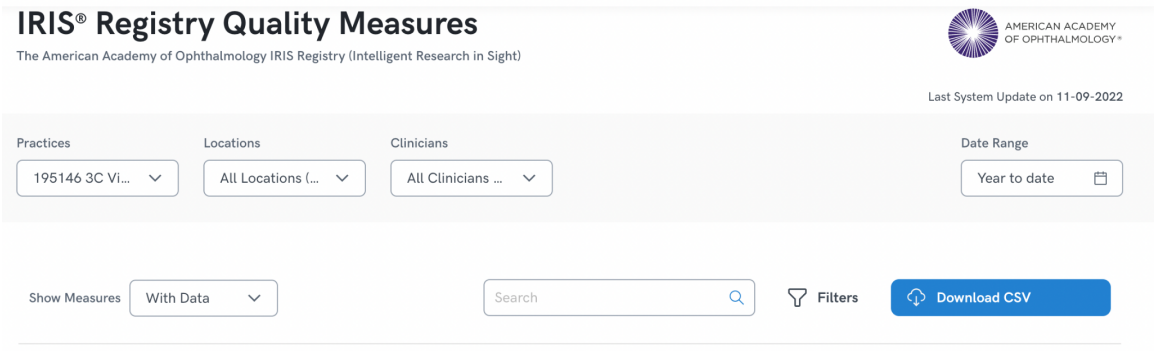
- More descriptive error messages specifying exact issue and next action for users.
- Location choice is optional.



Verana Quality Measures Dashboard Enhancements

Quality Measure Summary Download

- Export CSV based on your dashboard filtering.

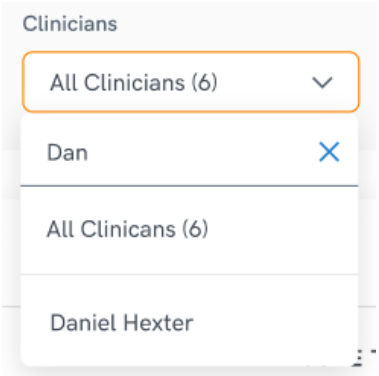


- Includes all measures in dashboard view.
- Contains all patient populations applicable to measure.
- No PHI contained in Export.

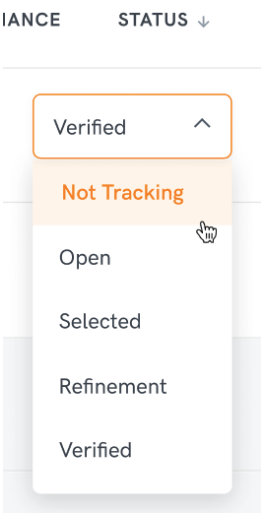
Date_Range_Type	Time_Frame(MMYYYY-MMYYYY)			
YEAR_TO_DATE	012022-122022			
Measure	Performance Rate	Status	Initial_Patient_Population	Denomina
Complications After Cataract Surgery	0	Selected	230	2
Documentation of Current Medications in the Medical Record	99.76	Refinement	2927	29
Use of High-Risk Medications in Older Adults	1.2	Refinement	1584	15
Diabetes: Eye Exam	98.33		478	4
Falls: Screening for Future Fall Risk	97.22		1584	15
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	95.21		235	2
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	93.33		111	1
Glaucoma: Intraocular Pressure Reduction	91.67		26	
Cataract Surgery: Difference Between Planned and Final Refraction	73.94		284	2
Closing the Referral Loop: Receipt of Specialist Report	65.22		23	
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	54.44		259	2
Endothelial Keratoplasty - Post-Operative Improvement in Best Corrected Visual Acuity to 20/40 or Better	38.46		14	
Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	12.75		251	2
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	8.5		153	1
Pneumococcal Vaccination Status for Older Adults	0		253	2
Preventive Care and Screening: Influenza Immunization	0		364	
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	0		356	3
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	100	Verified	74	

Additional Changes

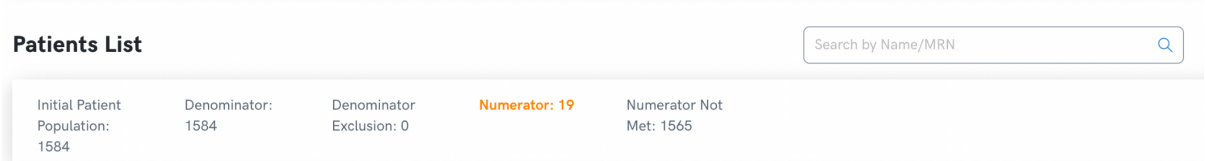
- Fixed sorting Patients List duplicating patients.
- Added Missing Registry ID in practice list.
- Added search for clinicians in the Clinician dropdown.



- Added **Not Tracking** to measure Status.



- Updated Patients List search to search within context of patient population.



September 2022

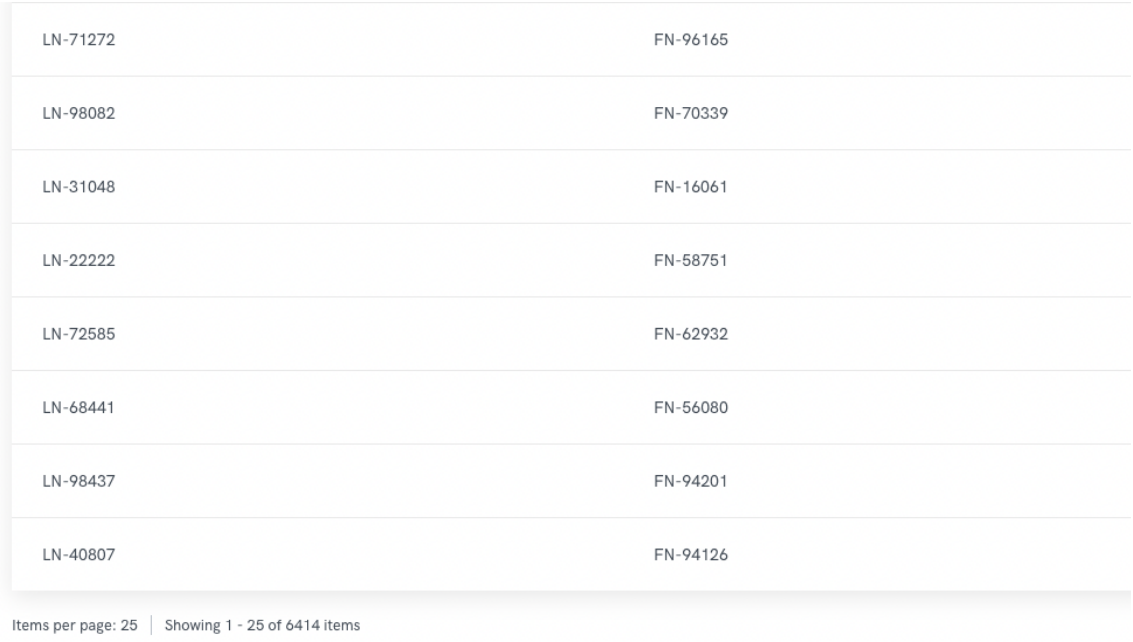
Key Updates

- Performance improvements to Measure Details screen
- MIPS Module
    - Promoting Interoperability (PI)
    - Improvement Activities (IA)
- Miscellaneous Verana Quality Measures Dashboard improvements

Performance Improvements

Key Updates:

- Implemented pagination on measure drill down
- Faster load times of patient lists for larger practices



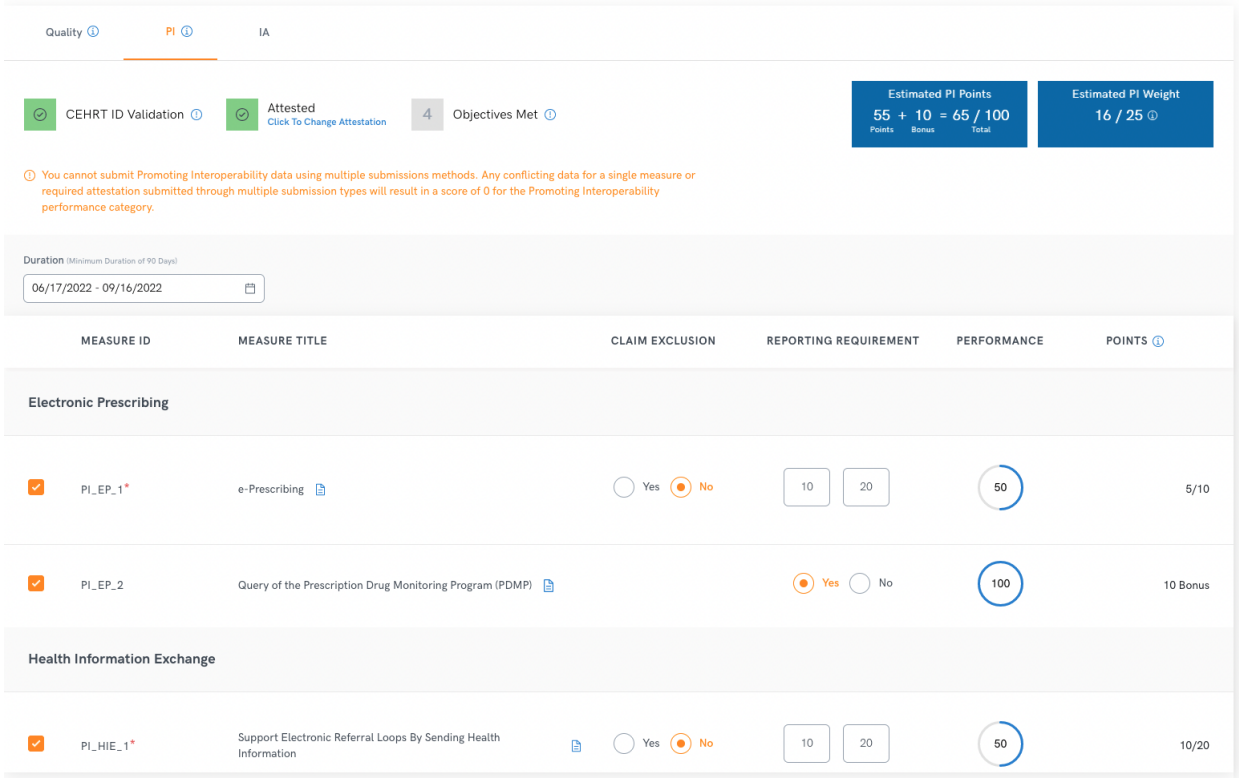
LN-71272	FN-96165
LN-98082	FN-70339
LN-31048	FN-16061
LN-22222	FN-58751
LN-72585	FN-62932
LN-68441	FN-56080
LN-98437	FN-94201
LN-40807	FN-94126

Items per page: 25 | Showing 1 - 25 of 6414 items

Promoting Interoperability

Key Features:

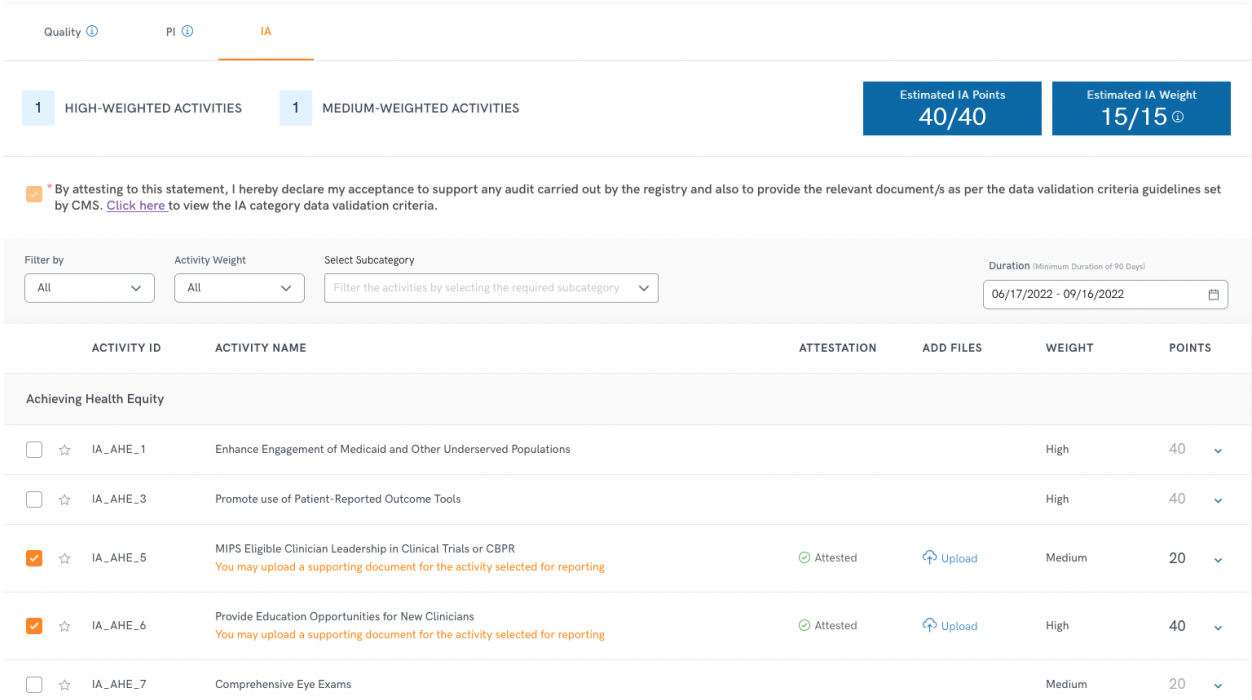
- Estimated scoring for PI
- Improved Exclusion and Reporting workflow for each measure
- Estimated PI Weight updated on Summary page



Improvement Activities

Key Features:

- Estimated scoring for IA
- Improved Attestation workflow for each measure
- Updated Registry Favorite lists
- Estimated Weight updated on Summary page



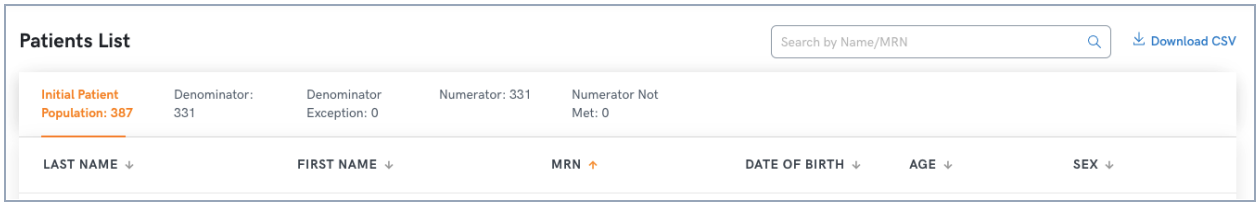
June 2022

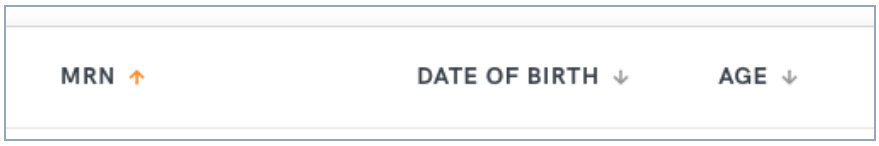
Measure Details Patient List Download

You can now download a patient list in the Measure Details screen by selecting the Download .CSV button. The patient list is downloaded in a .CSV format.

Measures Details Patient Table Enhancements

Date of Birth has been added to the patients list to streamline validation of quality performance measures data.

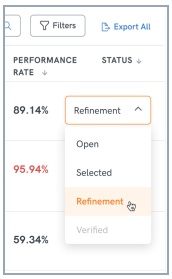




Measures Data Status Tagging

You may now track your quality performance measures data. Various tags will be available for use within your Verana Quality Measures Dashboard.

- "Open" means baseline data is available.
- "Selected" means the practice has selected the measure for review and validation.
- "Refinement" means the practice is actively mapping and refining data for that measure.
- "Verified" means the practice has signed off on the data quality and the measure is now ready for submission to CMS.



Verana Health

IRIS® Registry DRCF User Guide

January 2023

Table of Contents

Overview

This user guide provides IRIS Registry administrators, practice administrators, and clinicians information for completing the Data Release Consent Form (DRCF) using the Verana Quality Measures Dashboard.

Recommended Browsers

- Google Chrome™ browser/85.0.4158.0 and higher
- Safari®

Practice Support

Contact Verana Health Practice Experience at datalink@veranahealth.com or call 877-353-0304 for help with your dashboard, including issues with logging in.

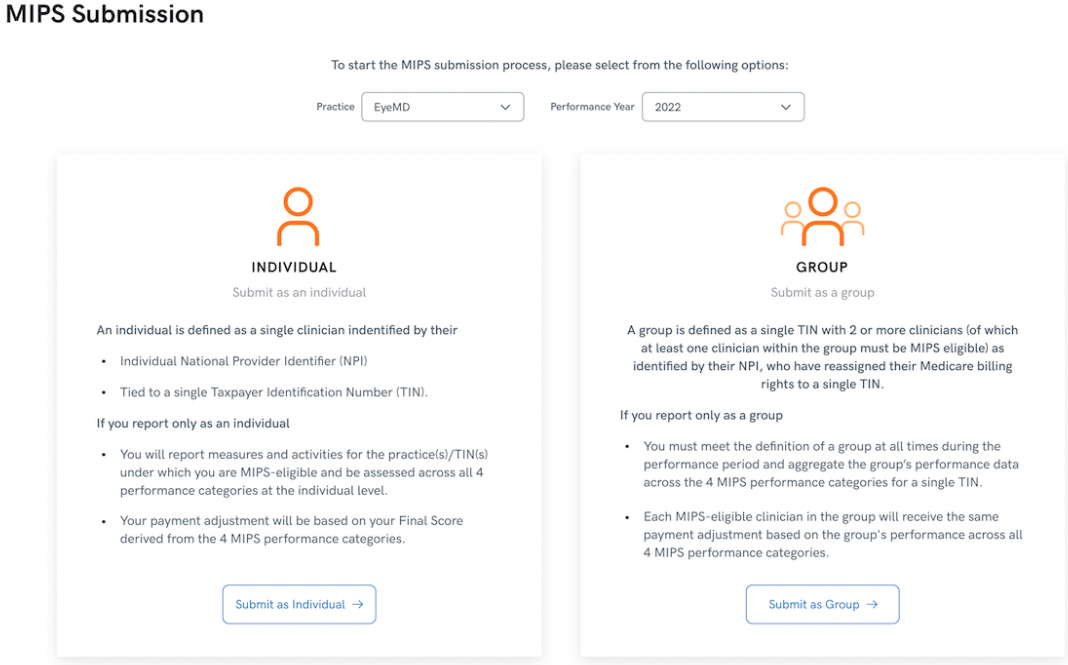
DRCF Completion Instructions

Access your Verana Quality Measures Dashboard MIPS Submission

To complete the Data Release Consent Form, you will need to log in to the Verana Quality Measures Dashboard and complete the following steps:

1. Select **MIPS Submission Tab** at the top of your Verana Quality Measures Dashboard.

2. Verify your practice name and performance year are correct, and then select if you are reporting as an **Individual** or **Group**.

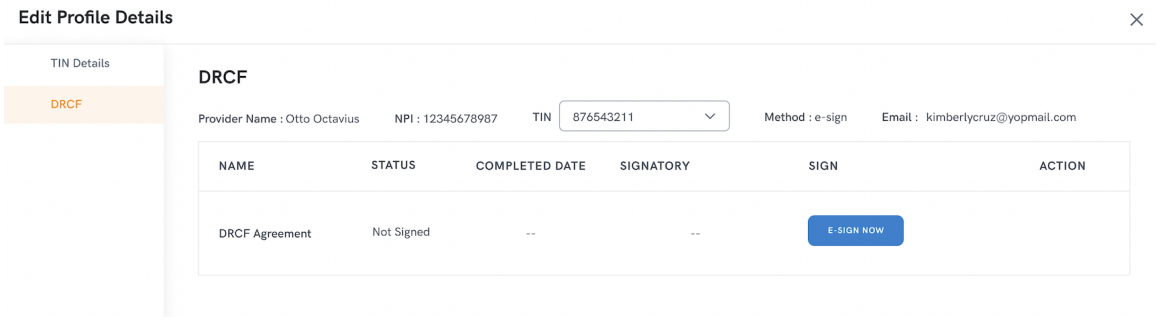


Individual Reporting

To complete the DRCF as an individual, follow these steps:

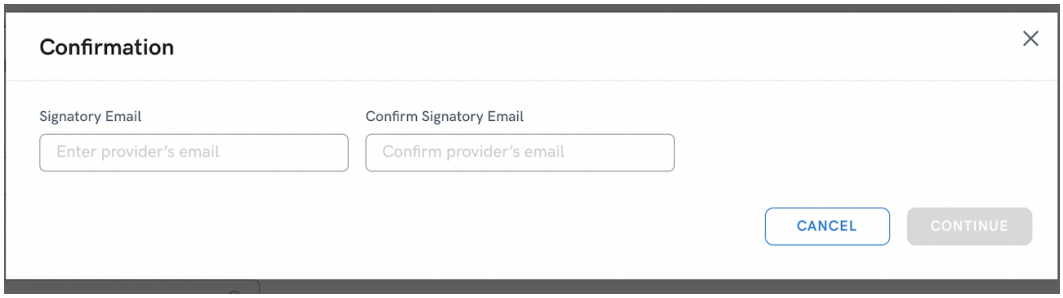
1. From the **Status** column, select **+ Sign**.
2. From the **TIN** dropdown menu, select the correct TIN for your practice.

   The **Provider Name** and **NPI** will be pre-populated.



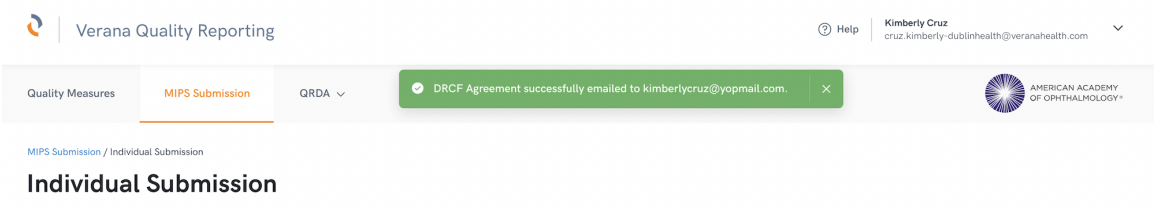
3. Click **E-Sign Now**.
4. In the **Signatory Email** field enter the email of the person responsible for signing and then re-enter the email address in the **Confirm Signatory Email** field to confirm this is the correct email to send the DocuSign DRCF.

   Note: This should be the clinician you are reporting.



5. Click **Continue**, after review and any necessary updates.

6. A banner will appear that shows the DRCF Agreement was successfully sent to the email address that you confirmed in step 4.



7. The **DRCF Status** shows as **Pending** until the document is signed.

NAME & NPI	TIN	ELIGIBILITY	DRCF STATUS
Otto Octavius 12345678987	876543211	Eligible	Pending

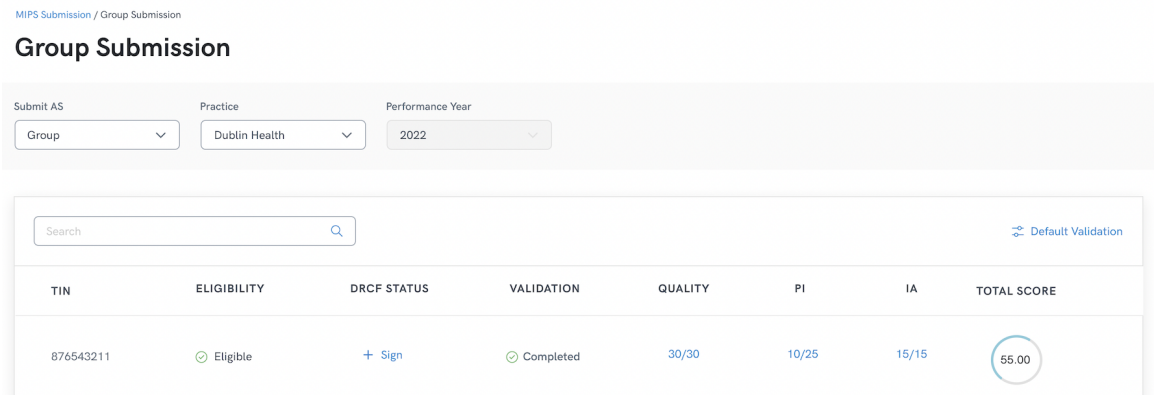
8. The **DRCF Status** shows as **Signed** after the document is signed.

NAME & NPI	TIN	ELIGIBILITY	DRCF STATUS
Otto Octavius 12345678987	876543211	Eligible	Signed

Group Reporting

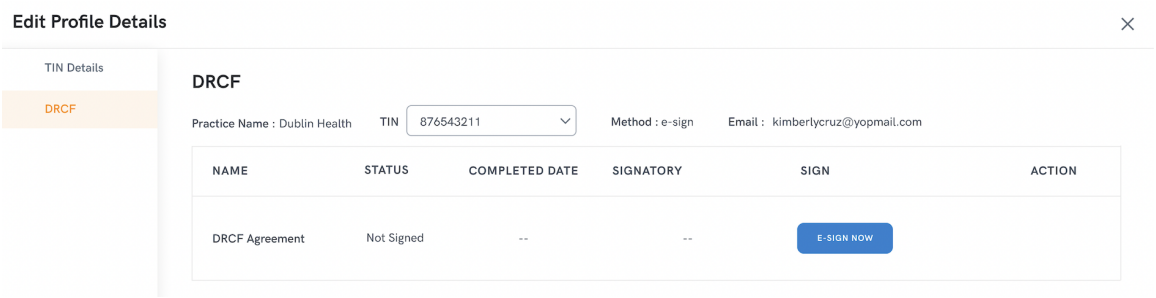
To complete the DRCF as a group, follow these steps:

1. From the **DRCF Status** column, select **+ Sign**.



2. From the **TIN** dropdown menu, select the correct TIN for your practice.

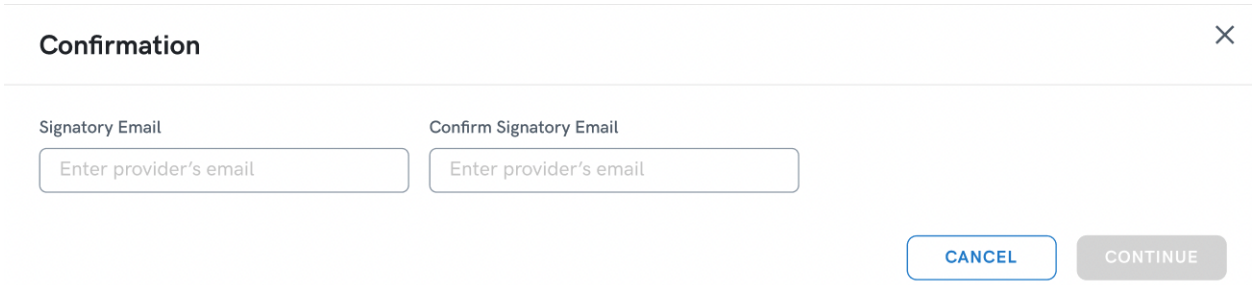
   The **Practice Name** will be pre-populated.



3. Click **E-Sign Now**.

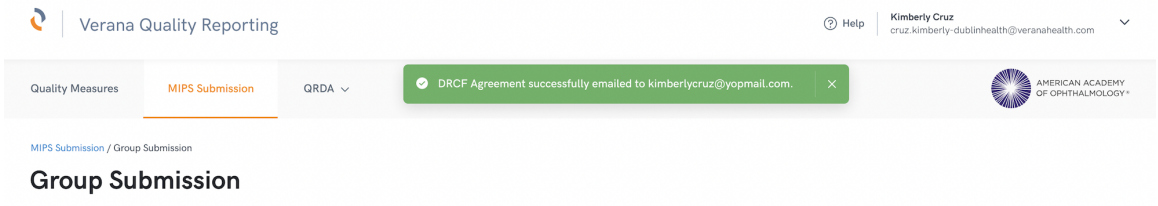
4. In the **Signatory Email** field enter the email address you wish to send the DocuSign DRCF, then re-enter the email address from the **Confirm Signatory Email** field to confirm this is the correct email to send the DocuSign DRCF.

   Note: This should be an authorized signer for the practice.

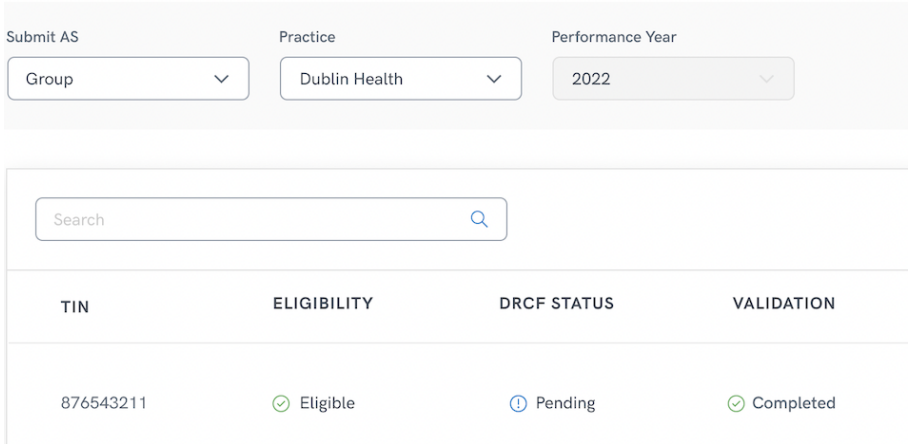


5. Click **Continue**, after review and any necessary updates.

6. A banner will appear that shows the DRCF Agreement was successfully sent to the email address that you confirmed in step 4.



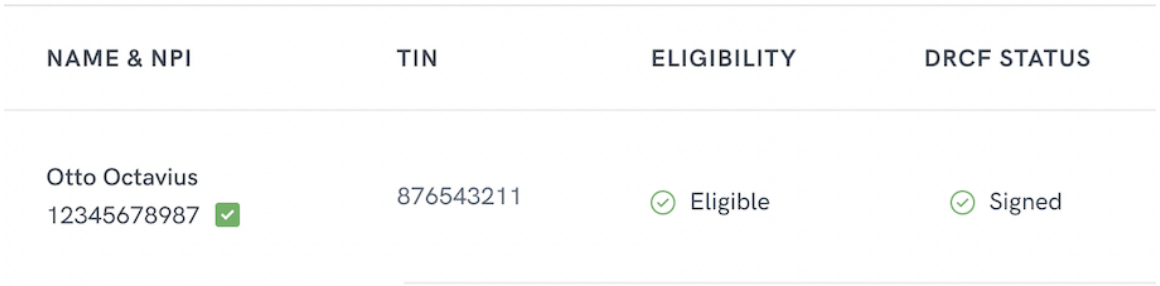
7. The **DRCF Status** shows as **Pending** and will change to **Signed** after the document is signed.



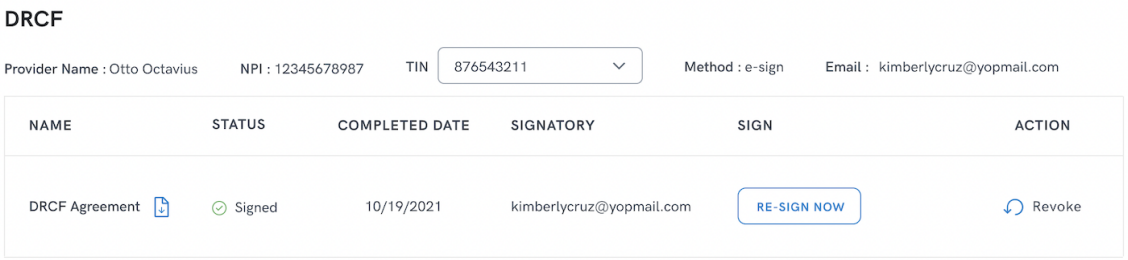
Re-signing DRCF

To re-sign the DRCF, follow these steps:

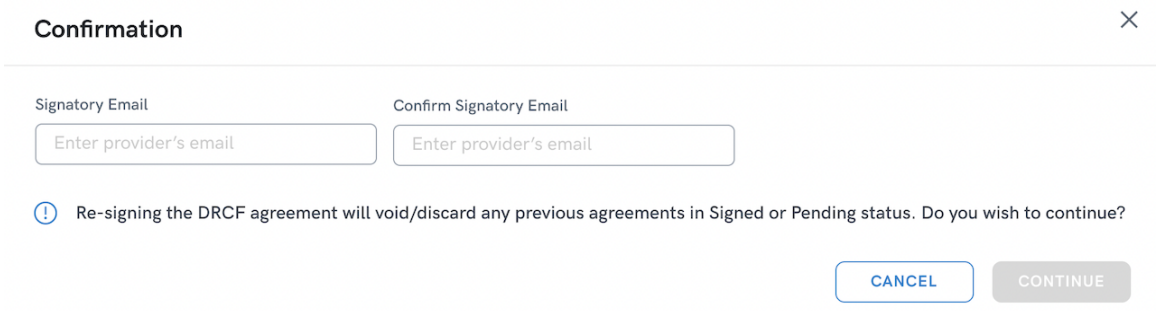
1. From the **DRCF Status** column, select **Signed**.



2. From the **Sign** column, select **Re-Sign Now**.

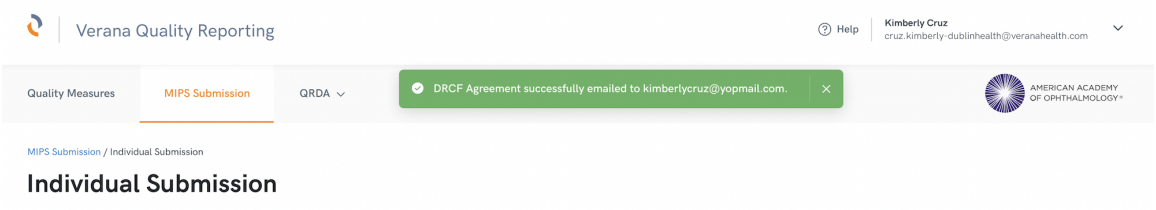


3. In the **Confirm Signatory Email** field, re-enter the email address from the **Signatory Email** field to confirm.



4. Click **Continue**, after review and any necessary updates.

5. A banner will appear that shows the DRCF Agreement was successfully sent to the email address that you confirmed in step 3.



6. The **DRCF Status** shows as **Pending** until the document is signed.

NAME & NPI	TIN	ELIGIBILITY	DRCF STATUS
Otto Octavius 12345678987	876543211	Eligible	Pending

7. The **DRCF Status** shows as **Signed** after the document is signed.

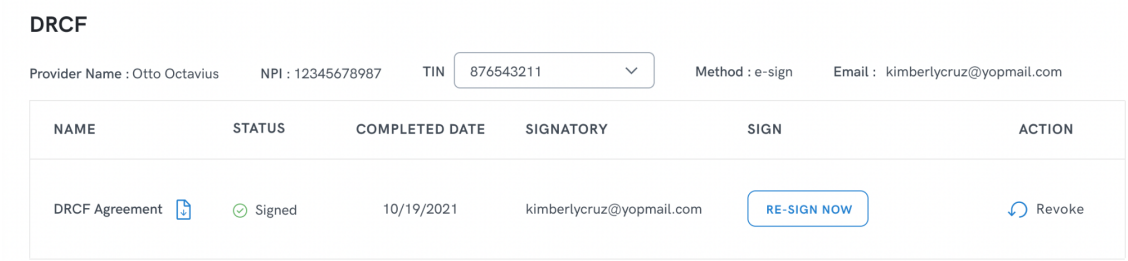
NAME & NPI	TIN	ELIGIBILITY	DRCF STATUS
Otto Octavius 12345678987	876543211	Eligible	Signed

Revoking DRCF

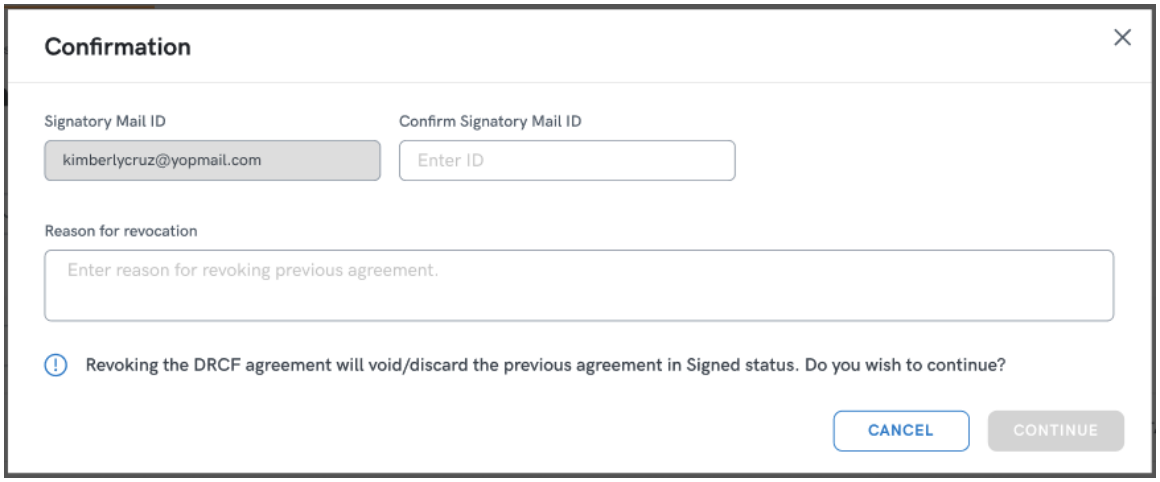
If you have previously signed the DRCF and make a decision not to report your data through IRIS Registry, you will need to revoke your signed DRCF.

To revoke your signed DRCF, follow these steps:

1. From the **Action** column, select **Revoke**.



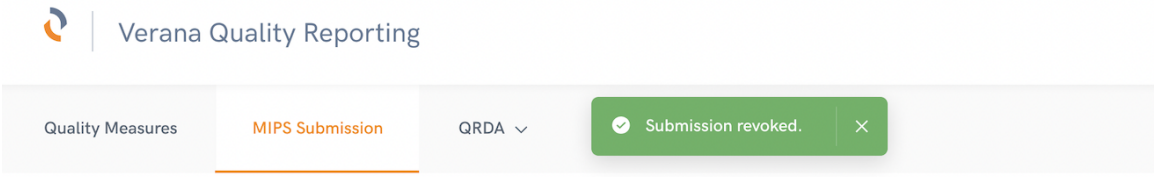
2. In the **Confirm Signatory Mail ID** field, re-enter the email address from the **Signatory Mail ID** field to confirm.



3. In the **Reason for revocation** field, enter the revocation reason.

4. Click **Continue**, after review and any necessary updates.

5. A banner will appear that shows the DRCF submission has been revoked.

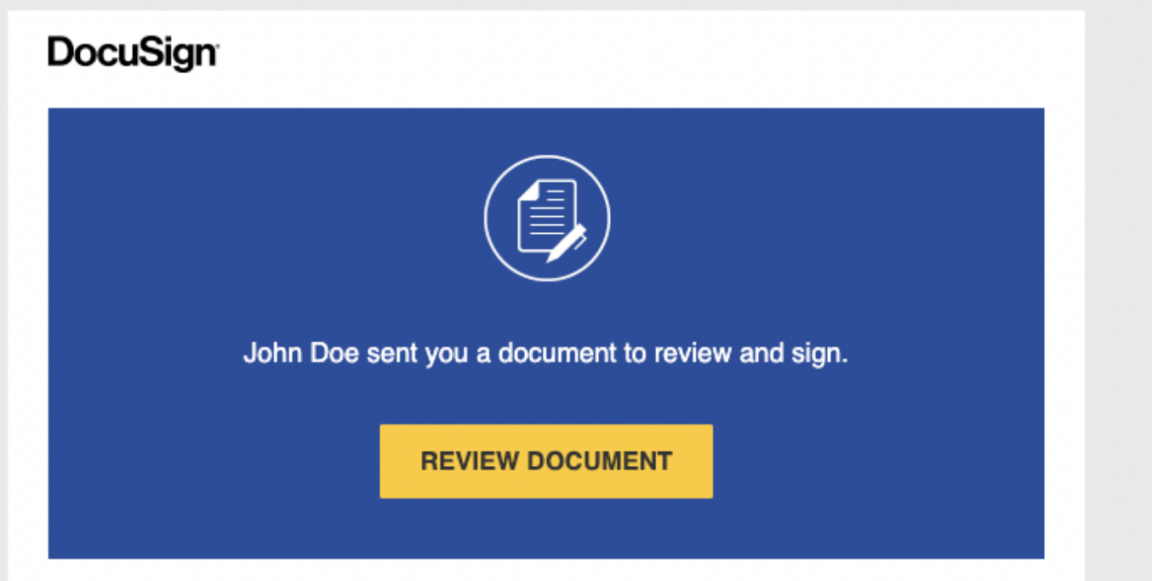


6. The **DRCF Status** now shows as **Revoked**.

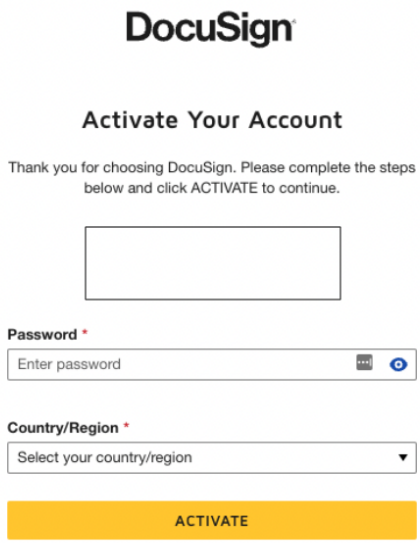
Completing DocuSign

To complete the DocuSign for the Data Release Consent Form, you will need to access the DRCF Agreement email from your email inbox, and complete the following steps:

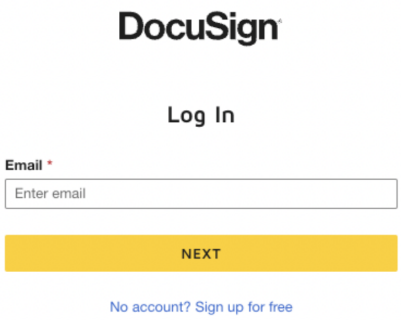
1. Select **Review Document**.



2. Activate Your Account.
    a. Enter a password.
    b. Select your **Country/Region** from the dropdown menu.
    c. Click **Activate**.



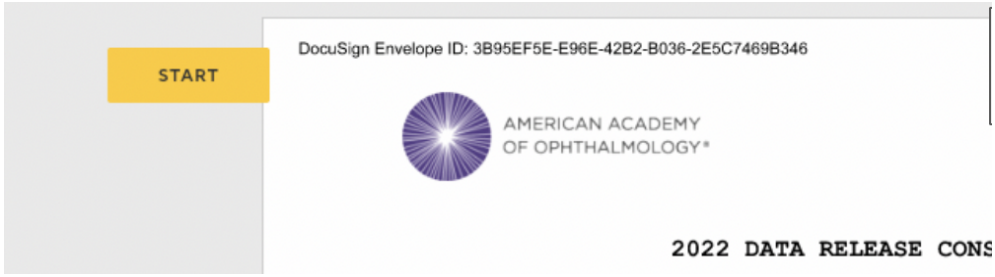
3. Log In.
    a. Enter your email address.
    b. Click **Next.**



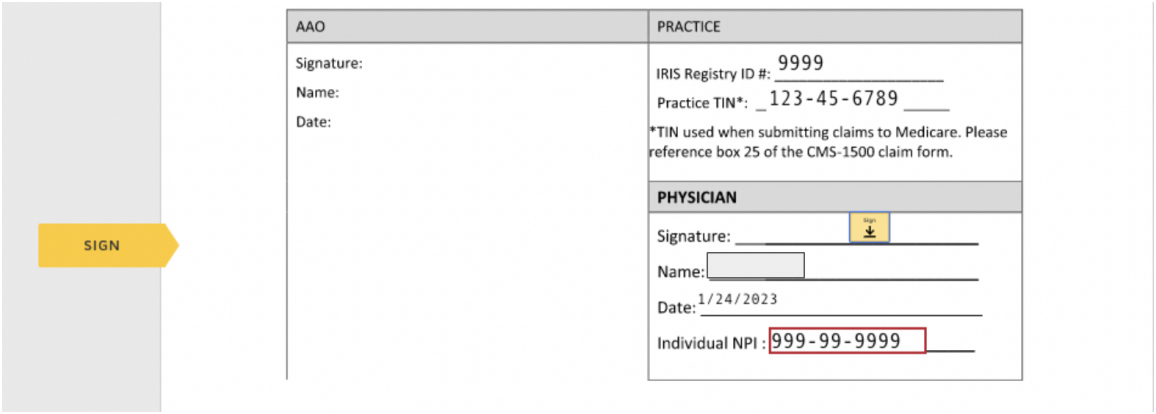
4. Mark the checkbox on the left to agree to the use of electronic records and signatures.

5. Click **Continue**.

6. Click **Start**.

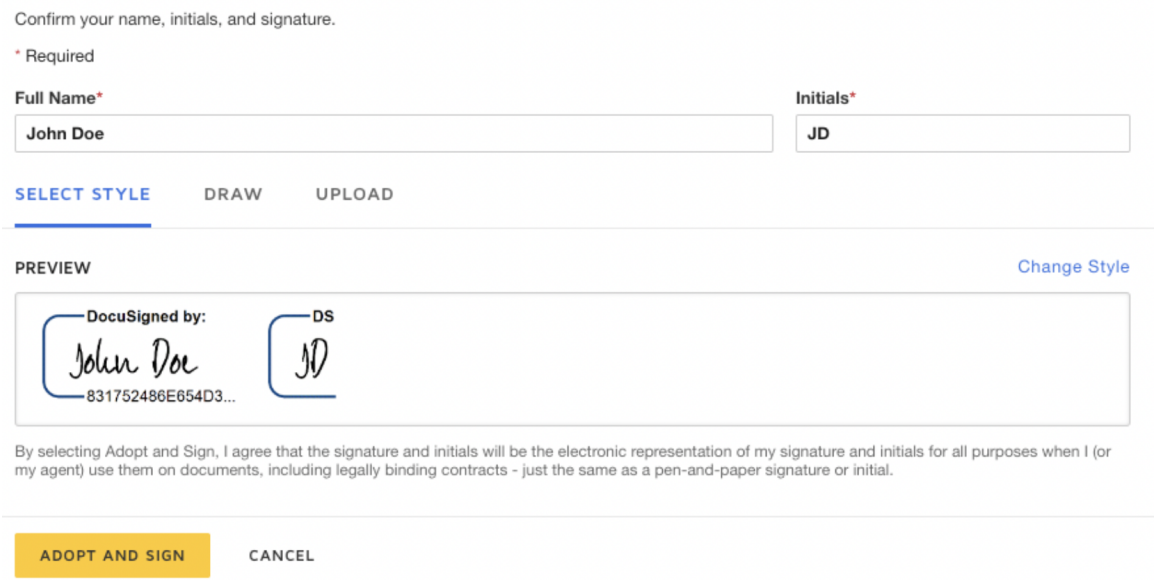


7. Click **Sign**.



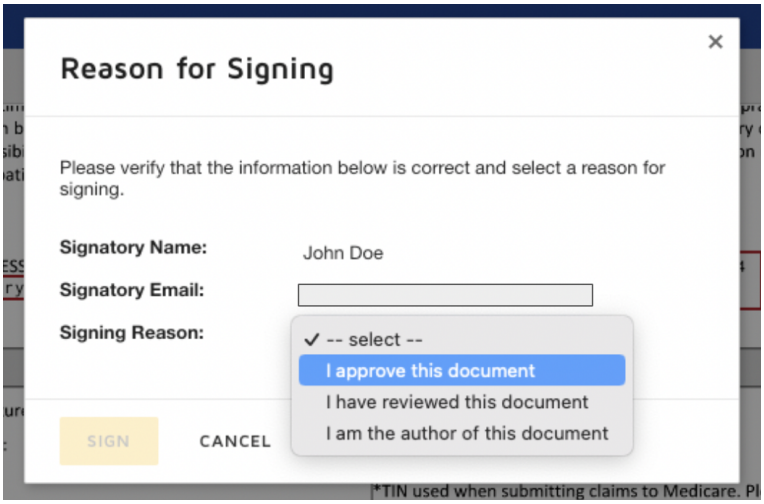
8. Review the signature for accuracy. If the **Full Name** field and/or **Initials** field needs to be updated, backspace to remove and then type the correct name and initials.

   Note:
   - Individual Submission - should be the clinician's signature.
   - Group Submission - should be the person authorized to sign for the practice.

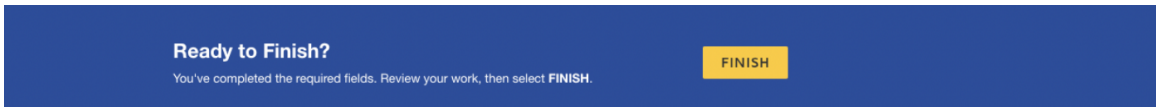


9. Click **Adopt and Sign**.

10. Reason for Signing.
    a. Select **I approve this document** from the **Signing Reason** dropdown menu.
    b. Click **Sign**.



11. Click **Finish** to complete the document.



12. Complete the Authentication.
    a. Click **Next**, and then review details of the DocuSign.
    b. Click **X** to close the document.

Verana Health

IRIS Registry

MIPS Submission Module User Guide v1.0

MIPS 2023

Table of Contents

MIPS Submission Module Introduction

This user guide provides practice administrators and clinicians step-by-step instructions to report 2022 Merit-based Incentive Payment System (MIPS) Individual or Group Submissions using the MIPS Submission module in the Verana Quality Measures Dashboard.

The MIPS Submission module includes reporting for 3 of the 4 MIPS performance categories:

- Quality
- Promoting Interoperability (PI)
- Improvement Activity (IA)

The MIPS Submission module does not include reporting for the Cost performance category.

Recommended Browsers

- Google Chrome™ browser/85.0.4158.0 and higher
- Safari®

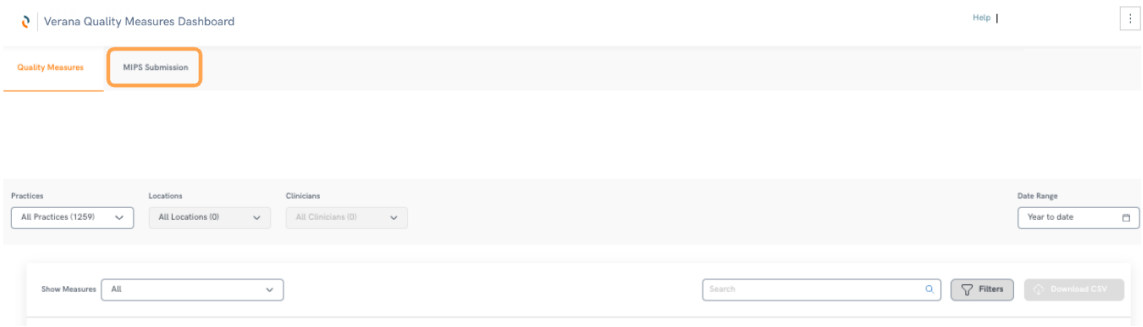
Practice Support

Contact Verana Health Practice Experience at datalink@veranahealth.com or call 877-353-0304 for help with your dashboard, including issues with logging in.

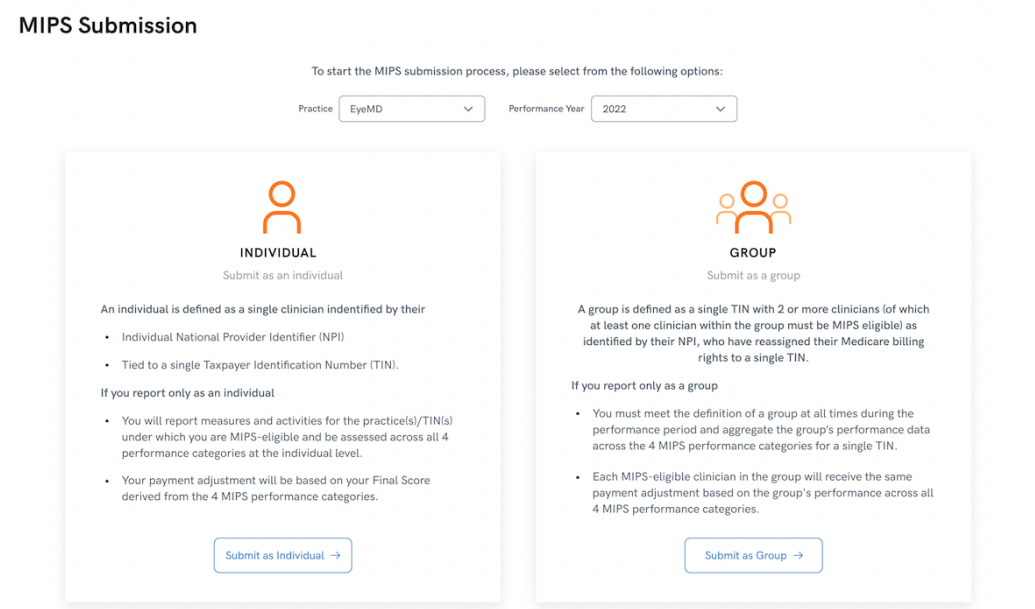
Access Your MIPS Submission Module

To begin the MIPS Submission process, you will need to log in to the Verana Quality Measures Dashboard, and complete the following steps:

1. Select the **MIPS Submission** tab at the top of your Verana Quality Measures Dashboard.



2. On the **MIPS Submission** page, select the following:
    a. Your **Practice Name** from the dropdown menu.
    b. Your **Performance Year** (January 1 - December 31).
    c. If you are reporting as an **Individual** or **Group**.



Individual Submission

To determine if you should submit an individual submission, follow these guidelines:

- An individual is defined as a single clinician identified by their:
    - Individual National Provider Identifier (NPI).
    - Tied to a single Taxpayer Identification Number (TIN).
- If you report only as an individual:
    - You will report measures and activities for the practice(s)/TIN(s) under which you are MIPS-eligible and be assessed across all 4 performance categories at the individual level.
    - Your payment adjustment will be based on your Final Score derived from the 4 MIPS performance categories.

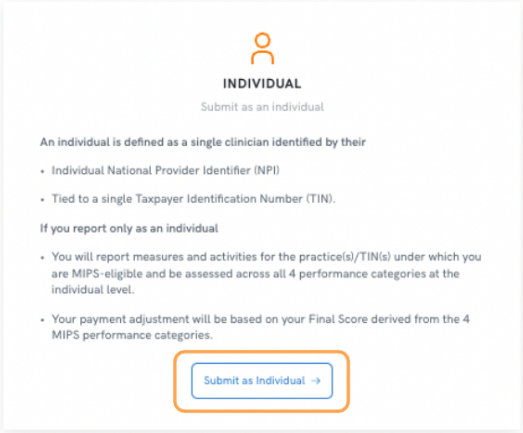
      Note: The **MIPS Submission** module includes 3 of the 4 MIPS performance categories (Quality, PI, and IA) and does not include the Cost category.

Completing the Individual MIPS Submission: Quick Start

This section provides a high-level overview of the Individual MIPS Submission process. For in-depth instructions, click on the underlined hyperlinks in each step.

To complete the MIPS Submission as an individual, follow these steps:

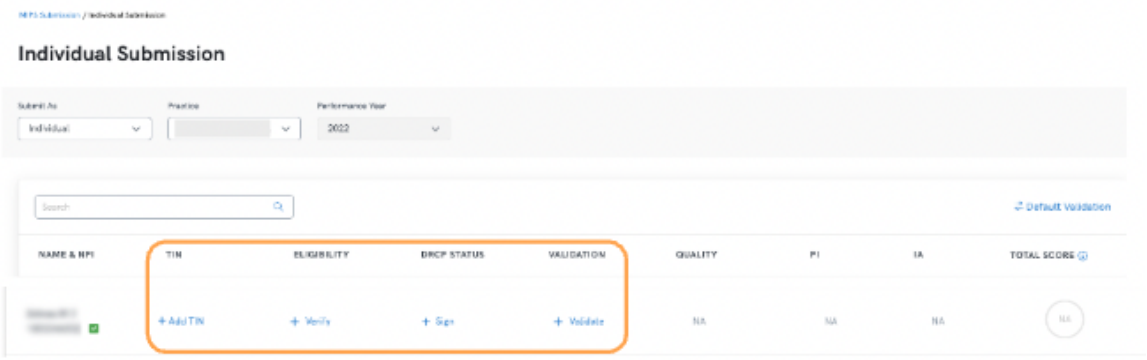
1. On the **MIPS Submission** page, select **Submit as Individual** to open the MIPS Individual Submission module.



2. On the **MIPS Individual Submission** module, complete each of the following **Prerequisite Categories** before accessing the Quality, PI, and IA performance categories:

   Note: Click on each category below for additional processing instructions.

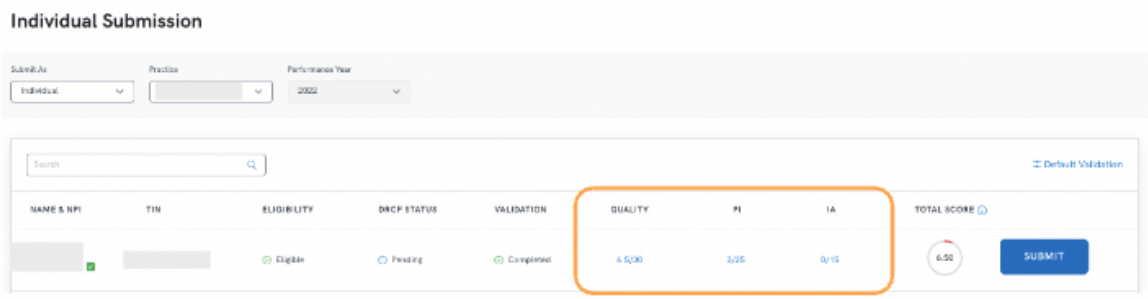
   - Name & NPI
   - TIN
   - Eligibility
   - DRCF Status
   - Validation



3. Complete each of the following **Performance Categories**:

   Note: Click on each category below for additional processing instructions.

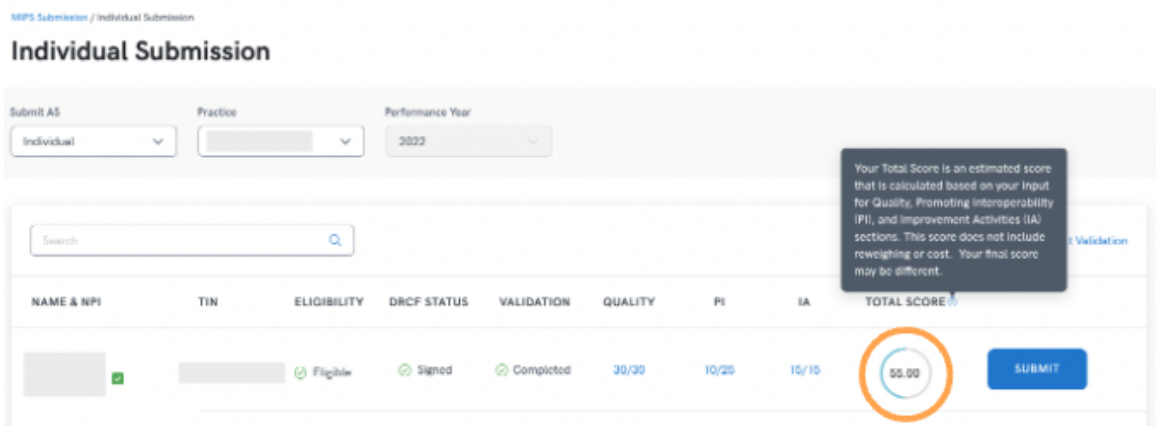
   - Quality
   - PI (Promoting Interoperability)
   - IA (Improvement Activity)



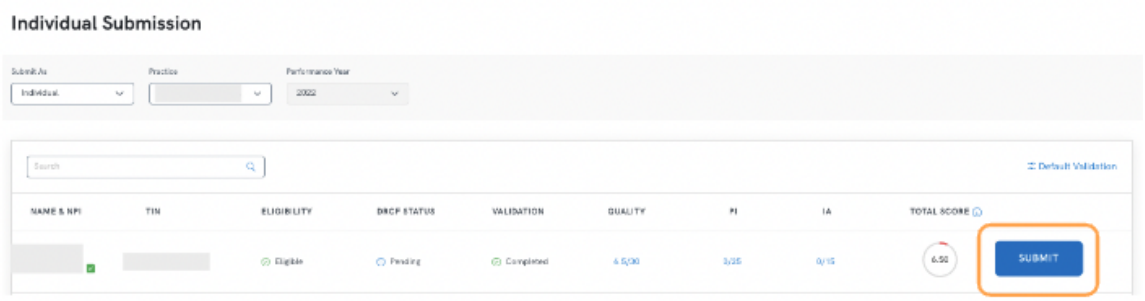
4. Review reporting information and Total Score.

   The **MIPS Individual Submission** module will display the total estimated score of all categories with entered data. If you are satisfied with the points you received in each performance category and the **Total Score**, you are ready to submit your reporting.

   Note: If you want to see if you can increase your score(s) you can go back to your performance categories and change your measures/activities selections.



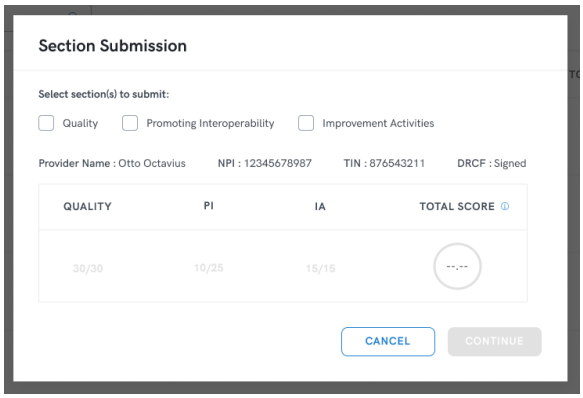
5. Click Submit.



6. Complete Section Submission.

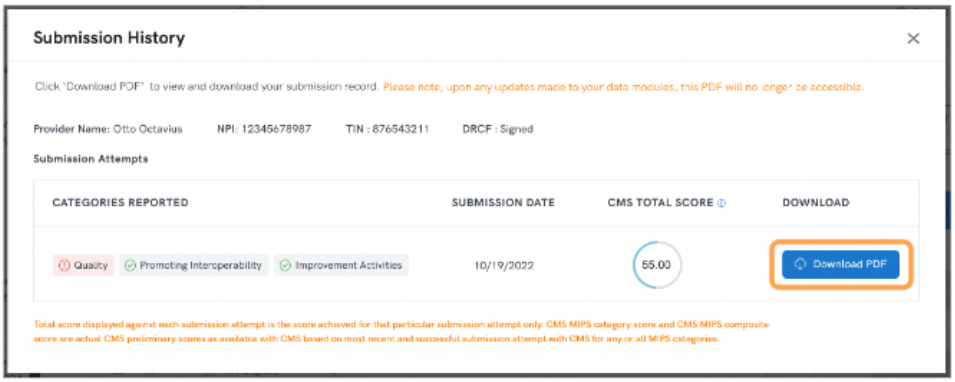
   In this section, you will choose the performance categories that you want to report to CMS. Each category that you choose populates based on the measures/activities that you selected to report in your data modules. The **Total Score** updates as you make your selections.

   Note: You can choose to report all 3 performance measures, or just 1 or 2.

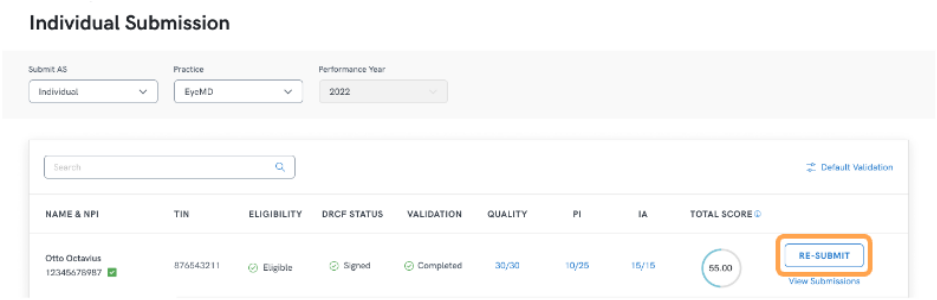


7. Click Download PDF in the **Submission History** section to view and download your **MIPS Submission Record**.

   Note: It is important that you download your submission right away. This **MIPS Submission Record** will be unavailable to view/download if you make any changes to your data modules after submission.



8. [Optional] Click **RE-SUBMIT** on the **Individual Submission Summary** page, if you choose to discard your submission and update your measures/activities selections for any of the performance categories. You will follow the same process for submitting your reporting and will complete steps 6 and 7.



Prerequisite Categories

Name & NPI

The clinician name and NPI are pre-populated. Contact your Practice Experience Manager (PEM) to make adjustments if either of these are incorrect.

TIN (Tax Identification Number)

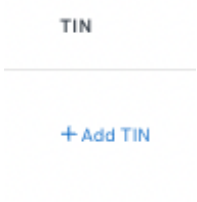
You will add the TIN information for this category. This is required for MIPS submission. You also have the option to add additional TINs if necessary.

Adding TIN information

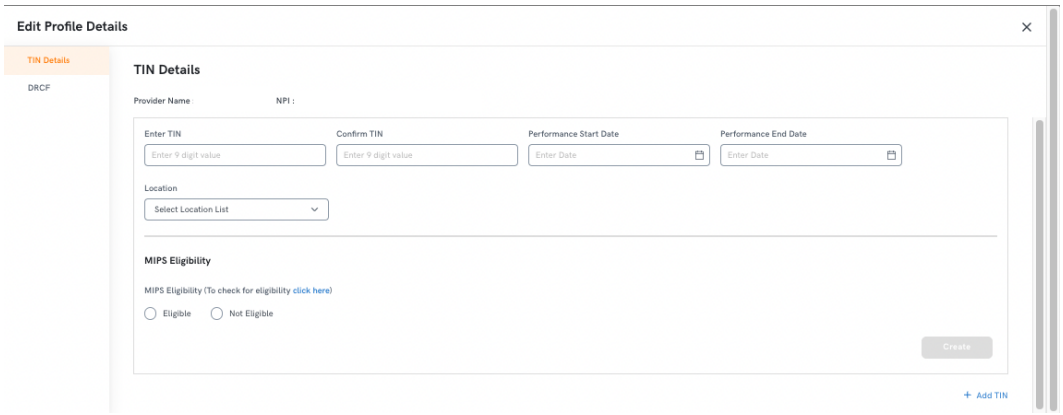
To enter the clinician TIN, follow these steps:

Note: TIN should be the information submitted for CMS 1500 Claims form.

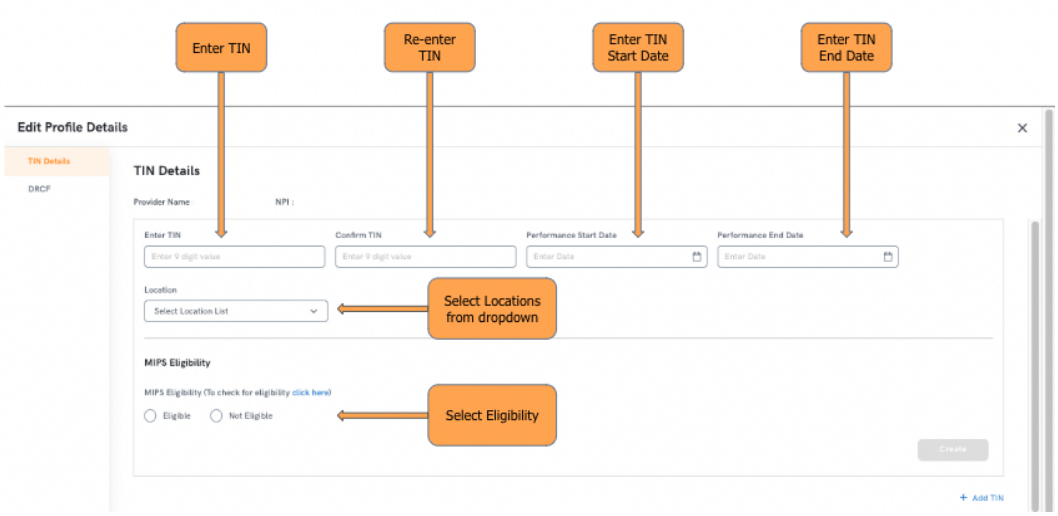
1. In the **TIN** column, select **+ Add TIN** to enter the clinician TIN.



2. The **Edit Profile Details**, **TIN Details** tab opens.



3. In the **Enter TIN** field, enter the *clinician TIN*.



4. In the **Confirm TIN** field, re-enter the *clinician TIN*.
5. In the **Performance Start Date**, select the *TIN start date*.
6. In the **Performance End Date**, select the *TIN end date*.
7. In the **Location**, select the location from the dropdown menu.
8. In **MIPS Eligibility**, select **Eligible** or **Not Eligible**.

   Note: Use the click here link to verify your MIPS eligibility for the TIN on the CMS website.

9. Click **Create**, and a banner will appear at the top of the screen that verifies you successfully added the TIN.
10. After you complete this section, go to the next category. If you need to add additional TINs, remain on the **TIN Details** tab, and follow the instructions for Adding Additional TINs.

Adding Additional TINs (Optional)

To add additional TINs, follow these guidelines:

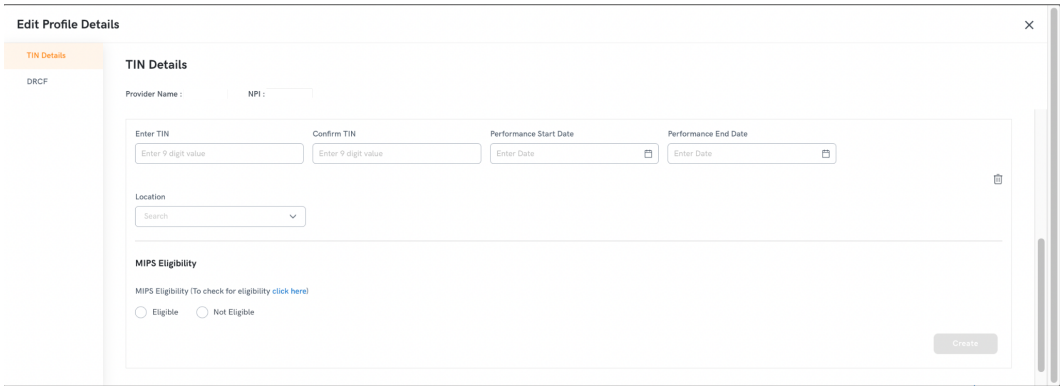
- Allowed options include the following scenarios:
    - Different TINs,
    - Different Locations, and
    - Same Duration.

  or
    - Different TINs,
    - Same Locations, and
    - Different Durations.

- Not allowed option includes the following scenario:
    - Same TINs,
    - Different Locations, and
    - Different Duration.

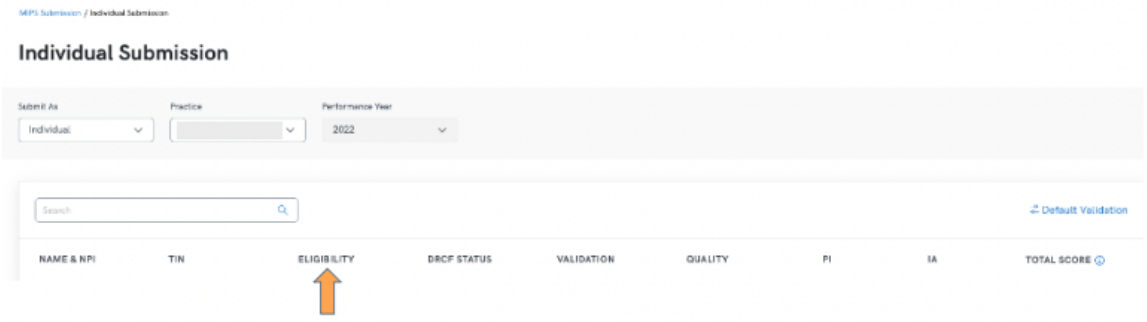
To add additional TINs, follow these steps:

1. In the same **TIN Details** tab, click **+ Add TIN**.
2. A new **TIN Details** section appears on the same page below the first entry.
3. Complete the steps in the previous section, Adding TIN Information.

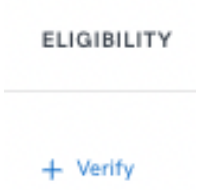


Eligibility

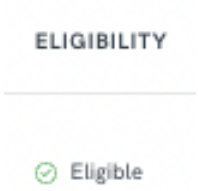
The **Eligibility** field is the next category. This is a required field for MIPS submission.



- The **Eligibility** field initially shows **+ Verify**.



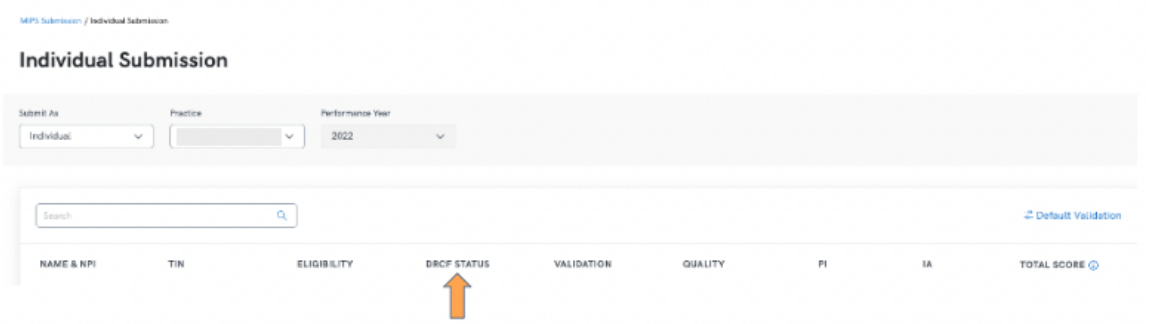
- It changes to **Eligible** after you complete the TIN category.



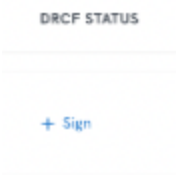
DRCF

You will complete the DRCF (Data Release Consent Form) signing process for this category. The DRCF is an agreement between the registry and clinicians, wherein the clinicians grant permission to the registry to transmit data to CMS on their behalf.

To complete the DRCF for an individual submission, follow these steps:



1. In the **DRCF Status** column, select **+ Sign**. This opens the DRCF tab in the **Edit Profile Details** dialog.



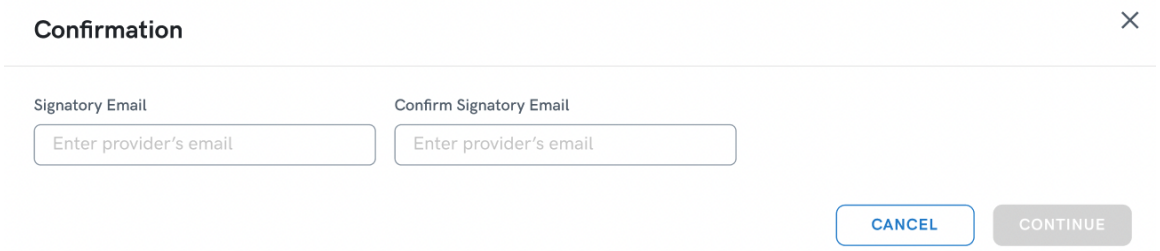
2. From the **TIN** dropdown menu, select the *correct TIN for your practice*.

   Note: The **Provider Name** and **NPI** will be pre-populated.

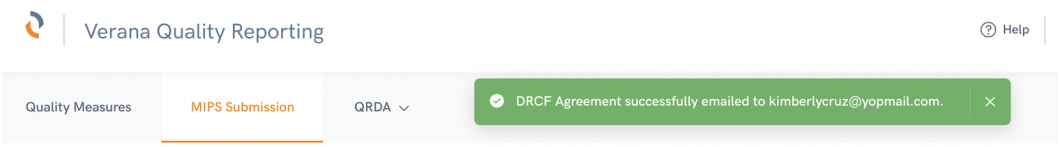
3. Click **E-Sign Now** to receive an email notification to electronically sign the agreement.

4. In the **Signatory Email** field, enter the email address to send the DocuSign DRCF, and then re-enter the email address in the **Confirm Signatory Email** field.

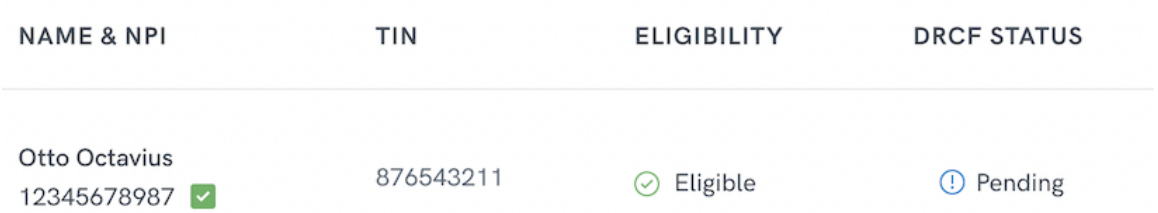
Note: This should be the clinician you are reporting.



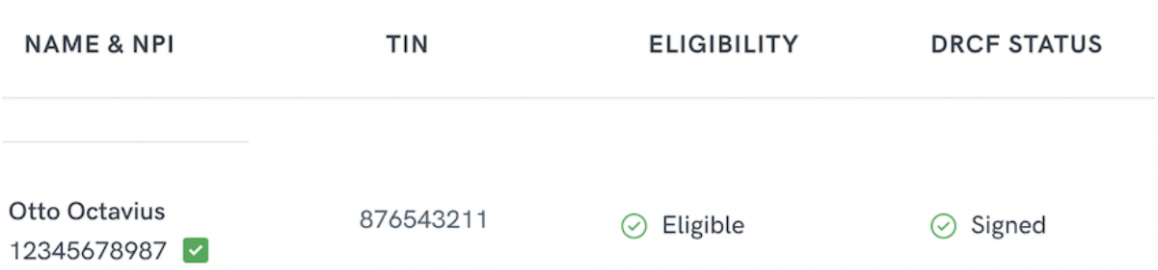
5. Click **Continue**, and a banner will appear at the top of the screen, "DRCF Agreement successfully emailed to *ConfirmedEmailAddress@email.com*."



6. The **DRCF Status** shows as **Pending** until the document is signed.



7. The **DRCF Status** shows as **Signed** after the document is signed.



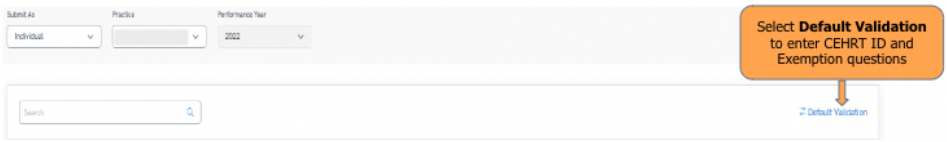
Default Validation

You will enter CEHRT Details and complete Exemption questions in this category. CMS mandates the use of 2015 CEHRT for reporting to MIPS 2022.

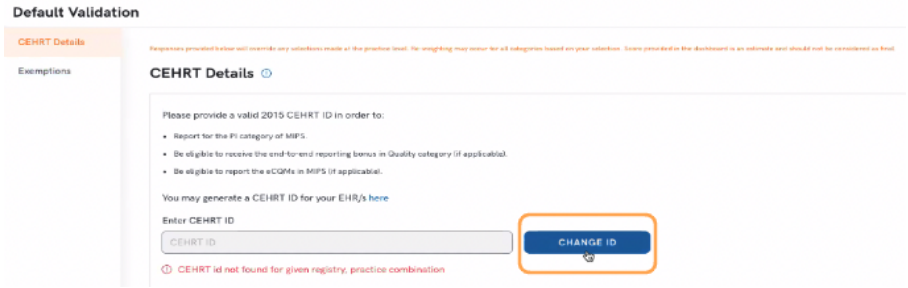
Adding CEHRT Details

To add CEHRT Details, follow these steps:

1. Select **Default Validation**.

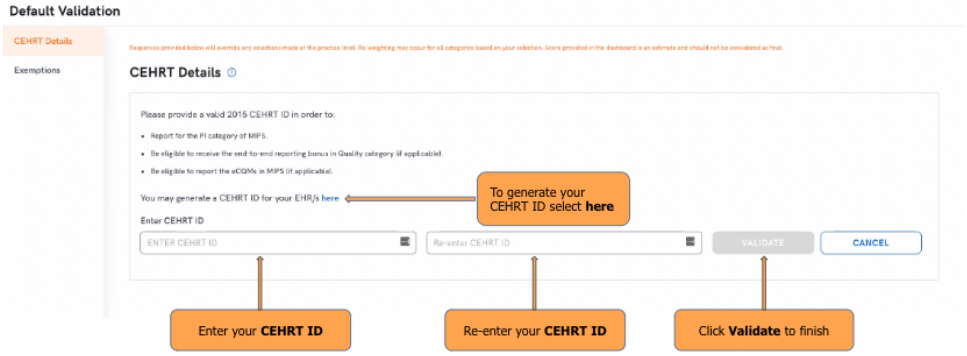


2. The **Default Validation** dialog, **CEHRT Details** tab opens.



3. Select **Change ID**.
4. In the **Enter CEHRT ID** field, enter your *CEHRT ID*.

   Note: Click the **here** link above the **Enter CEHRT ID** fields to generate your CEHRT ID.



5. Re-enter your **CEHRT ID** in the next field.
6. Click **Validate**.

Completing the Exemptions Questionnaire

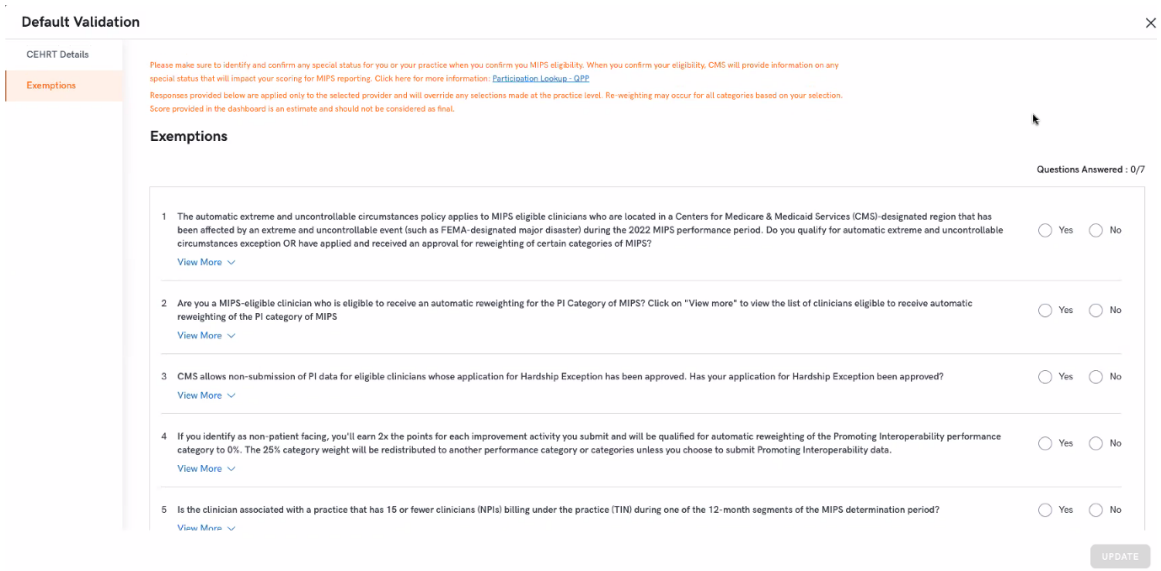
The questionnaire contains questions that are relevant to your MIPS reporting. Please make sure to identify and confirm any special status for you or your practice when you confirm your MIPS eligibility. When you confirm your eligibility, CMS will provide information on any special status that will impact your scoring for MIPS reporting. Click here for more information: Participation Lookup - QPP.

Responses provided are applied only to the selected clinician and will override any selections made at the practice level. Re-weighting may occur for all categories based on your selection. Score provided in the dashboard is an estimate and should not be considered as final.

To complete the Exemptions questionnaire, follow these steps:

1. In the **Default Validation** dialog, select the **Exemptions** tab.
2. To complete the **Exemptions** questionnaire, answer each of the 7 questions by selecting **Yes** or **No**.

   Note: Click the View More link below each question for additional details about the CMS rule and exception parameters.

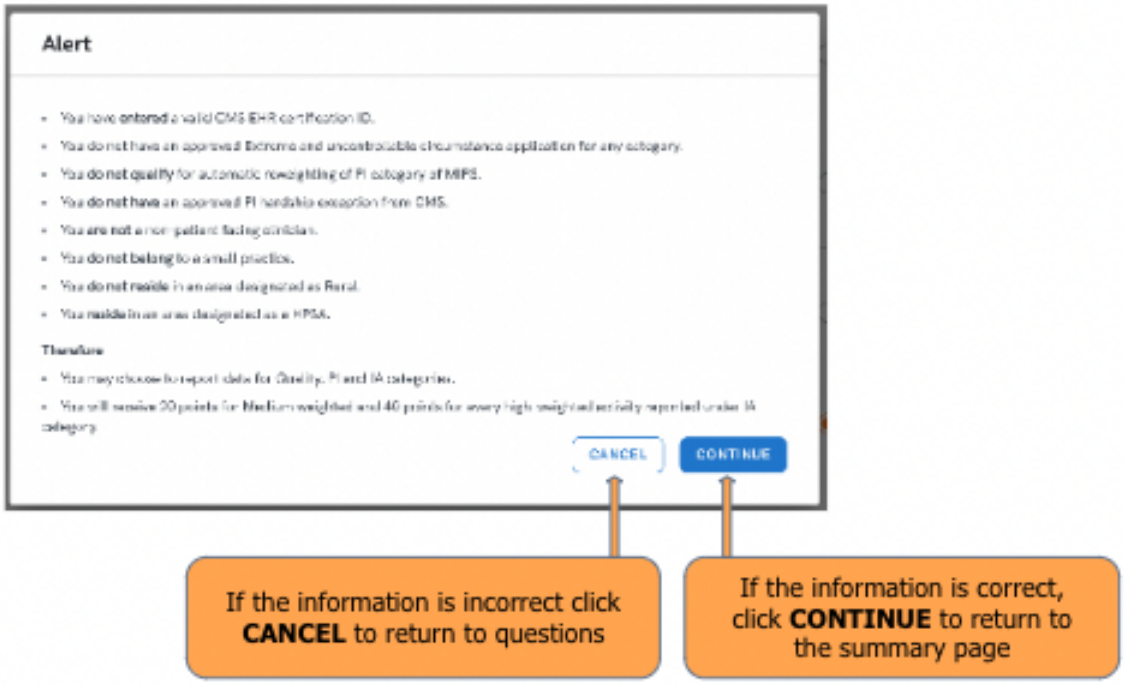


3. Click **Update** after you finish answering the 7 questions.

4. The **Alert** dialog opens and shows a summary of the questionnaire responses. Review the information, and then follow these steps:

    a. If the information is correct, click **Continue** to return to the **Individual Submission** page.

    b. If the information is incorrect and requires updates, click **Cancel** to return to the **Exemptions** questionnaire and edit responses.

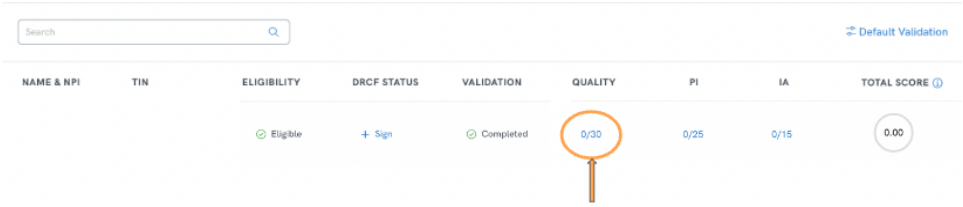


Performance Categories

Quality

The Quality category assesses the quality of care you deliver based on measures of performance and is 30% of the final MIPS score. To report Quality, complete this section by following these steps:

1. Select the link in the **Quality** category.



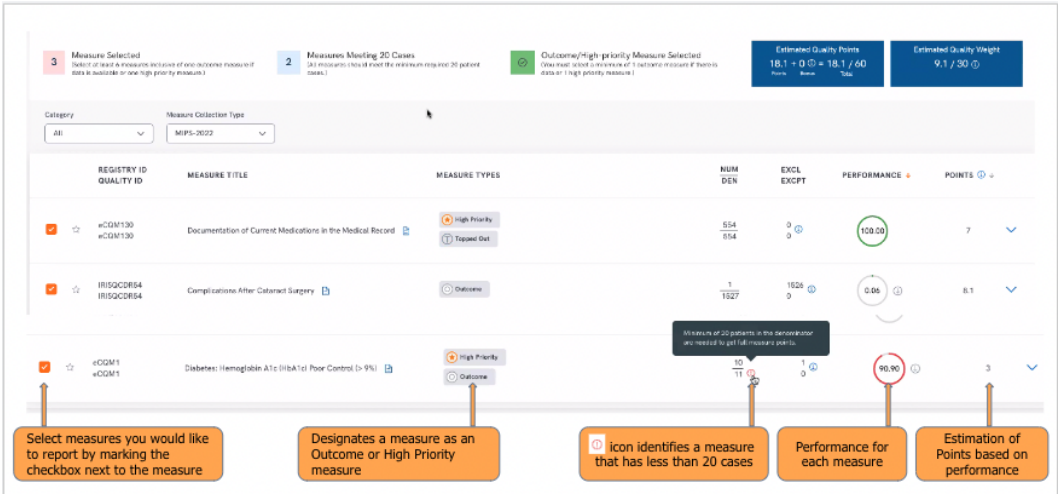
The top portion of the **Quality** tab shows:

- How many measures you selected.
- How many of those measures meet the 20 case minimum.
- If those measures are outcome or high priority.
- The Estimated Quality and Weighted Score.

The next section of the **Quality** tab provides the list of measures for reporting. To select the measures to report, review the information in the following areas to determine which measures are the best choice:

- **Measure Types**
  Designates a measure as an outcome or high priority.
- **NUM/DEN**

  icon identifies a measure that has less than 20 cases.
- **Performance**
  Displays performance for each measure.
- **Points**
  Displays an estimate of possible points based on performance.

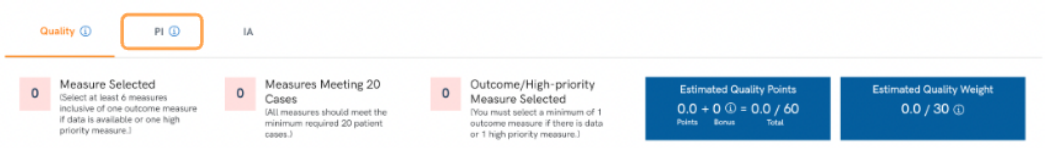


2. After review, mark the checkbox next to the measure(s) you wish to report.
3. Continue to the next section of performance reporting.

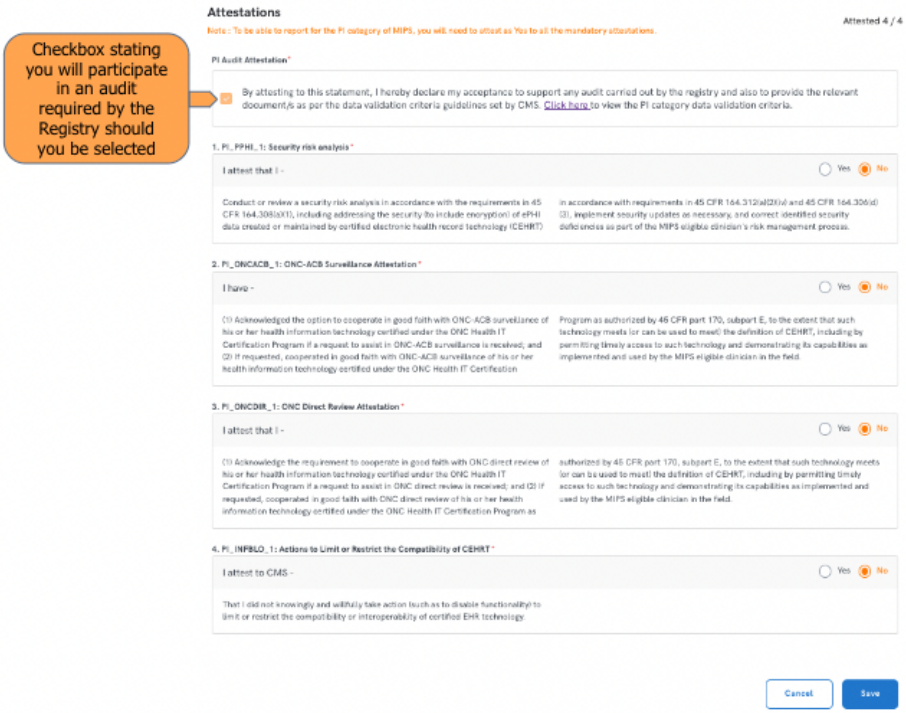
PI (Promoting Interoperability)

The PI category assesses your promotion of patient engagement and electronic exchange of health information using certified electronic health record technology (CEHRT) and is 25% of the final MIPS score. To report PI, complete this section by following these steps:

1. Click the **PI** tab.



2. The **Attestations** page opens.



3. Select **Yes** or **No** to answer each question.

   Note: All of the questions except SAFER Guides require a **Yes** answer to report for the PI category.

4. Mark the **PI Audit Attestation** checkbox to confirm compliance with any audit for the Registry.

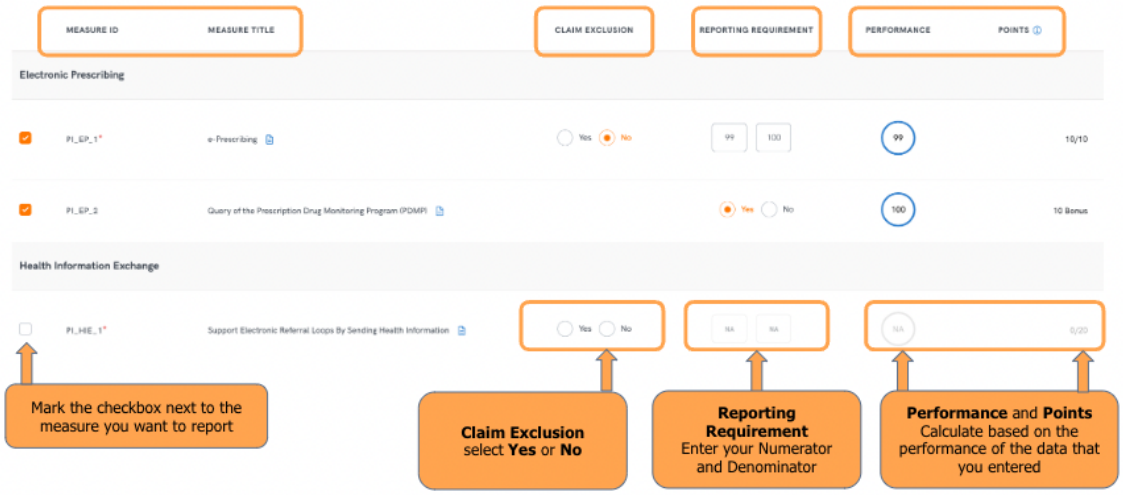
5. Click **Save**.

The following screen appears, and the top portion of the **PI** tab shows:

- **CEHRT ID Validation**
  A green check mark indicates completion of this task.
- **Attested**
  A green check mark indicates completion of this task.
- **Objectives Met**
  The number will populate after data is entered for objectives.
- **Estimated PI Points/Estimated PI Weight**
  The Estimated PI Points and Weighted Scores will update as you select measures.
- **Duration**
  Select the duration of data (minimum of 90 days).

To enter data for PI, follow these steps:

1. **Measure ID** and **Measure Title** are shown. In the **Measure ID** column, mark the checkbox next to the measure you wish to report.



2. In the **Claim Exclusion** column, select **Yes** or **No**.
3. In the **Reporting Requirement** column, enter your numerator and denominator counts from your EHR report.
4. **Performance** and **Points** will be calculated based on the performance of the data you entered.
5. Continue to the next section of reporting.

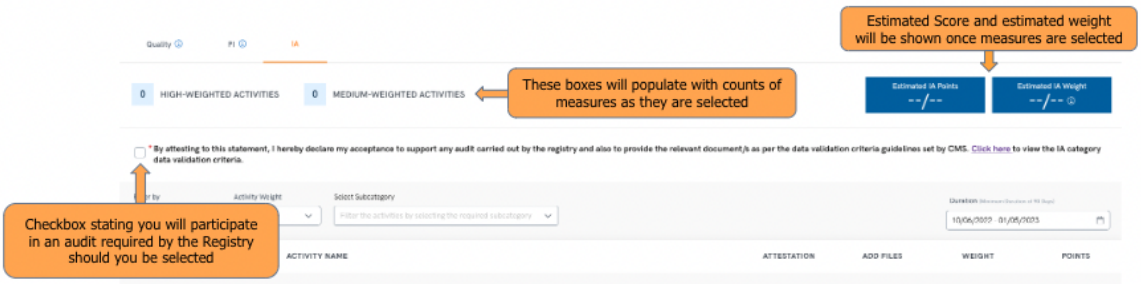
IA (Improvement Activity)

The IA category assesses your participation in activities that improve clinical practice and support patient engagement and is 15% of the final MIPS score. To report IA, complete this section by following these steps:

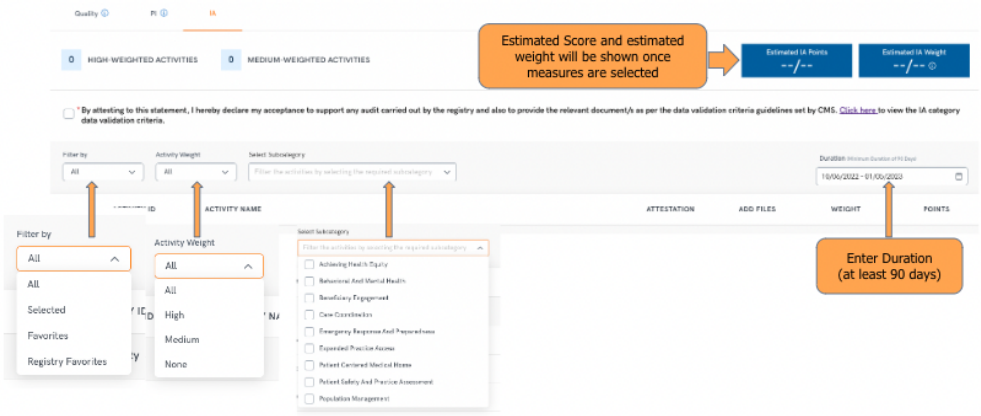
1. Click the **IA** tab.

2. The following screen opens, and the top portion of the **IA** tab shows:

   - **High-Weighted Activities/Medium Weighted Activities**
     These categories will populate with counts of measures as you select measures.
   - **Estimated IA Score/Estimated IA Weight**
     The Estimated PI Points and Weighted Scores will update as you select measures.
   - **IA Audit Attestation**
     Mark the **IA Audit Attestation** checkbox to confirm compliance with any audit for the Registry.



- **Filters**
  Available for selections, Activity Weight, and Subcategory.
- **Duration**
  Select the duration of data (minimum of 90 days).



To enter data for IA, follow these steps:

1. **Activity ID** and **Activity Name** are shown. In the **Activity ID** column, mark the checkbox next to the measure(s) you wish to report.

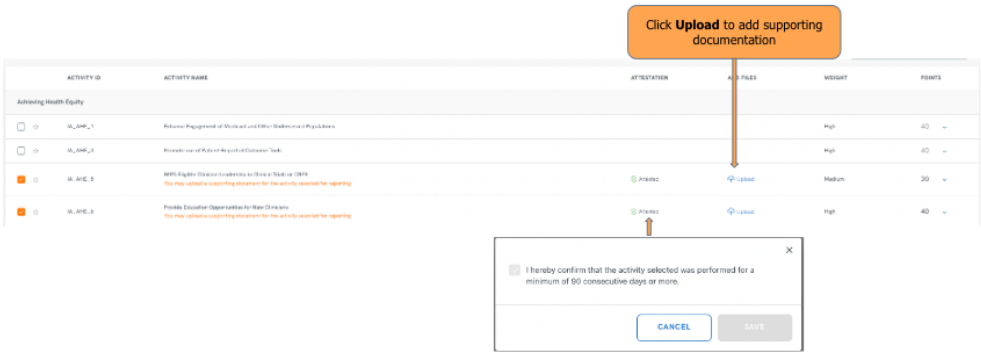
2. In the **Attestations** column, click **Attest** to confirm that the selected activity was performed for a minimum of 90 consecutive days or more.

3. In the **Add Files** column, click **Upload** to add supporting documentation.

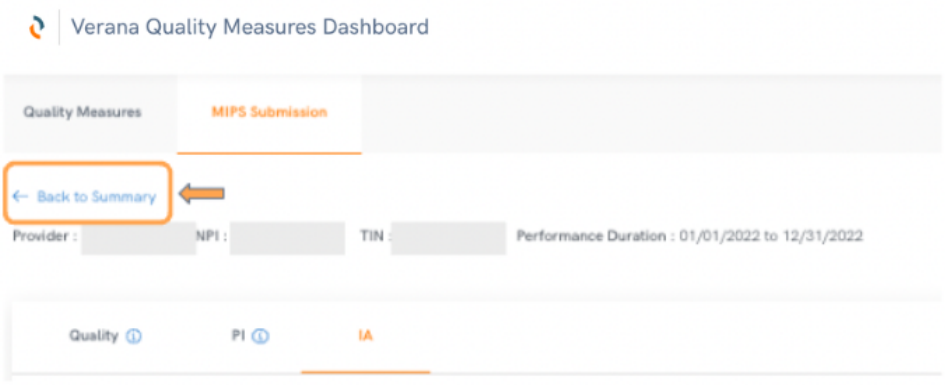
   Note: This field is optional; however, adding supporting documents may be helpful to reference if audited by the registry in the future.

4. In the **Weight** column, the Weight of each measure is shown.

5. In the **Points** column, the total points available is shown. The dropdown arrow provides a description of the measure.



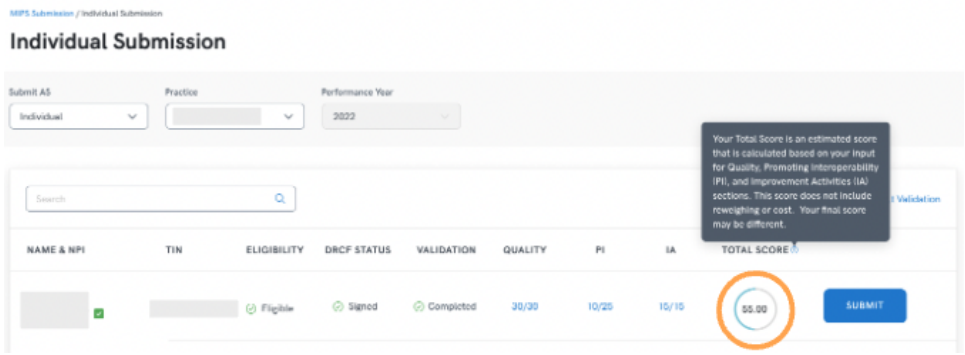
6. After completing the IA category, click **Back to Summary** to return to your Individual Submission page.



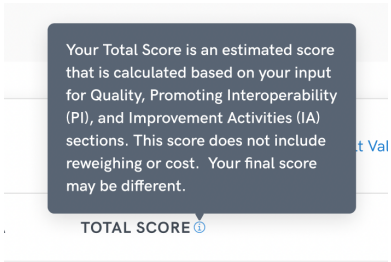
View Total Score

The MIPS Individual Submission module will show the total estimated score of all categories with entered data. If you are satisfied with the points you received in each performance category and the Total Score, you are ready to submit your reporting.

Note: If you want to see if you can increase your score(s) you can go back to your performance categories and change your measures/activities selections.

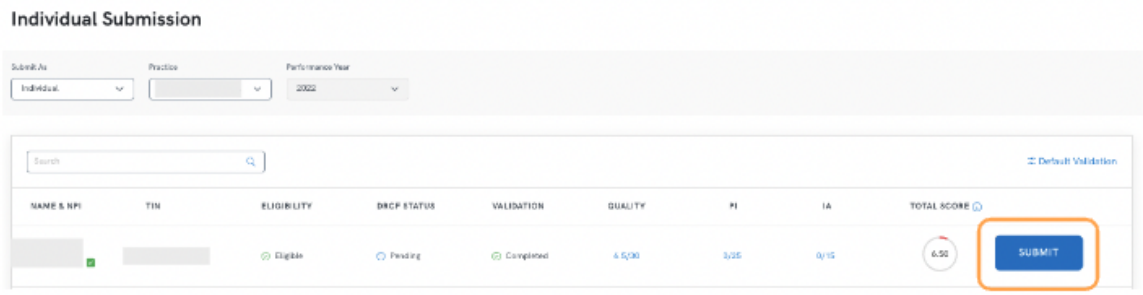


If you hover over the information ⓘ icon, the following message will appear:



To Submit

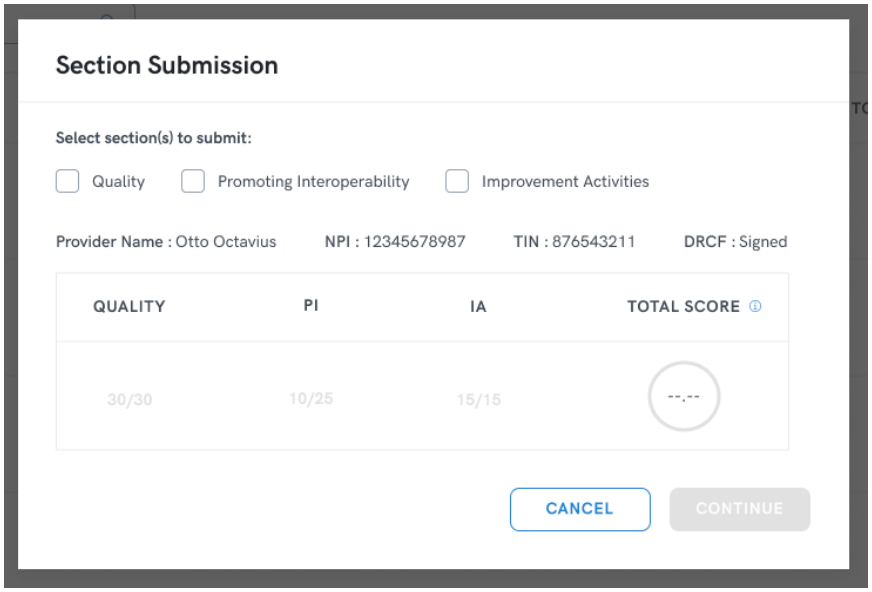
The **Submit** button is disabled until you complete the performance categories. To submit your MIPS Individual Submission, click **Submit**.



Completing the Section Submission

After you click **Submit**, the **Section Submission** dialog opens and shows the Provider Name, NPI, TIN, and DRCF status. In this section, you will choose the performance categories that you want to report to CMS. Each category that you choose populates based on the measures/activities that you selected to report in your data modules. The **Total Score** updates as you make your selections.

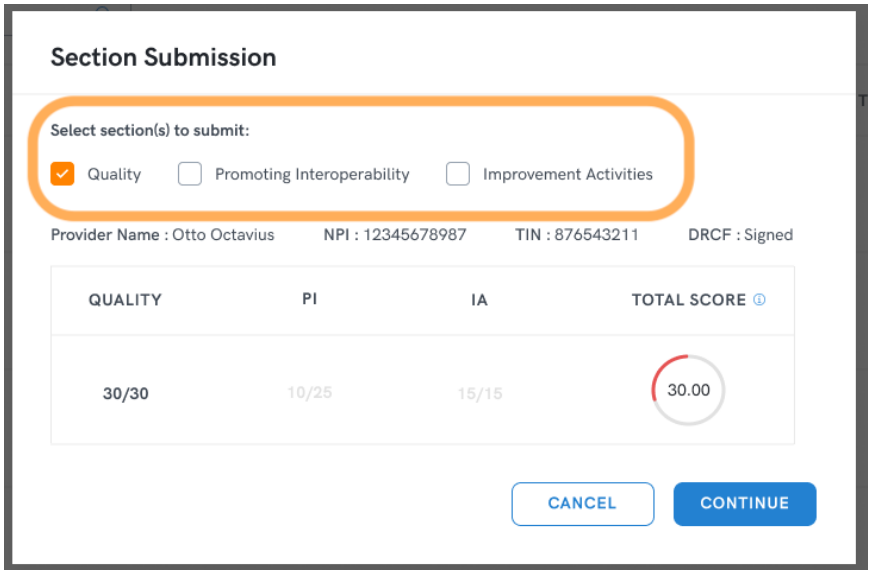
Note: You can choose to report all 3 performance measures, or just 1 or 2.



To complete this section, follow these steps:

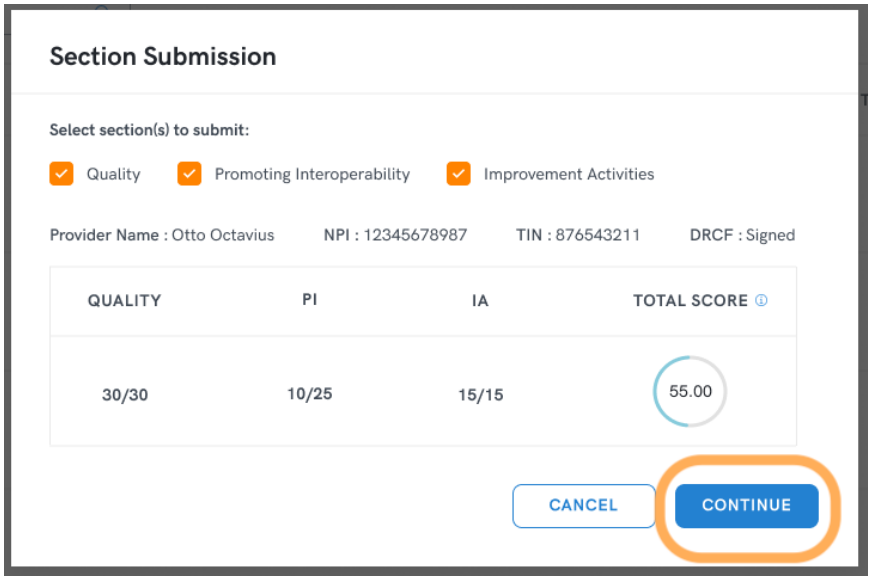
1. Mark the checkboxes next to the performance categories that you want to report.

   The table updates the performance category points and **Total Score**.

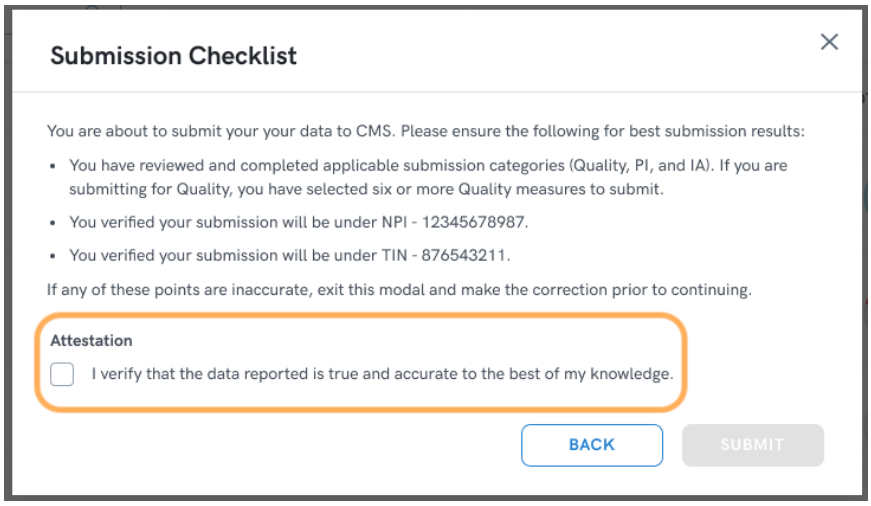


2. Click **Cancel** to return to the **Individual Submission Summary** page if you do not want to submit this version. This will allow you to return to any of the performance categories to update your measures/activities selections in your data modules with the intent to increase your points and Total Score.

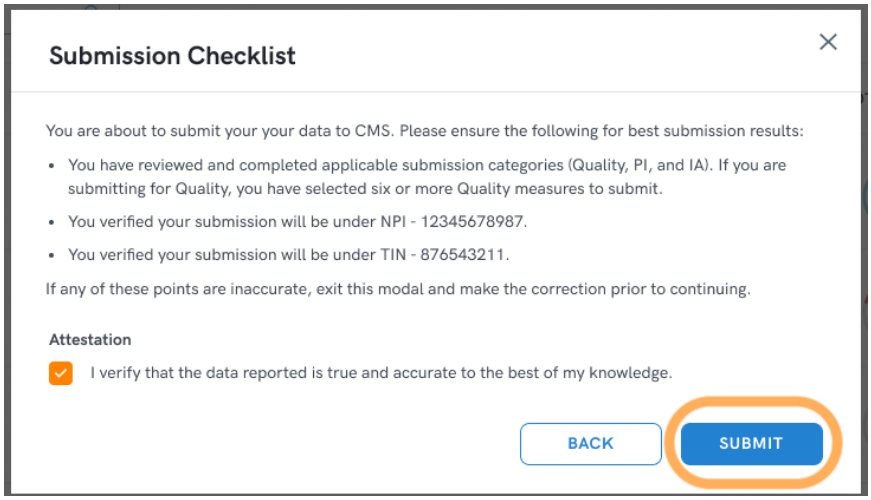
3. Click **Continue** if you want to report the current selection(s).



4. The **Submission Checklist** opens. The checklist allows you to review the information about your submission prior to reporting to CMS.



5. Click **Back** if you need to make any changes to your submission.
6. Mark the **Attestation** checkbox, to verify that the data reported is true and accurate to the best of your knowledge.
7. Click **Submit**.



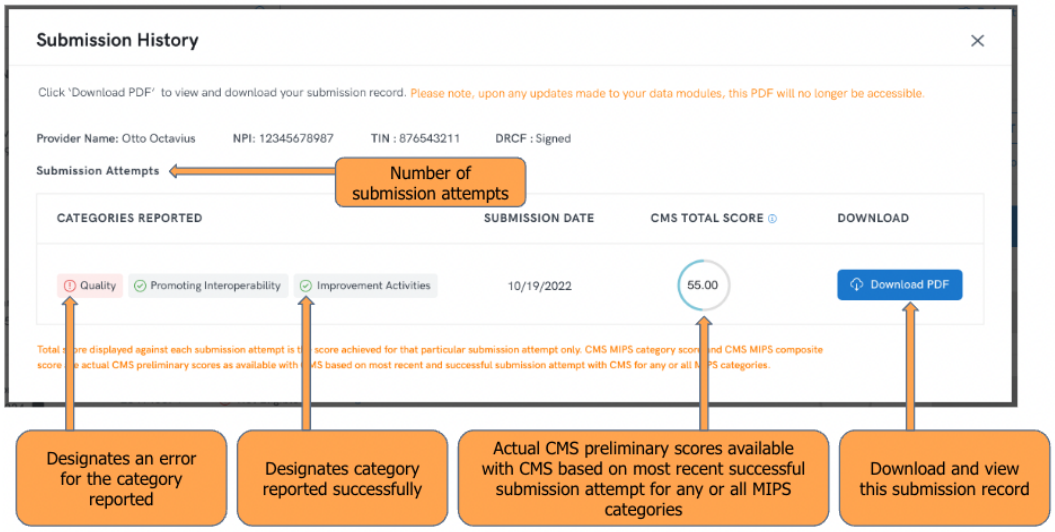
Downloading PDF in the Submission History Section

After you click **Submit**, the **Submission History** dialog opens. This is where you can view and download your submission record.

Note: It is important that you download your submission right away. This MIPS Submission Record will be unavailable to view/download if you make any changes to your data modules after submission.

The **Submission History** shows:

- **Provider Name, NPI, TIN, and DRCF status**
- **Submission Attempts**
  Multiple attempts will show stacked in the table with the latest version on top.
- **Categories Reported**
  Hover over tooltips for status:
  - Red exclamation point icon indicates submission error for category reported.
  - Green checkmark icon indicates successfully submitted scores to CMS.
  - Grayed out field indicates the category was not reported.
- **Submission Date**
  The date of the current submission.
- **CMS Total Score**
  Total score displayed against each submission attempt is the score achieved for that particular submission attempt only. CMS MIPS category score and CMS MIPS composite score are actual CMS preliminary scores available with CMS based on most recent and successful submission attempt with CMS for any or all MIPS categories.
- **Download PDF**
  Button that allows you to download and view this submission record.



Follow these steps to complete the submission process:

1. Click **Download PDF** to view your **MIPS Submission Record** and maintain the copy for your files.

2. The **MIPS Submission Record** opens and shows:
    - **Submission Date**
      The date of the current submission.
    - **Submitter**
    - **Date of Download**
    - **Provider Name, NPI, TIN, and DRCF status**
    - **Measures Submitted**
      Some of the information specific to each performance category includes:

      Quality Measures
        - Type
        - Registry ID/Quality ID
        - Measure Name
        - NUM/DEN
        - Performance Rate

      Promoting Interoperability
        - Performance Duration
        - Measure ID
        - Measure Name
        - NUM/DEN
        - YES/NO
        - Exclusions

      Improvement Activity
        - Performance Duration
        - Activity ID
        - Activity Name
        - Weight

Verana Health

MIPS Submission Record

Submission Date: 12/09/2022
Submitter: Kimberly Cruz
Date of Download: 12/10/2022

Provider Name: Otto Octavius NPI: 12345678987 TIN : 876543211 DRCF : Signed

SCORE SUMMARY

QUALITY	PI	IA	CMS TOTAL SCORE
30/30	10/25	15/15	65.00

MEASURES SUBMITTED

For individual measure scores, visit qpp.cms.gov.

Quality Measures

TYPE	REGISTRY ID QUALITY ID	MEASURE NAME	NUM / DEN	PERFORMANCE RATE
QCDR	IRIS107	Preventive Care and Screening: Influenza Immunization	5861 / 6172	86.85
QCDR	IRIS111	Pneumococcal Vaccination Status for Older Adults	5861 / 6172	56.85

Promoting Interoperability

Performance Duration : 01/01/2022 to 12/31/2022

MEASURE ID	MEASURE NAME	NUM / DEN	YES/NO	EXCLUSIONS
PI_EP_1*	e-Prescribing Required Measure	5 / 10	--	No
PI_PHCDRR_1*	Immunization Registry Reporting	--	Yes	Yes

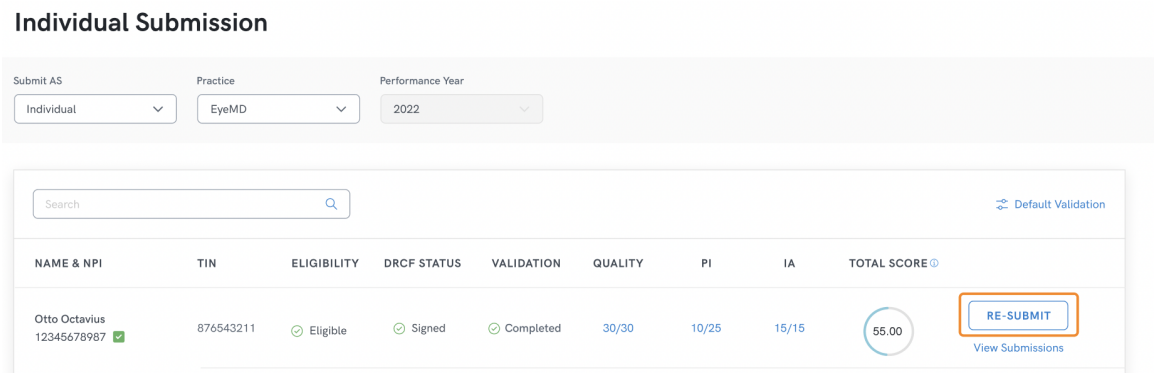
Improvement Activity

Performance Duration : 01/01/2022 to 12/31/2022

ACTIVITY ID	ACTIVITY NAME	WEIGHT
IA_AHE_1	Engagement of new Medicaid patients and follow-up	High

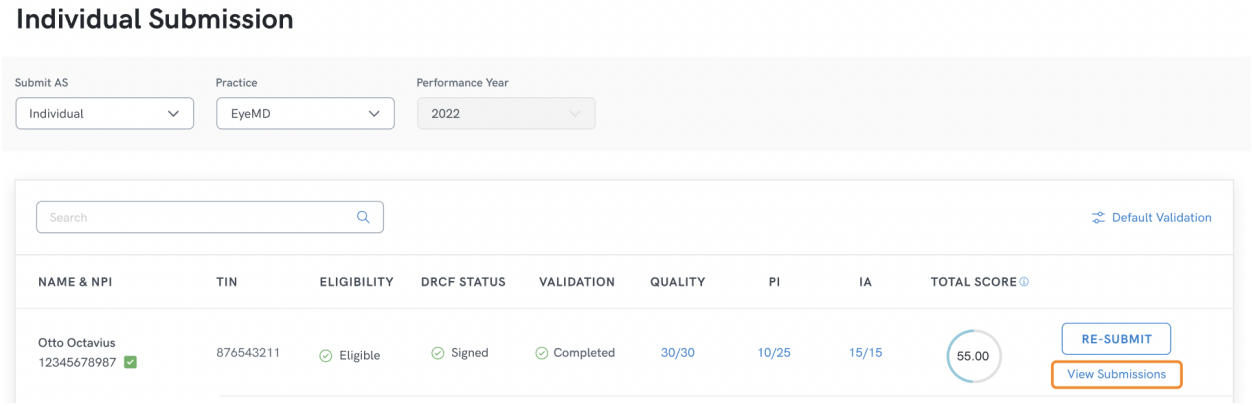
3. Click **X** in the upper right corner to close the **Submission History** dialog and return to the **Individual Submission Summary** page.

   You will see the **Submit** button is now a **RE-SUBMIT** button.



4. [Optional] Click **View Submission**, to view the **Submission History** and access the **Download PDF** button for your MIPS Submission Record.

   Note: This **MIPS Submission Record** will be unavailable to view/download if you make any changes to your data modules after submission.



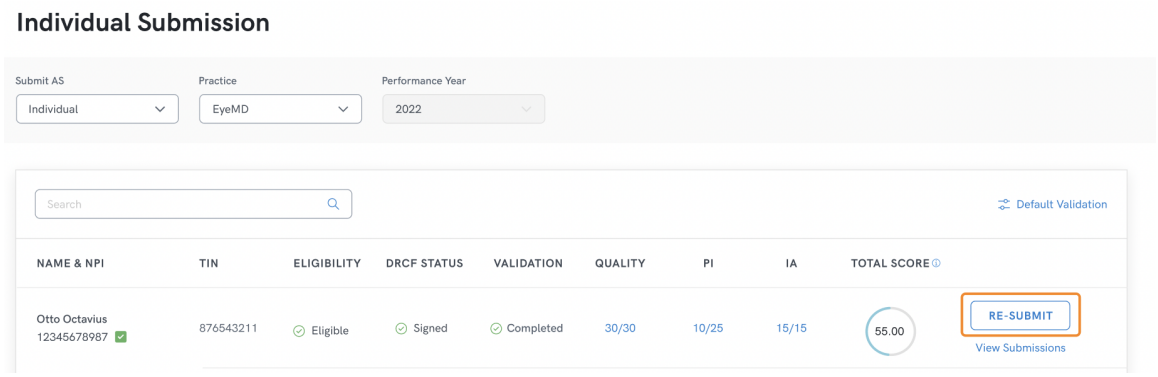
To Re-submit

You can re-submit your submission if you want to attempt to achieve a more favorable outcome. Return to any of the performance categories and update any/all of your measures/activities selections in your data modules with the intent to increase your points and Total Score.

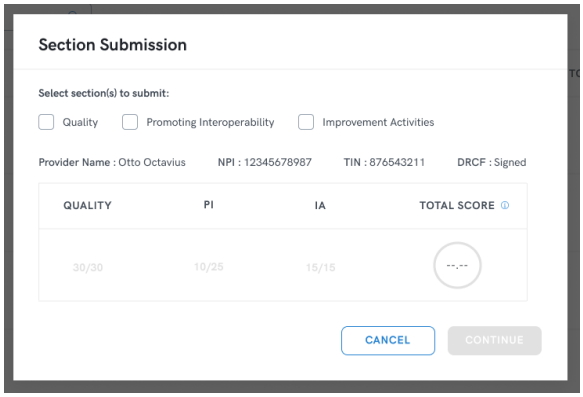
Note: If you re-submit, your previous MIPS Submission Record will be unavailable to download/view.

To re-submit your MIPS Individual Submission after you update any of your measures/activities sections in your data modules, follow these steps:

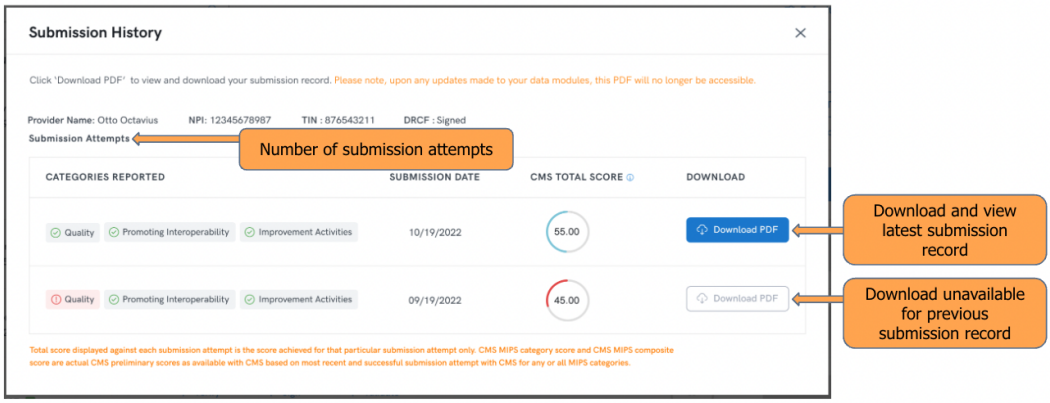
1. Click **RE-SUBMIT**.



2. The **Section Submission** dialog opens. Follow the instructions in the previous section, Completing the Section Submission.



3. After you complete the workflow, the **Submission History** dialog will show your latest and previous submission records.



Group Submission

To determine if you should submit a group submission, follow these guidelines:

- A group is defined as a single TIN with 2 or more clinicians (of which at least one clinician within the groups must be MIPS eligible) as identified by their NPI, who have reassigned their Medicare billing rights to a single TIN.
- If you report only as a group:
    - You must meet the definition of a group at all times during the performance period and aggregate the group's performance data across the 4 MIPS performance categories for a single TIN.
    - Each MIPS-eligible clinician in the group will receive the same payment adjustment based on the group performance across all 4 MIPS performance categories.

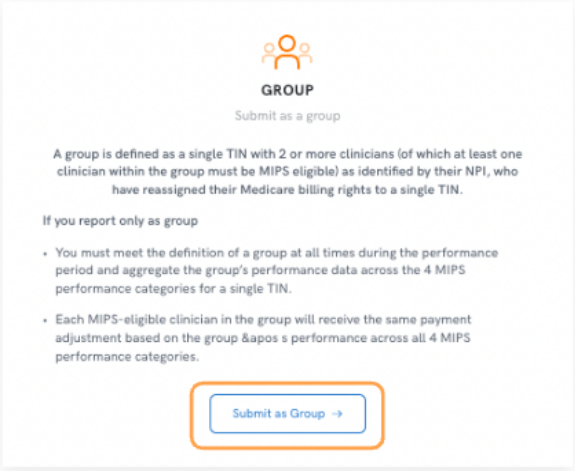
      Note: The MIPS Submission module includes 3 of the 4 MIPS performance categories (Quality, PI, and IA) and does not include the Cost category.

Completing the Group MIPS Submission: Quick Start

This section provides a high-level overview of the Group MIPS Submission process. For in-depth instructions, click on the underlined hyperlinks in each step.

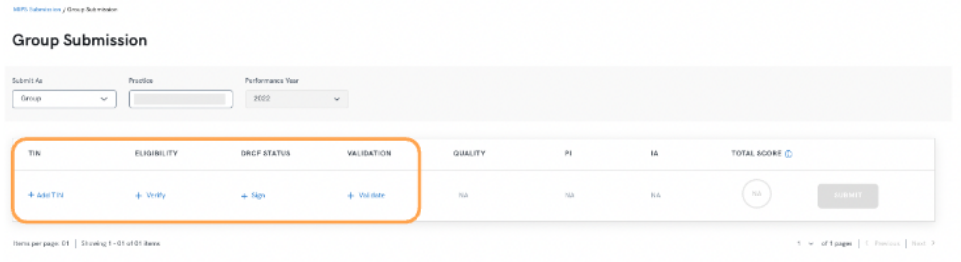
To complete the MIPS Submission as a group, follow these steps:

1. On the **MIPS Submission** page, select **Submit as Group** to open the MIPS Group Submission module.



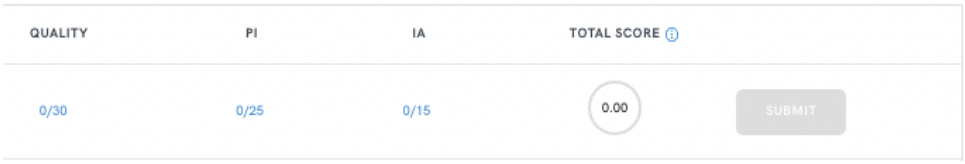
2. On the **MIPS Group Submission** module, complete each of the following Prerequisite Categories before accessing the Quality, PI, and IA performance categories:

    - TIN
    - Eligibility
    - DRCF Status
    - Validation



3. Complete each of the following Performance Categories:

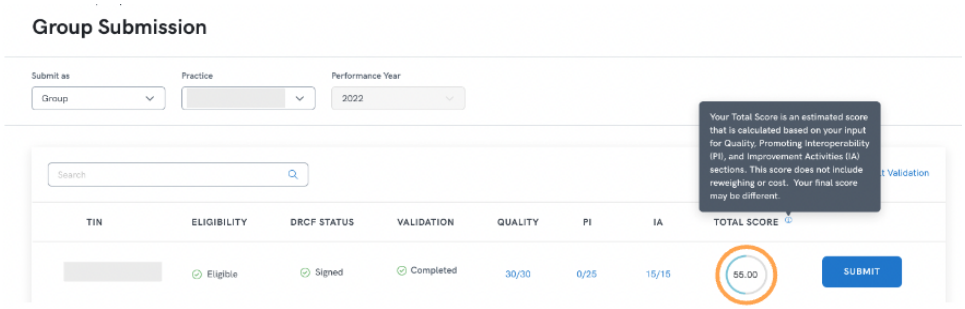
    - Quality
    - PI (Promoting Interoperability)
    - IA (Improvement Activity)



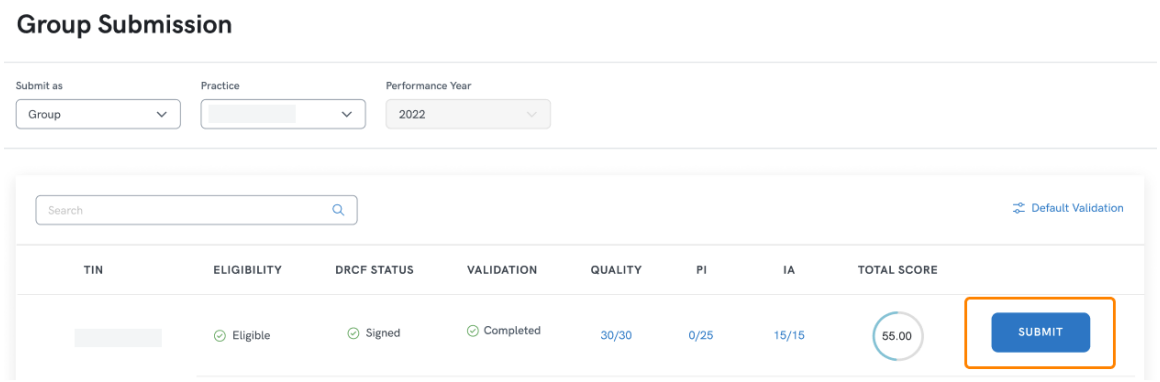
4. Review reporting information and Total Score.

    The **MIPS Group Submission** module will show the total estimated score of all categories with entered data. If you are satisfied with the points you received in each performance category and the **Total Score**, you are ready to submit your reporting.

    Note: If you want to see if you can increase your score(s) you can go back to your performance categories and change your measures/activities selections.



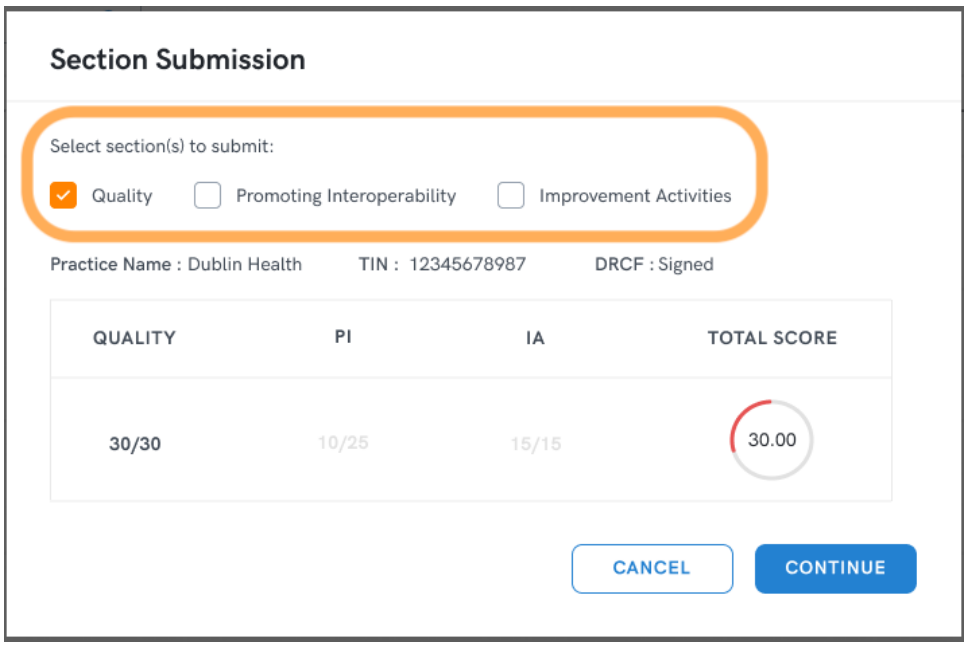
5. Click Submit.



6. Complete Section Submission.

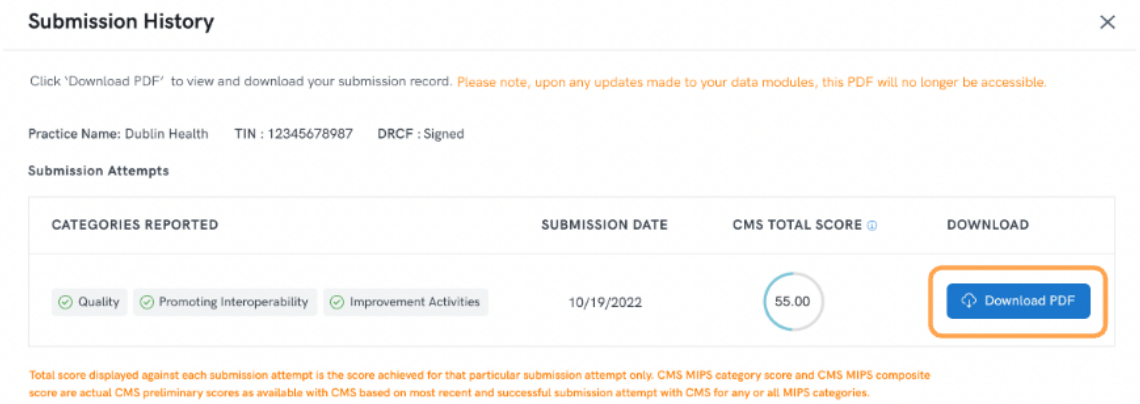
   In this section, you will choose the performance categories that you want to report to CMS. Each category that you choose populates based on the measures/activities that you selected to report in your data modules. The **Total Score** updates as you make your selections.

   Note: You can choose to report all 3 performance measures, or just 1 or 2.

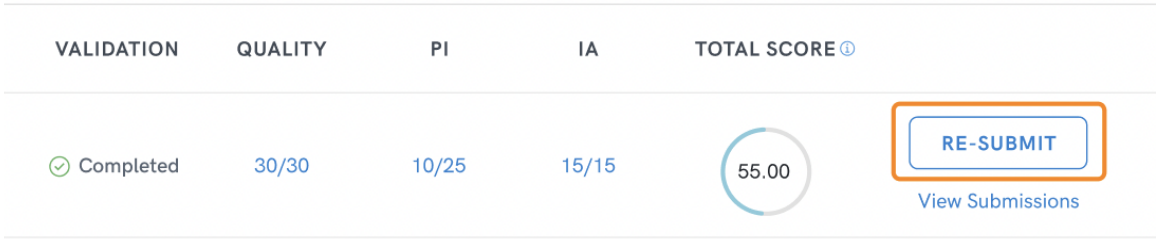


7. Click Download PDF in the **Submission History** section to view and download your **MIPS Submission Record**.

   Note: It is important that you download your submission right away. This **MIPS Submission Record** will be unavailable to view/download if you make any changes to your data modules after submission.



8. [Optional] Click **RE-SUBMIT** on the **Individual Submission Summary** page, if you choose to discard your submission and update your measures/activities selections for any of the performance categories. You will follow the same process for submitting your reporting and will complete steps 6 and 7.



Prerequisite Categories

TIN (Tax Identification Number)

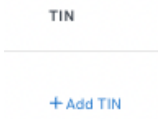
You will add the TIN information for this category. This is required for MIPS submission.

Adding TIN information

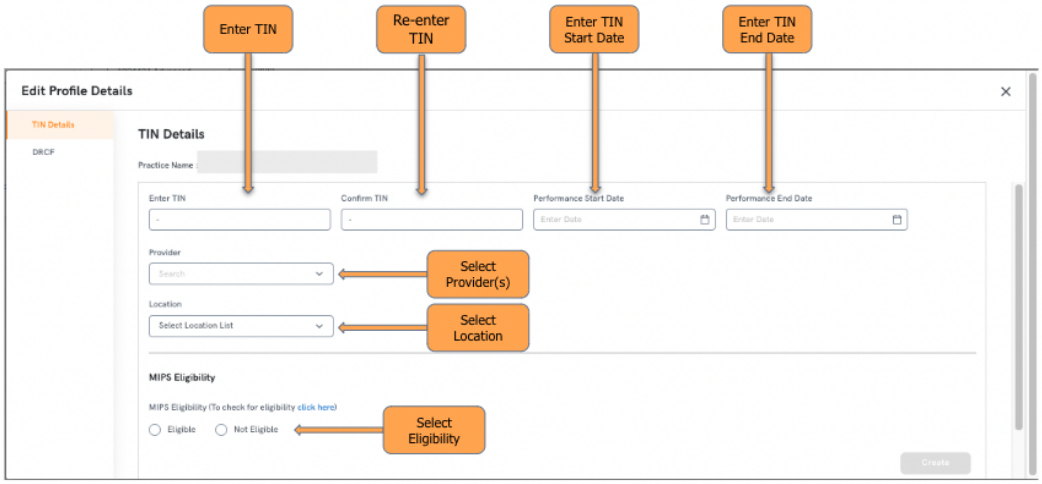
To enter the practice TIN, follow these steps:

Note: TIN should be the information submitted for CMS 1500 Claims form.

1. In the **TIN** column, select **+ Add TIN** to enter the *group TIN*.



2. The **Edit Profile Details** dialog, **TIN Details** tab opens.



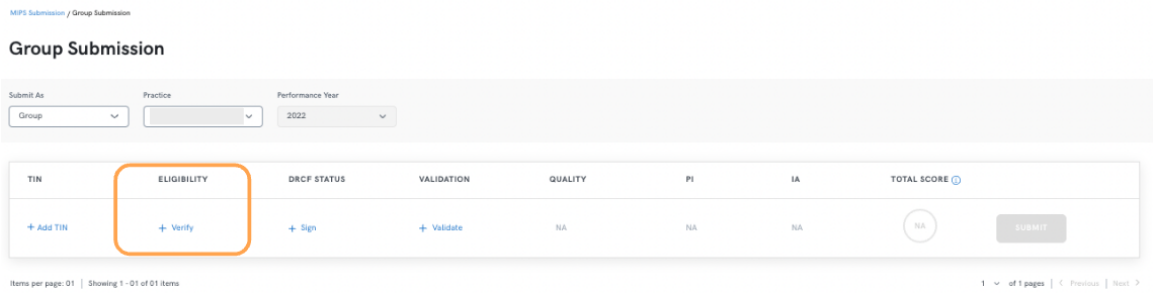
3. In the **Enter TIN** field, enter the *TIN*.
4. In the **Confirm TIN** field, re-enter the *TIN*.
5. In the **Performance Start Date**, select the *TIN start date*.
6. In the **Performance End Date**, select the *TIN end date*.
7. In the **Provider** section, select the *clinician(s)* from the dropdown menu.

8. In the **Location**, select the *location* from the dropdown menu.
9. In **MIPS Eligibility**, select **Eligible** or **Not Eligible**.

   Note: Use the click here link to verify your MIPS eligibility for the TIN on the CMS website.
10. Click **Create**, and a banner will appear at the top of the screen that verifies you successfully added the TIN.

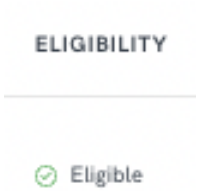
Eligibility

The **Eligibility** field is the next category. This is a required field for MIPS submission.



- The **Eligibility** field initially shows **+ Verify**.

- It changes to **Eligible** after you complete the **TIN** category.

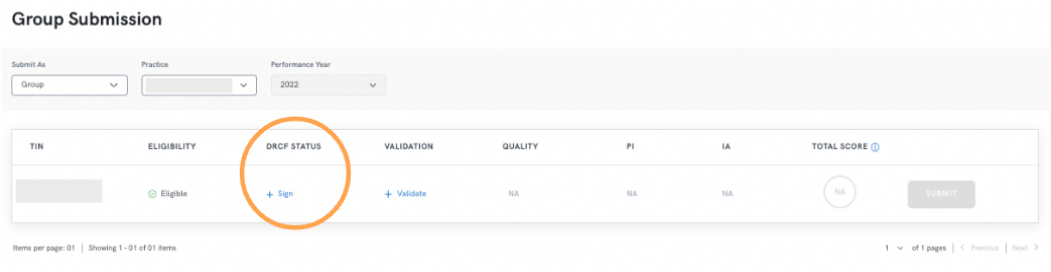


DRCF

You will complete the DRCF (Data Release Consent Form) signing process for this category. The DRCF is an agreement between the registry and clinicians, wherein the clinicians grant permission to the registry to transmit data to CMS on their behalf.

To complete the DRCF for a group submission, follow these steps:

1. From the **DRCF Status** column, select **+ Sign**.



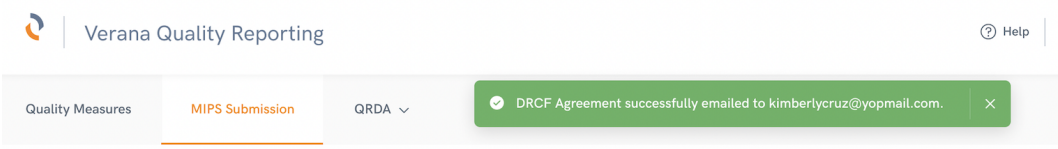
2. From the **TIN** dropdown menu, select the correct TIN for your practice.

   Note: The **Practice Name** will be pre-populated.

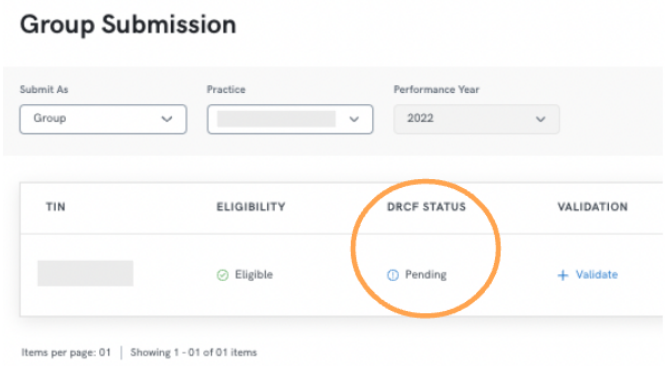
3. Click **E-Sign Now** to receive an email notification to electronically sign the agreement.
4. In the **Signatory Email** field, enter the email address to send the DocuSign DRCF, and then re-enter the email address in the **Confirm Signatory Email** field.

   Note: This should be an authorized signer for the practice.

5. Click **Continue**, and a banner will appear at the top of the screen, "DRCF Agreement successfully emailed to *ConfirmedEmailAddress@email.com*."



6. The **DRCF Status** shows as **Pending** and will change to **Signed** after the document is signed.



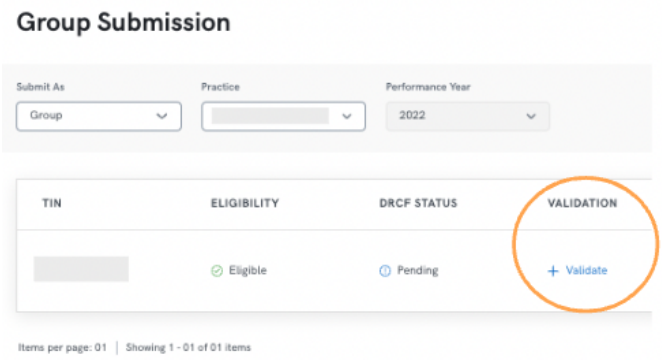
Validation

You will enter CEHRT Details and complete Exemption questions in this category. CMS mandates the use of 2015 CEHRT for reporting to MIPS 2022.

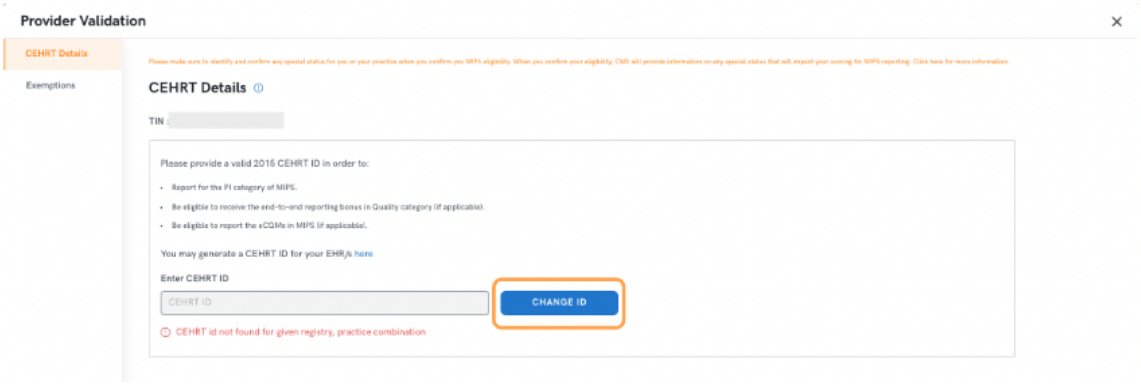
Adding CEHRT Details

To add CEHRT Details, follow these steps:

1. In the **Validations** column, select **+ Validate**.

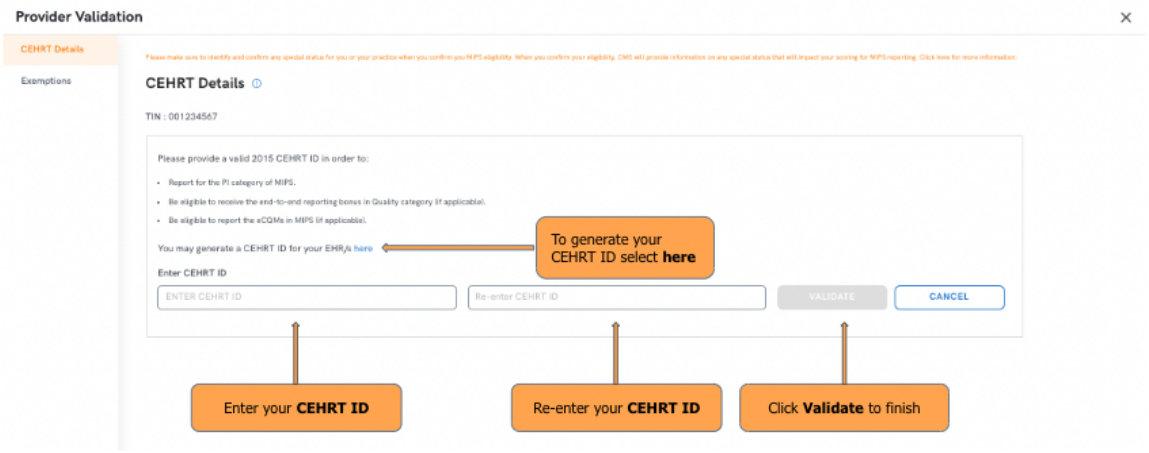


2. The **Provider Validation** dialog, **CEHRT Details** tab opens.



3. Select **Change ID**.
4. In the **Enter CEHRT ID** field, enter your *CEHRT ID*.

   Note: Click the **here** link above the **Enter CEHRT ID** fields to generate your CEHRT ID.



5. Re-enter your **CEHRT ID** in the next field.
6. Click **Validate**.

Completing the Exemptions Questionnaire

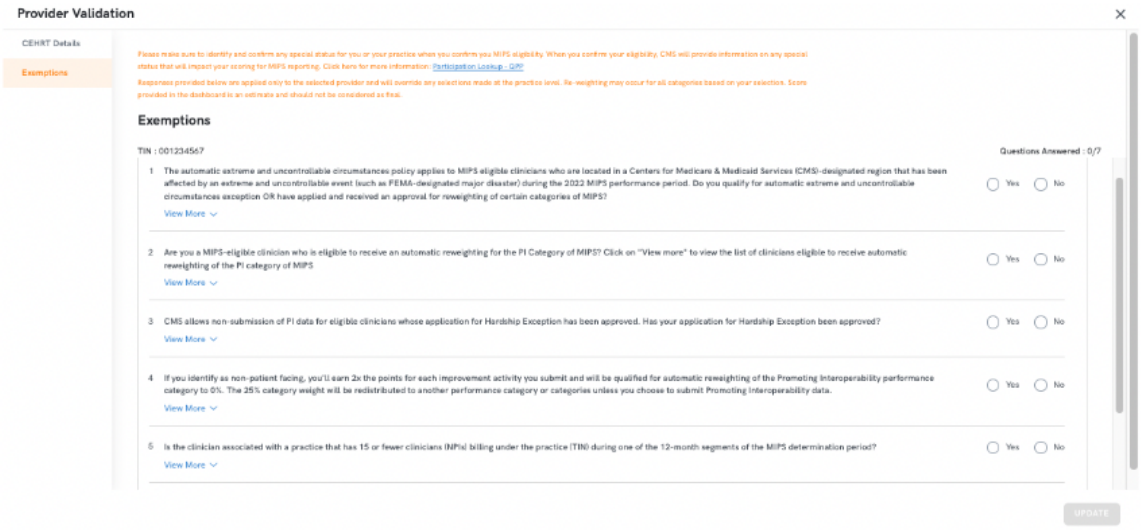
The questionnaire contains questions that are relevant to your MIPS reporting. Please make sure to identify and confirm any special status for you or your practice when you confirm your MIPS eligibility. When you confirm your eligibility, CMS will provide information on any special status that will impact your scoring for MIPS reporting. Click here for more information: Participation Lookup - QPP.

Responses provided are applied only to the selected clinician and will override any selections made at the practice level. Re-weighting may occur for all categories based on your selection. Score provided in the dashboard is an estimate and should not be considered as final.

To complete the Exemptions questionnaire, follow these steps:

1. In the **Default Validation** dialog, select the **Exemptions** tab.
2. To complete the Exemptions questionnaire, answer each of the 7 questions by selecting **Yes** or **No**.

   Note: Click the **View More** link below each question for additional details about the CMS rule and exception parameters.

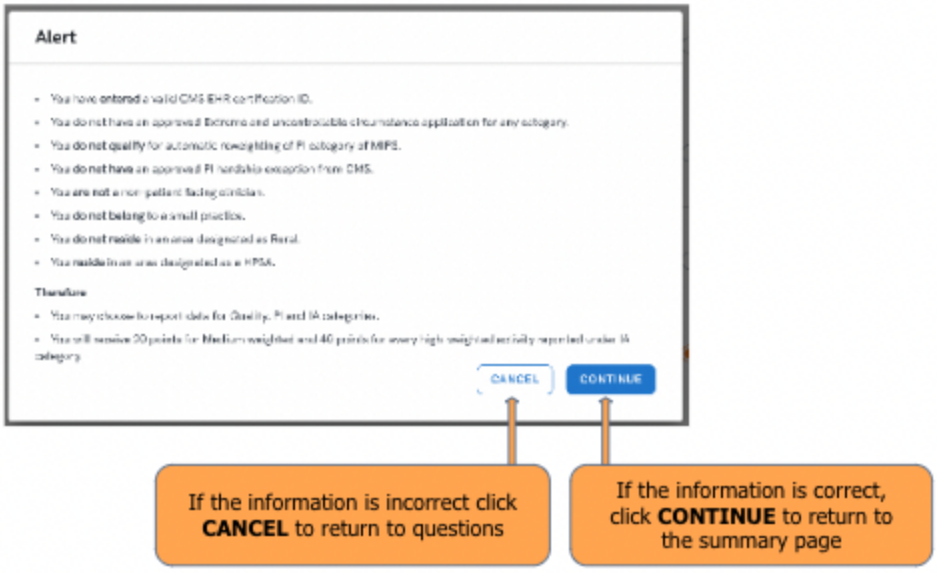


3. Click **Update** after you finish answering the 7 questions.

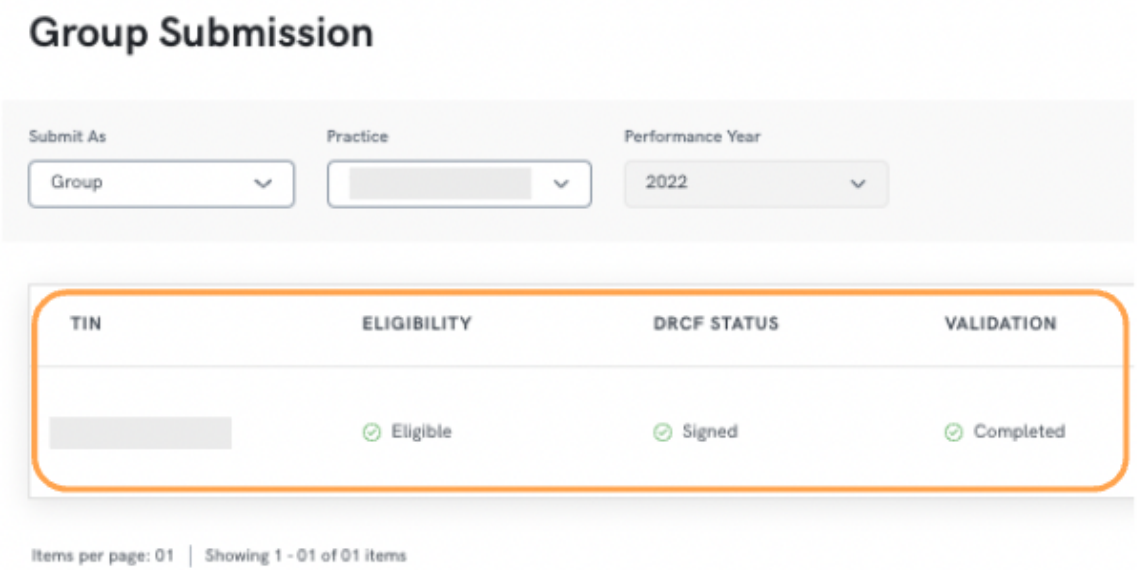
4. The **Alert** dialog opens and shows a summary of the questionnaire responses. Review the information, and then follow these steps:

    a. If the information is correct, click **Continue** to return to the **Group Submission** page.

    b. If the information is incorrect and requires updates, click **Cancel** to return to the questionnaire and edit responses.



5. The first four categories are complete, and you can begin the performance categories.

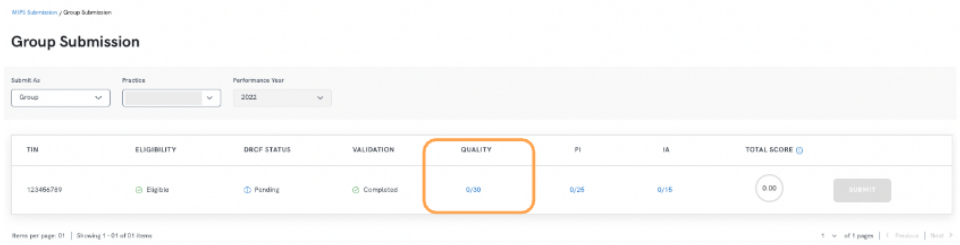


Performance Categories

Quality

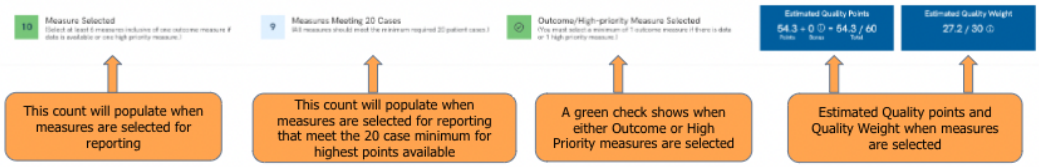
The Quality category assesses the quality of care you deliver based on measures of performance and is 30% of the final MIPS score. To report Quality, complete this section by following these steps:

1. Select the link in the **Quality** category.



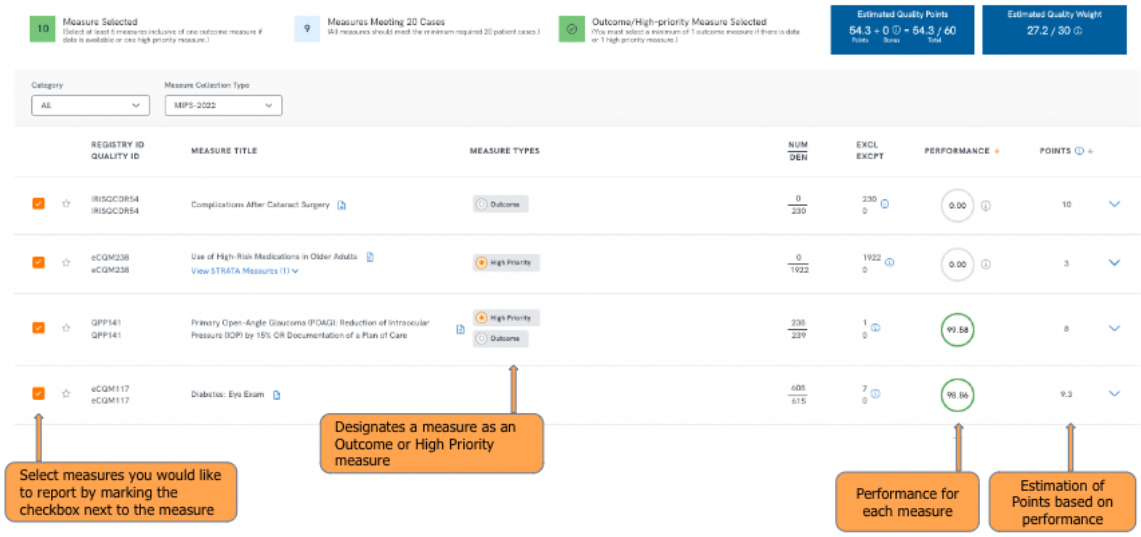
The top portion of the **Quality** tab shows:

- How many measures you selected.
- How many of those measures meet the 20 case minimum.
- If those measures are outcome or high priority.
- The Estimated Quality and Weighted Score.



The next section of the **Quality** tab provides the list of measures for reporting. To select the measures to report, review the information in the following areas to determine which measures are the best choice:

- **Measure Types**
  Designates a measure as an outcome or high priority.
- **NUM/DEN**
  icon identifies a measure that has less than 20 cases.
- **Performance**
  Displays performance for each measure.
- **Points**
  Displays an estimate of possible points based on performance.

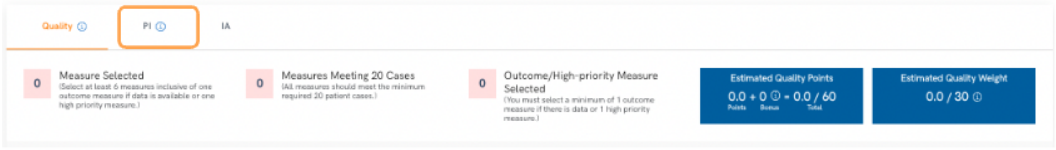


2. After review, mark the checkbox next to the measure(s) you wish to report.
3. Continue to the next section of performance reporting.

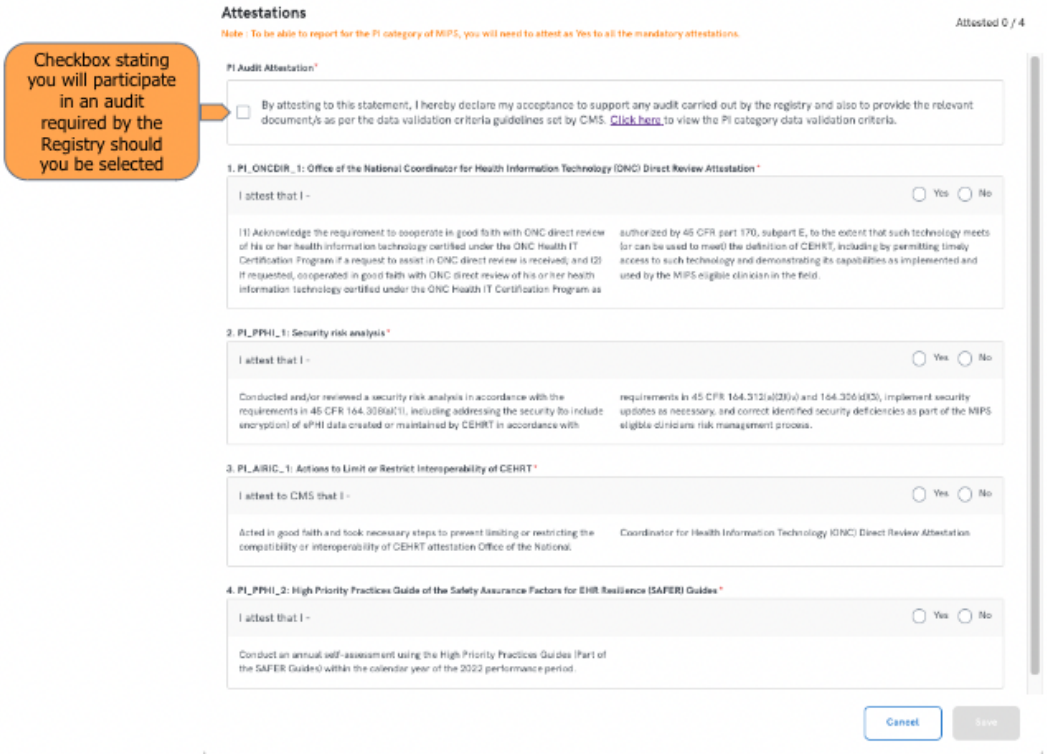
PI (Promoting Interoperability)

The PI category assesses your promotion of patient engagement and electronic exchange of health information using certified electronic health record technology (CEHRT) and is 25% of the final MIPS score. To report PI, complete this section by following these steps:

1. Click the **PI** tab.



2. The **Attestations** page opens.



3. Select **Yes** or **No** to answer each question.

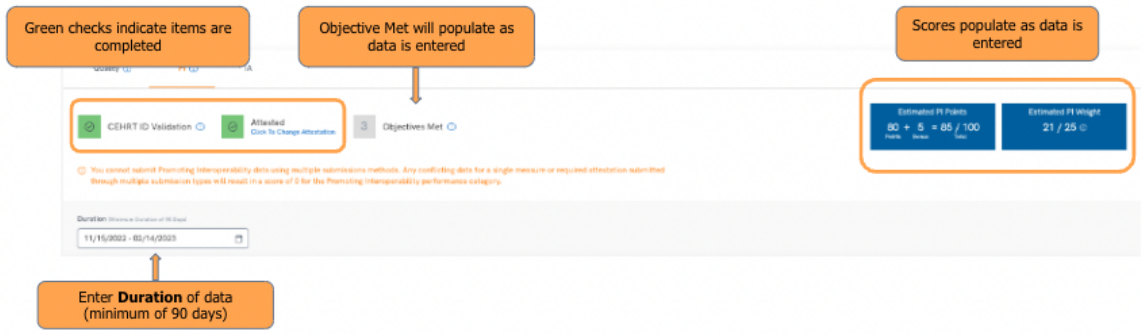
   Note: All of the questions require a **Yes** answer to report for the PI category.

4. Mark the **PI Audit Attestation** checkbox to confirm compliance with any audit for the Registry.

5. Click **Save**.

The following screen appears, and the top portion of the **PI** tab shows:

- **CEHRT ID Validation**
  A green check mark indicates completion of this task.
- **Attested**
  A green check mark indicates completion of this task.
- **Objectives Met**
  The number will populate once data is entered for objectives.
- **Estimated PI Points/Estimated PI Weight**
  The Estimated PI Points and Weighted Scores will update as you select measures.
- **Duration**
  Select the duration of data (minimum of 90 days).



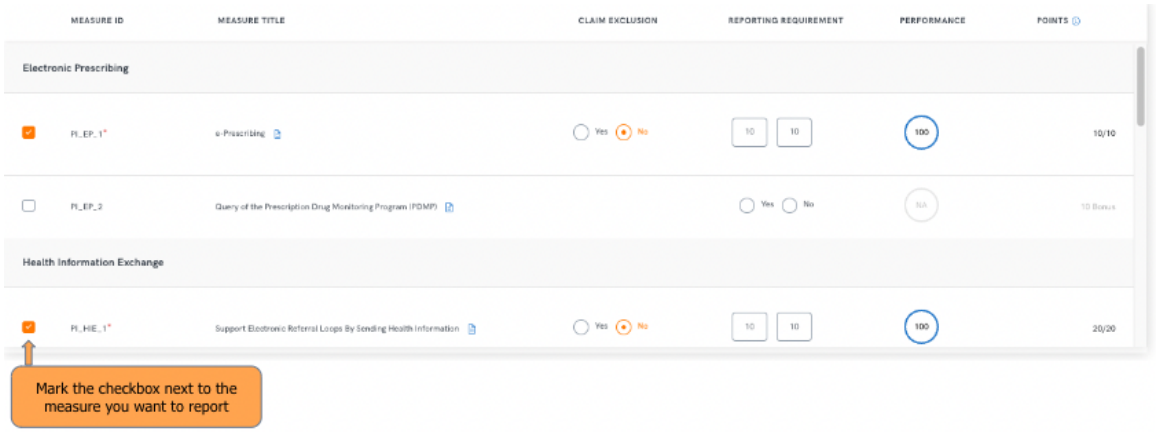
To enter data for PI, follow these steps:

1. **Measure ID** and **Measure Title** are shown. In the **Measure ID** column, mark the checkbox next to the measure you wish to report.

2. In the **Claim Exclusion** column, select **Yes** or **No**.

3. In the **Reporting Requirement** column, enter your numerator and denominator counts from your EHR report.

4. **Performance** and **Points** will be calculated based on the performance of the data you entered.

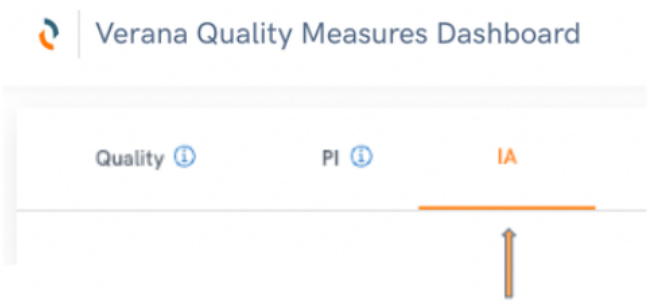


5. Continue to the next section of performance reporting.

IA (Improvement Activity)

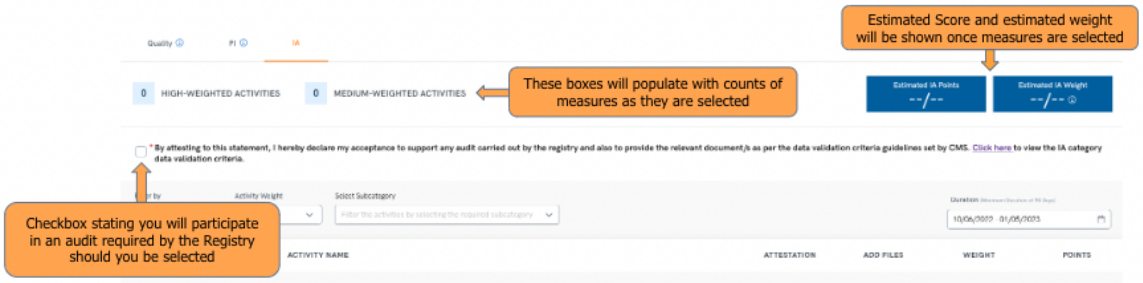
The IA category assesses your participation in activities that improve clinical practice and support patient engagement and is 15% of the final MIPS score. To report IA, complete this section by following these steps:

1. Click the **IA** tab.

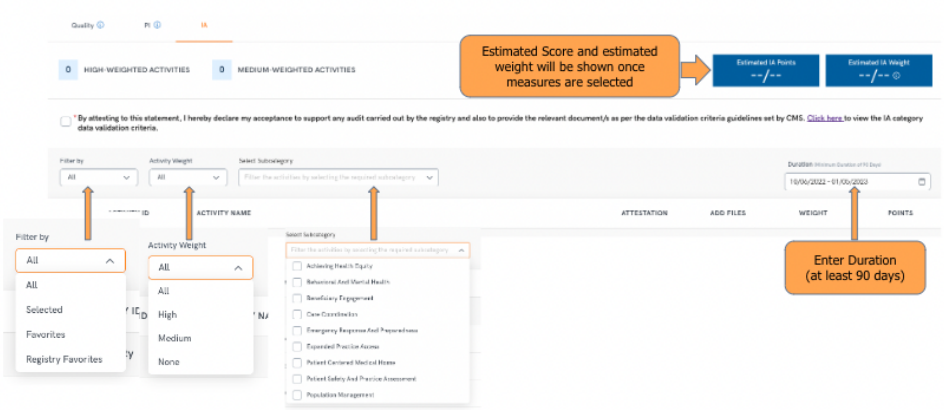


2. The following screen appears, and the top portion of the IA tab shows:

   - **High-Weighted Activities/Medium Weighted Activities**
     These categories will populate with counts of measures as you select measures.
   - **Estimated IA Score/Estimated IA Weight**
     The Estimated PI Points and Weighted Scores will update as you select measures.
   - **IA Audit Attestation**
     Mark the **IA Audit Attestation** checkbox to confirm compliance with any audit for the Registry.



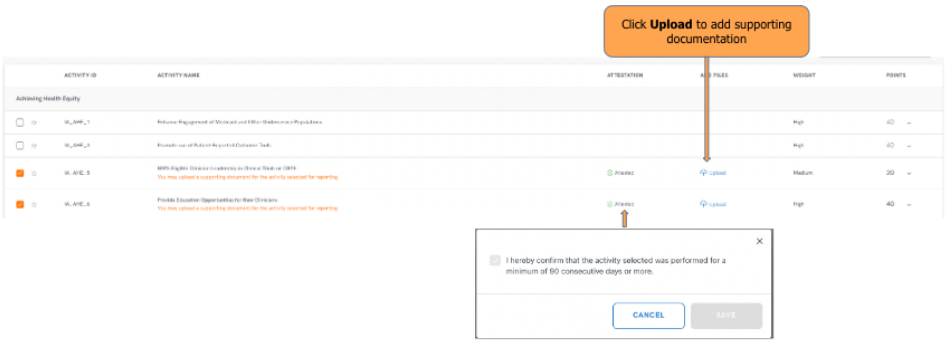
- **Filters**
  Available for selections, Activity Weight, and Subcategory.
- **Duration**
  Select the duration of data (minimum of 90 days).



To enter data for IA, follow these steps:

1. **Activity ID** and **Activity Name** are shown. In the **Activity ID** column, mark the checkbox next to the measure(s) you wish to report.
2. In the **Attestations** column, click **+ Attest** to confirm that the activity selected was performed for a minimum of 90 consecutive days or more.
3. In the **Add Files** column, click **Upload** to add supporting documentation.

   Note: This field is optional; however, adding supporting documents may be helpful to reference if audited by the registry in the future.
4. In the **Weight** column, the Weight of each measure is shown.
5. In the **Points** column, the total points available is shown. The dropdown arrow provides a description of the measure.

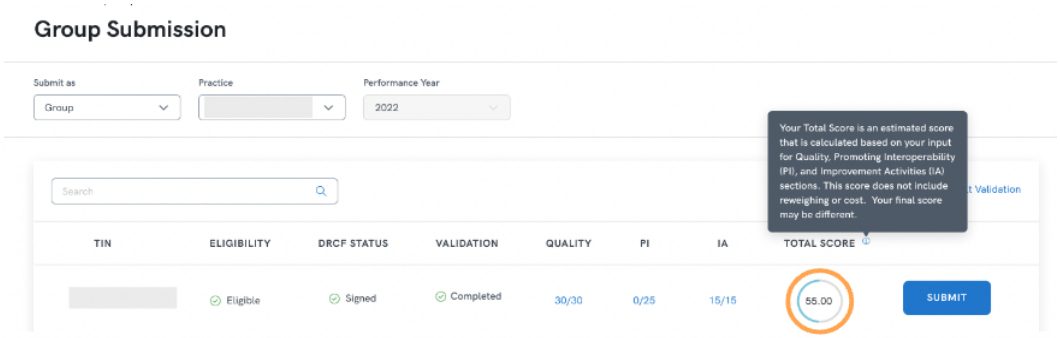


6. After completing the IA category, click **Back to Summary** to return to your Group Submission page.

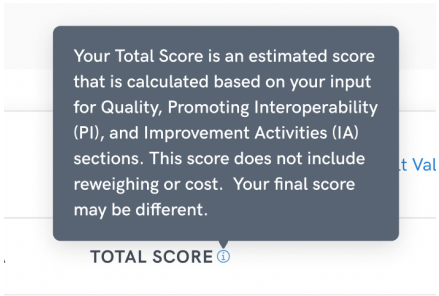
View Total Score

The MIPS Group Submission module will show the total estimated score of all categories with entered data. If you are satisfied with the points you received in each performance category and the **Total Score**, you are ready to submit your reporting.

Note: If you want to see if you can increase your score(s) you can go back to your performance categories and change your measures/activities selections.

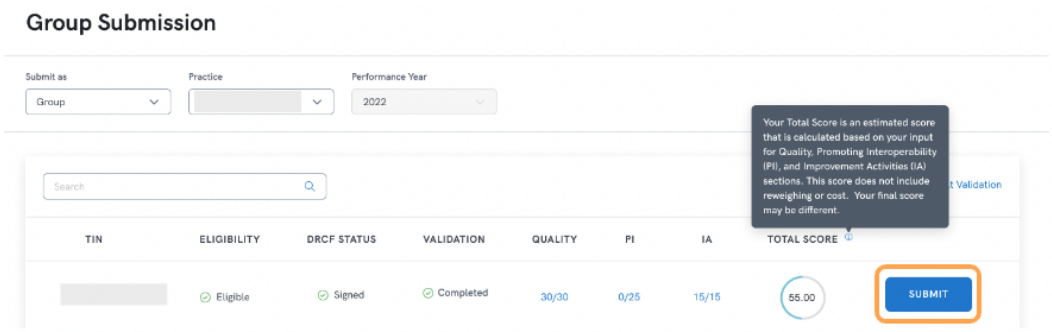


If you hover over the information icon, the following message will appear:



To Submit

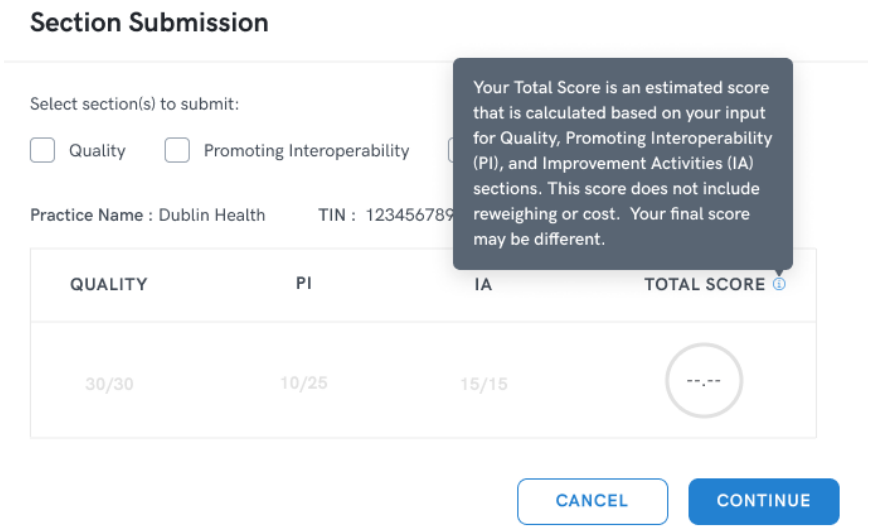
The **Submit** button is disabled until you complete the performance categories. To submit your MIPS Individual Submission, click **Submit**.



Completing the Section Submission

After you click **Submit**, the **Section Submission** dialog opens and shows the Practice Name, TIN, and DRCF status. In this section, you will choose the performance categories that you want to report to CMS. Each category that you choose populates based on the measures/activities that you selected to report in your data modules. The **Total Score** updates as you make your selections.

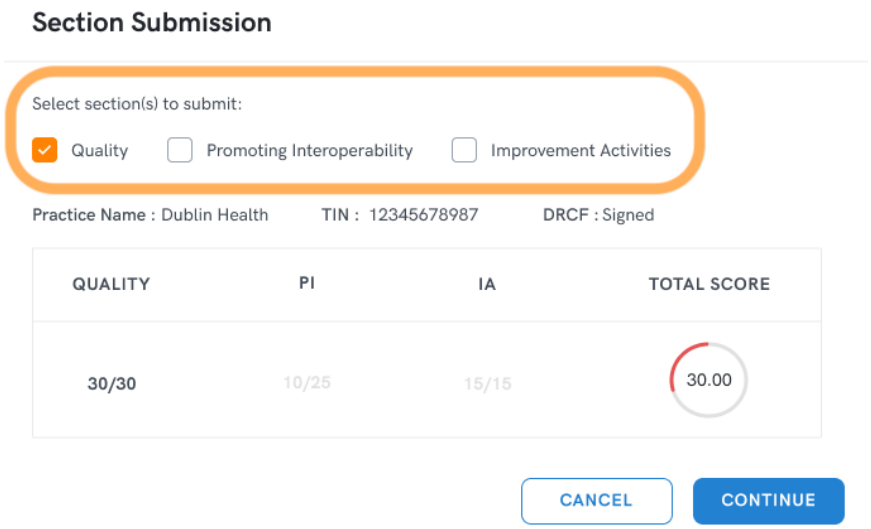
Note: You can choose to report all 3 performance measures, or just 1 or 2.



To complete this section, follow these steps:

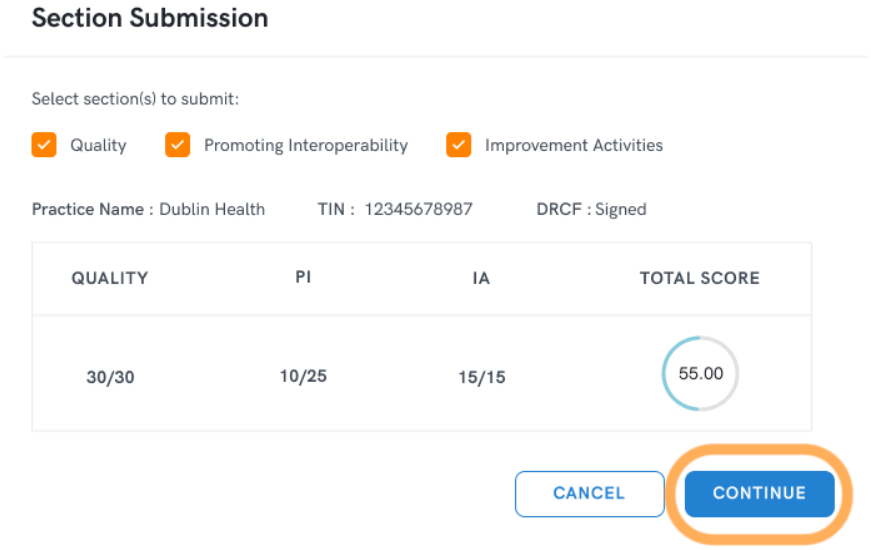
8. Mark the checkboxes next to the performance categories that you want to report.

   The table updates the performance category points and **Total Score**.

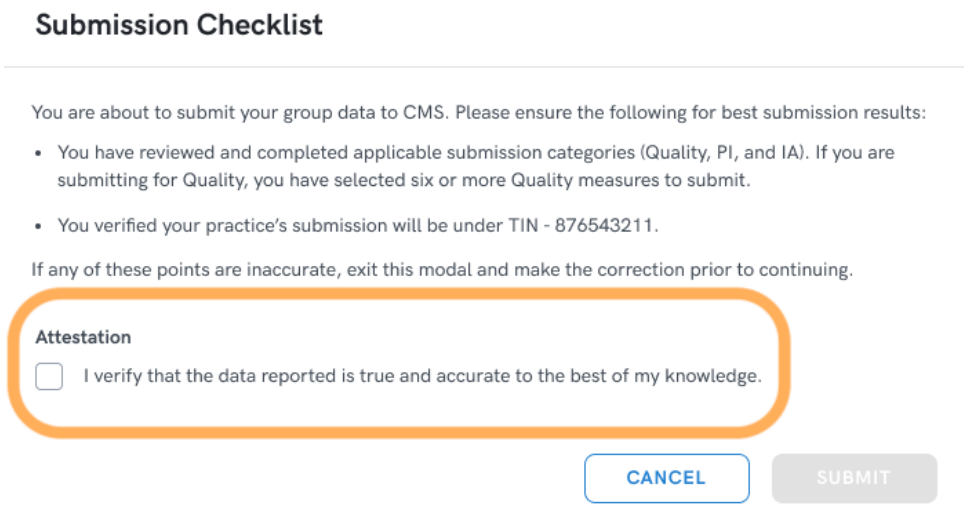


9. Click **Cancel** to return to the **Group Submission Summary** page if you do not want to submit this version. This will allow you to return to any of the performance categories to update your measures/activities selections in your data modules with the intent to increase your points and Total Score.

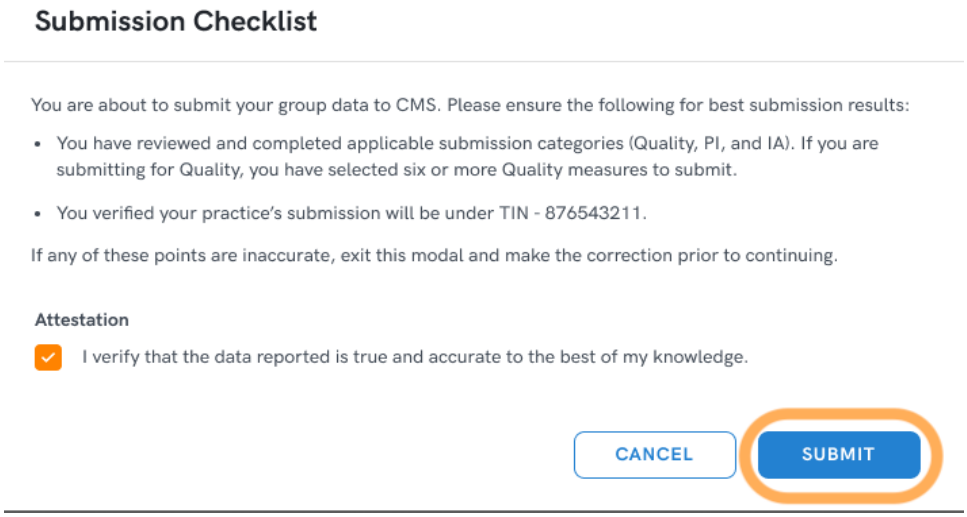
10. Click **Continue** if you want to report the current selection(s).



11. The **Submission Checklist** opens. The checklist allows you to review the information about your submission prior to reporting to CMS.



12. Click **Cancel** if you need to make any changes to your submission.
13. Mark the **Attestation** checkbox, to verify that the data reported is true and accurate to the best of your knowledge.
14. Click **Submit**.



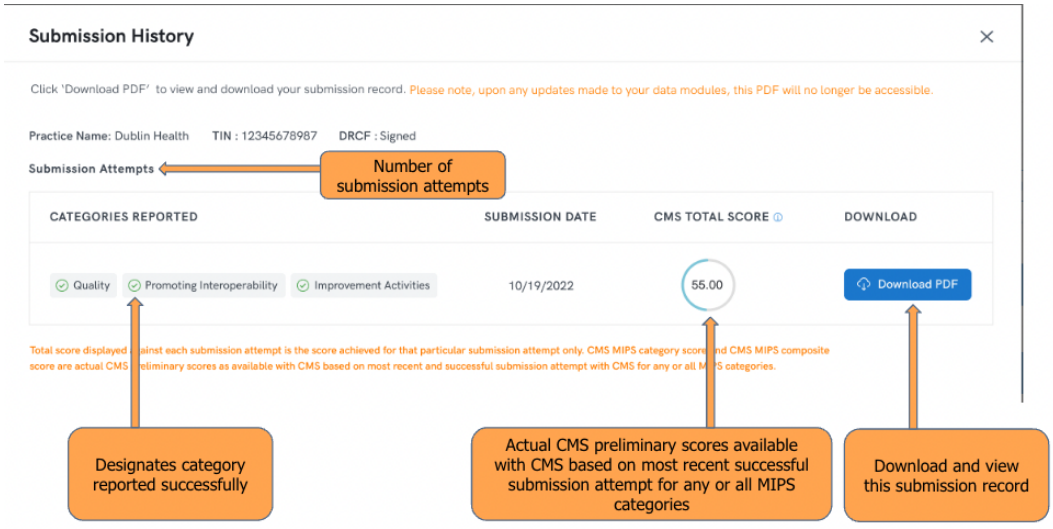
Downloading PDF in the Submission History Section

After you click **Submit**, the **Submission History** dialog opens. This is where you can view and download your submission record.

Note: It is important for you to download your submission right away. This MIPS Submission Record will be unavailable to view/download if you make any changes to your data modules after submission.

The **Submission History** shows:

- **Practice Name, TIN, and DRCF status**
- **Submission Attempts**
  Multiple attempts will show stacked in the table with the latest version on top.
- **Categories Reported**
  Hover over tooltips for status:
  - Red exclamation point icon indicates submission error for category reported.
  - Green checkmark icon indicates successfully submitted scores to CMS.
  - Grayed out field indicates the category was not reported.
- **Submission Date**
  The date of the current submission.
- **CMS Total Score**
  Total score displayed against each submission attempt is the score achieved for that particular submission attempt only. CMS MIPS category score and CMS MIPS composite score are actual CMS preliminary scores available with CMS based on most recent and successful submission attempt with CMS for any or all MIPS categories.
- **Download PDF**
  Button that allows you to download and view this submission record.



Follow these steps to complete the submission process:

1. Click **Download PDF** to view your MIPS Submission Record and maintain the copy for your files.

2. The **MIPS Submission Record** opens and shows:
    - **Submission Date**
      The date of the current submission.
    - **Submitter**
    - **Date of Download**
    - **Provider Name, NPI, TIN, and DRCF status**
    - **Measures Submitted**
      Some of the information specific to each performance category includes:

      Quality Measures
        - Type
        - Registry ID/Quality ID
        - Measure Name
        - NUM/DEN
        - Performance Rate

      Promoting Interoperability
        - Performance Duration
        - Measure ID
        - Measure Name
        - NUM/DEN
        - YES/NO
        - Exclusions

      Improvement Activity
        - Performance Duration
        - Activity ID
        - Activity Name
        - Weight

Verana Health

MIPS Submission Record

Submission Date: 12/09/2022
Submitter: Kimberly Cruz
Date of Download: 12/10/2022

Practice Name: Dublin Health NPI: 12345678987 TIN : 876543211 DRCF : Signed

SCORE SUMMARY

QUALITY	PI	IA	CMS TOTAL SCORE
30/30	10/25	15/15	55.00

MEASURES SUBMITTED

For individual measure scores, visit qpp.cms.gov.

Quality Measures

TYPE	REGISTRY ID / QUALITY ID	MEASURE NAME	NUM / DEN	PERFORMANCE RATE
QCDR	IRIS107	Preventive Care and Screening: Influenza Immunization	5861 / 6172	86.85
QCDR	IRIS111	Pneumococcal Vaccination Status for Older Adults	5861 / 6172	56.85

Promoting Interoperability

Performance Duration : 01/01/2022 to 12/31/2022

MEASURE ID	MEASURE NAME	NUM / DEN	YES/NO	EXCLUSIONS
PI_EP_1*	e-Prescribing Required Measure	5 / 10	--	No
PI_PHCDRR_1*	Immunization Registry Reporting	--	Yes	Yes

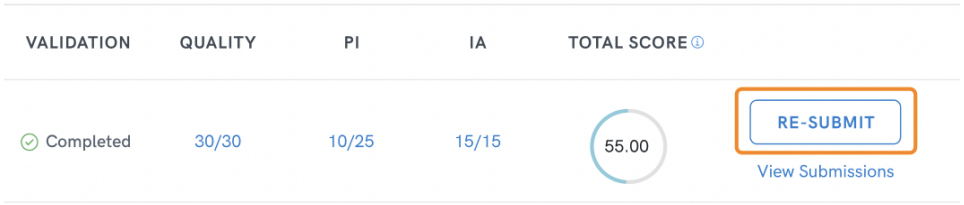
Improvement Activity

Performance Duration : 01/01/2022 to 12/31/2022

ACTIVITY ID	ACTIVITY NAME	WEIGHT
IA_AHE_1	Engagement of new Medicaid patients and follow-up	High

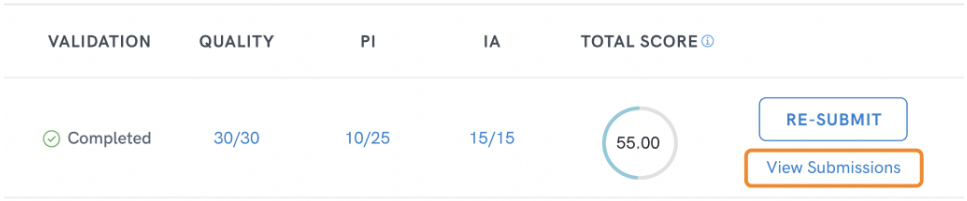
3. Click **X** in the upper right corner to close the **Submission History** dialog, and return to the **Group Submission Summary** page.

   You will see the **Submit** button is now a **RE-SUBMIT** button.



4. [Optional] Click **View Submission**, to view the **Submission History** and access the download PDF button for your MIPS Submission Record.

   Note: This **MIPS Submission Record** will be unavailable to view/download if you make any changes to your data modules after submission.



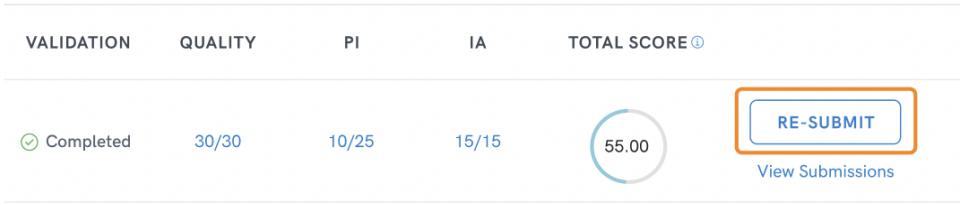
To Re-submit

You can re-submit your submission if you want to attempt to achieve a more favorable outcome. Return to any of the performance categories and update any of your measures/activities selections in your data modules with the intent to increase your points and Total Score.

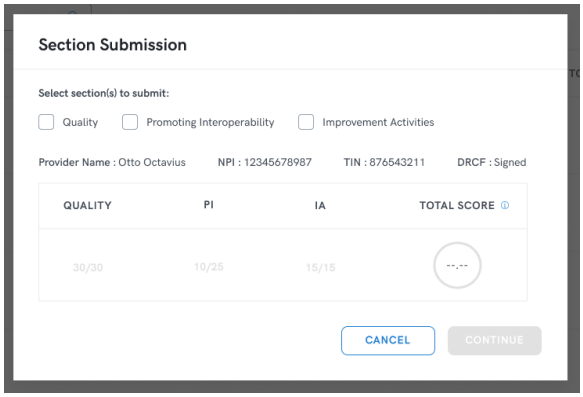
Note: If you re-submit, your previous **MIPS Submission Record** will be unavailable to download/view.

To re-submit your MIPS Group Submission after you update any of your measures/activities sections in your data modules, follow these steps:

1. Click **RE-SUBMIT**.



2. The Section Submission dialog opens. Follow the instructions in the previous section, Completing the Section Submission.



3. After you complete the workflow, the **Submission History** dialog will show your latest and previous submission records.

eCQM Title	**Closing the Referral Loop: Receipt of Specialist Report**		
eCQM Identifier (Measure Authoring Tool)	50	**eCQM Version Number**	11.2.000
NQF Number	Not Applicable	**GUID**	f58fc0d6-edf5-416a-8d29-79afbfd24dea
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	Centers for Medicare & Medicaid Services (CMS)		
Measure Developer	Mathematica		
Endorsed By	None		
Description	Percentage of patients with referrals, regardless of age, for which the referring clinician receives a report from the clinician to whom the patient was referred		
Copyright	Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. CPT(R) contained in the Measure specifications is copyright 2004-2021 American Medical Association. LOINC(R) is copyright 2004-2021 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2021 International Health Terminology Standards Development Organisation.		
Disclaimer	This performance Measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Due to technical limitations, registered trademarks are indicated by (R) or [R] and unregistered trademarks are indicated by (TM) or [TM].		
Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	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 et al., 2000; Forrest et al., 2000; Stille et al., 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 et al., 2000), pediatricians scheduled appointments with specialists for only 39% and sent patient information to the specialists for only 51% of referrals. In a 2006 report to Congress, the Medicare Payment Advisory Commission (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, van't Hooft, van der Wouden, Moorman & van Bemmel (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 et al., 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 (2008) recently highlighted care coordination as one of the most critical areas for development of quality measurement and improvement.		
Clinical Recommendation Statement	None		
Improvement Notation	A higher score indicates better quality		
Reference	Reference Type: CITATION Reference Text: 'Branger, P. J., van't Hooft, A., van der Wouden, J. C., Moorman, P. W., & van Bemmel, J. H. (1999). Shared care for diabetes: Supporting communication between primary and secondary care. International Journal of Medical Informatics, 53(2-3), 133-142. doi: 10.1016/s1386-5056(98)00154-3'		
Reference	Reference Type: CITATION Reference Text: 'Forrest, C. B., Glade, G. B., Baker, A. E., Bocian, A., von Schrader, S., & Starfield, B. (2000). Coordination of specialty referrals and physician satisfaction with referral care. Archives of Pediatrics and Adolescent Medicine, 154(5), 499-506. doi: 10.1001/archpedi.154.5.499'		
Reference	Reference Type: CITATION Reference Text: 'Gandhi, T. K., Sittig, D. F., Franklin, M., Sussman, A. J., Fairchild, D. G., & Bates, D. W. (2000). Communication breakdown in the outpatient referral process. Journal of General Internal Medicine, 15(9), 626-631. doi: 10.1046/j.1525-1497.2000.91119.x'		
Reference	Reference Type: CITATION Reference Text: 'MedPAC. (2006, March). Report to the Congress: Medicare payment policy. Retrieved from https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Mar06_EntireReport.pdf'		
Reference	Reference Type: CITATION Reference Text: 'National Priorities Partnership. (2008). National priorities and goals: Aligning our efforts to transform America's healthcare. Washington, DC: National Quality Forum.'		
Reference	Reference Type: CITATION Reference Text: 'Stille, C. J., Jerant, A., Bell, D., Meltzer, D., & Elmore, J. G. (2005). Coordinating care across diseases, settings, and clinicians: A key role for the generalist in practice. Annals of Internal Medicine, 142(8), 700-708. doi: 10.7326/0003-4819-142-8-200504190-00038'		

Definition	Referral: A request from one clinician to another clinician for evaluation, treatment, or co-management of a patient's condition. This term encompasses referral and consultation as defined by Centers for Medicare & 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, provides summary of care information about findings, diagnostics, assessments and/or plans of care, and is provided to the referring eligible clinician.
Guidance	The clinician who refers the patient to another clinician is the clinician who should be held accountable for the performance of this measure. Only the first referral made between January 1 – October 31 of the measurement period will be considered for this measure to allow adequate time for the referring clinician to collect the consult report by the end of the measurement period. If there are multiple referrals for a patient during the measurement period, use the first referral. The clinician to whom the patient was referred is responsible for sending the consultant report that will fulfill the communication. Note: this is not the same clinician who would report on the measure. The consultant report that will successfully close the referral loop should be related to the first referral for a patient during the measurement period. If there are multiple consultant reports received by the referring clinician which pertain to a particular referral, use the first consultant report to satisfy the measure. Eligible clinicians reporting on this measure should note that all data for the performance period is to be submitted by the deadline established by CMS. Therefore, eligible clinicians who refer patients towards the end of the performance period (i.e., October), should request that clinicians 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 measurement period. When clinicians to whom patients are referred communicate the consult report as soon as possible with the referring clinician, it ensures that the communication loop is closed in a timely manner and that the data are included in the submission to CMS. This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	Number of patients, regardless of age, who had an encounter during the measurement period and were referred by one clinician to another clinician on or before October 31
Denominator	Equals Initial Population
Denominator Exclusions	None
Numerator	Number of patients with a referral on or before October 31, for which the referring clinician received a report from the clinician 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

Table of Contents

Population Criteria

◢ Initial Population

"Has Encounter during Measurement Period"
and "First Referral during First 10 Months of Measurement Period" is not null

◢ Denominator

"Initial Population"

◢ Denominator Exclusions

None

◢ Numerator

"Referring Clinician Receives Consultant Report to Close Referral Loop"

◢ Numerator Exclusions

None

◢ Denominator Exceptions

None

◢ Stratification

None

Definitions

◢ Denominator

```
"Initial Population"
```

First Referral during First 10 Months of Measurement Period

```
First((["Intervention, Performed": "Referral"] ReferralPerform
      where Global."NormalizeInterval"(ReferralPerform.relevantDatetime, ReferralPerform.relevantPeriod)ends during Interval[start of "Measurement Period", start of
"Measurement Period" + 10 months]
      return {
        identification: ReferralPerform.id,
        dateIntervention:
        end of Global."NormalizeInterval"(ReferralPerform.relevantDatetime, ReferralPerform.relevantPeriod)
      }
  )
    union(["Intervention, Order": "Referral"] ReferralOrder
       where ReferralOrder.authorDatetime during Interval[start of "Measurement Period", start of "Measurement Period" + 10 months]
       return {
         identification: ReferralOrder.id,
         dateIntervention: ReferralOrder.authorDatetime
       }
    ))ReferralInterventions
    sort by dateIntervention ascending
)
```

Has Encounter during Measurement Period

```
exists ( ( ["Encounter, Performed": "Office Visit"]
    union ["Encounter, Performed": "Ophthalmological Services"]
    union ["Encounter, Performed": "Preventive Care Services - Established Office Visit, 18 and Up"]
    union ["Encounter, Performed": "Preventive Care Services, Initial Office Visit, 0 to 17"]
    union ["Encounter, Performed": "Preventive Care Services-Initial Office Visit, 18 and Up"]
    union ["Encounter, Performed": "Preventive Care, Established Office Visit, 0 to 17"] ) Encounter
    where Encounter.relevantPeriod during "Measurement Period"
)
```

Initial Population

```
"Has Encounter during Measurement Period"
  and "First Referral during First 10 Months of Measurement Period" is not null
```

Numerator

```
"Referring Clinician Receives Consultant Report to Close Referral Loop"
```

Referring Clinician Receives Consultant Report to Close Referral Loop

```
exists ( ["Communication, Performed": "Consultant Report"] ConsultantReportCommunicated
    with "First Referral during First 10 Months of Measurement Period" FirstReferral
      such that FirstReferral.identification in ConsultantReportCommunicated.relatedTo
        and ConsultantReportCommunicated.receivedDatetime after FirstReferral.dateIntervention
        and ConsultantReportCommunicated.receivedDatetime during "Measurement Period"
)
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- valueset "Consultant Report" (2.16.840.1.113883.3.464.1003.121.12.1006)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Preventive Care Services - Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services, Initial Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1022)
- valueset "Preventive Care Services-Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Preventive Care, Established Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1024)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Referral" (2.16.840.1.113883.3.464.1003.101.12.1046)

Data Criteria (QDM Data Elements)

- "Communication, Performed: Consultant Report" using "Consultant Report (2.16.840.1.113883.3.464.1003.121.12.1006)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Ophthalmological Services" using "Ophthalmological Services (2.16.840.1.113883.3.526.3.1285)"
- "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up" using "Preventive Care Services - Established Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1025)"
- "Encounter, Performed: Preventive Care Services, Initial Office Visit, 0 to 17" using "Preventive Care Services, Initial Office Visit, 0 to 17 (2.16.840.1.113883.3.464.1003.101.12.1022)"
- "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up" using "Preventive Care Services-Initial Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1023)"

- "Encounter, Performed: Preventive Care, Established Office Visit, 0 to 17" using "Preventive Care, Established Office Visit, 0 to 17 (2.16.840.1.113883.3.464.1003.101.12.1024)"
- "Intervention, Order: Referral" using "Referral (2.16.840.1.113883.3.464.1003.101.12.1046)"
- "Intervention, Performed: Referral" using "Referral (2.16.840.1.113883.3.464.1003.101.12.1046)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	Not Applicable

eCQM Title	**Documentation of Current Medications in the Medical Record**
eCQM Identifier (Measure Authoring Tool)	68
eCQM Version Number	12.0.000
NQF Number	Not Applicable
GUID	9a032d9c-3d9b-11e1-8634-00237d5bf174
Measurement Period	January 1, 20XX through December 31, 20XX
Measure Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Developer	Mathematica
Endorsed By	None
Description	Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.
Copyright	CPT(R) contained in the Measure specifications is copyright 2004-2021 American Medical Association. LOINC(R) copyright 2004-2021 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2021 International Health Terminology Standards Development Organisation. ICD-10 is copyright 2021 World Health Organization. All Rights Reserved. These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.
Disclaimer	THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Due to technical limitations, registered trademarks are indicated by (R) or [R] and unregistered trademarks are indicated by (TM) or [TM].
Measure Scoring	Proportion
Measure Type	Process
Stratification	None
Risk Adjustment	None
Rate Aggregation	None
Rationale	According to the National Center for Health Statistics, during the years of 2013-2016, 48.4% of patients (both male and female) were prescribed at least one prescription medication with 12.6% taking 5 or more medications. Additionally, 89.8% of patients (both male and female) aged 65 years and older were prescribed at least one medication with 40.9% taking 5 or more medications (2018). In this context, maintaining an accurate and complete medication list has proven to be a challenging documentation endeavor for various health care provider settings. While most of outpatient encounters (two-thirds) result in providers prescribing at least one medication, hospitals have been the focus of medication safety efforts (Stock, Scott, & Gurtel, 2009). Nassaralla, Naessens, Chaudhry, Hansen, and Scheitel (2007) caution that this is at odds with the current trend, where patients with chronic illnesses are increasingly being treated in the outpatient setting and require careful monitoring of multiple medications. Additionally, Nassaralla et al. (2007) reveal that it is in fact in outpatient settings where more fatal adverse drug events (ADE) occur when these are compared to those occurring in hospitals (1 of 131 outpatient deaths compared to 1 in 854 inpatient deaths). In the outpatient setting, ADEs occur 25% of the time and over one-third of these are considered preventable (Tache, Sonnichsen, & Ashcroft, 2011). Particularly vulnerable are patients over 65 years, with evidence suggesting that the rate of ADEs per 10,000 person per year increases with age; 25-44 years old at 1.3; 45-64 at 2.2, and 65 + at 3.8 (Sarkar, López, & Maselli, 2011). Other vulnerable groups include individuals who are chronically ill or disabled (Nabhanizadeh, Oppewal, Boot, & Maes, 2019). These population groups are more likely to experience ADEs and subsequent hospitalization. A multiplicity of providers and inadequate care coordination among them has been identified as barriers to collecting complete and reliable medication records. A study conducted by Poornima et al. (2015) indicates that reconciliation and documentation continue to be poorly executed with discrepancies occurring in 92% of patients (74 of 80 patients) of medication lists among admittance to the emergency room. Of 80 patients included in the study, the home medications were reordered for 65% of patients on their admission and of the 65% the majority (29%) had a change in their dosing interval, while 23% had a change in their route of administration, and 13% had a change in dose. A total of 361 medication discrepancies, or the difference between the medications patients were taking before admission and those listed in their admission orders, were identified in at least 74 patients. The study found that "Through an appropriate reconciliation programme, around 80% of errors relating to medication and the potential harm caused by these errors could be reduced" (Poornima et al., 2015, p. 243). Presley et al. (2020) also recognized specific barriers to sufficient medication documentation and reconciliation in rural and resource-limited care settings. Documentation of current medications in the medical record facilitates the process of medication review and reconciliation by the provider, which is necessary for reducing ADEs and promoting medication safety. The need for provider to provider coordination regarding medication records, and the existing gap in implementation, is highlighted in the American Medical Association's Physician's Role in Medication Reconciliation, which states that "critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes" (2007, p. 7). This is because clinical decisions based on information that is incomplete and/or inaccurate are likely to lead to medication error and ADEs. Weeks, Corbette, and Stream (2010) noted similar barriers and identified the utilization of health information technology as an opportunity for facilitating the creation of universal medication lists. One 2015 meta-analysis showed an association between EHR documentation with an overall RR of 0.46 (95% CI = 0.38 to 0.55; P < 0.001) and ADEs with an overall RR of 0.66 (95% CI = 0.44 to 0.99; P = 0.045). This meta-analysis provides evidence that the use of the EHR can improve the quality of healthcare delivered to patients by reducing medication errors and ADEs (Campanella et al., 2016).
Clinical Recommendation Statement	The Joint Commission's 2020 Ambulatory Health Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section "Use Medicines Safely NPSG.03.06.01" states the following: “Record and pass along correct information about a patient’s medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.” The National Quality Forum's Safe Practices for Better Healthcare (2010), states the following: "the healthcare organization must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care".
Improvement Notation	Higher score indicates better quality
Reference	Reference Type: CITATION Reference Text: 'American Medical Association. (2007). The physician’s role in medication reconciliation: Issues, strategies, and safety principles. Retrieved from https://pogoe.org/sites/default/files/Medication%20Reconciliation.pdf'
Reference	Reference Type: CITATION

	Reference Text: 'Campanella, P., Lovato, E., Marone, C., Fallacara, L., Mancuso, A., Ricciardi, W., & Specchia, M. L. (2016). The impact of electronic health records on health care quality: A systematic review and meta-analysis. European Journal of Public Health, 26(1), 60-64. http://doi:org/10.1093/eurpub/ckv122'
	Reference Type: CITATION
Reference	Reference Text: 'Nabhanizadeh, A., Oppewal, A., Boot, F. H., & Maes-Festen, D. (2019). Effectiveness of medication reviews in identifying and reducing medication-related problems among people with intellectual disabilities: A systematic review. Journal of Applied Research in Intellectual Disabilities, 32(4), 750–761. https://doi.org/10.1111/jar.12580'
	Reference Type: CITATION
Reference	Reference Text: 'Nassaralla, C. L., Naessens, J. M., Chaudhry, R., Hansen, M. A., & Scheitel, S. M. (2007). Implementation of a medication reconciliation process in an ambulatory internal medicine clinic. Quality and Safety in Health Care, 16(2), 90-94. http://doi.org/10.1136/qshc.2006.021113'
	Reference Type: CITATION
Reference	Reference Text: 'National Center for Health Statistics. (2018). Health, United States, 2018: Supplementary Table 38. Prescription drug use in the past 30 days, by sex, race and Hispanic origin, and age: United States, selected years 1988–1994 through 2013–2016 Retrieved from https://www.cdc.gov/nchs/data/hus/2018/038.pdf'
	Reference Type: CITATION
Reference	Reference Text: 'National Quality Forum. (2010). Safe practices for better healthcare - 2010 update. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2020/simplified_2020-ahc-npsg-eff-july-final.pdf'
	Reference Type: CITATION
Reference	Reference Text: 'Poornima, P., Reshma, P., Ramakrishnan, T. V., Rani, N. V., Devi, G. S., Seshadri, P. (2015). Medication reconciliation and medication error prevention in an emergency department of a tertiary care hospital. Journal of Young Pharmacists, 7(3), 241-249. https://www.jyoungpharm.org/sites/default/files/JYP_7_3_15.pdf'
	Reference Type: CITATION
Reference	Reference Text: 'Presley, C. A., Wooldridge, K. T., Byerly, S. H., Aylor, A. R., Kaboli, P. J., Roumie, C. L., Schnipper, J. L., Dittus, R. S., Mixon, A. S. (2020). The Rural VA Multi-Center Medication Reconciliation Quality Improvement Study (R-VA-MARQUIS). American Journal of Health-System Pharmacy, 77, 128-137. https://doi.org/10.1093/ajhp/zxz275'
	Reference Type: CITATION
Reference	Reference Text: 'Sarkar, U., López, A., Maselli, J. H., Gonzales, R. (2011). Adverse drug events in U.S. adult ambulatory medical care. Health Services Research, 46(5), 1517-1533. http://doi.org/10.1111/j.1475-6773.2011.01269.x'
	Reference Type: CITATION
Reference	Reference Text: 'Stock, R., Scott, J., & Gurtel, S. (2009). Using an electronic prescribing system to ensure accurate medication lists in a large multidisciplinary medical group. The Joint Commission Journal on Quality and Patient Safety, 35(5), 271-277'
	Reference Type: CITATION
Reference	Reference Text: 'Tache, S. V., Sonnichsen, A., & Ashcroft, D. M. (2011). Prevalence of adverse drug events in ambulatory care: A systematic review. The Annals of Pharmacotherapy, 45(7-8), 977-989. http://doi.org/10.1345/aph.1P627'
	Reference Type: CITATION
Reference	Reference Text: 'The Joint Commission. (2020). Ambulatory Health Care National Patient Safety Goals. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2020/simplified_2020-ahc-npsg-eff-july-final.pdf'
	Reference Type: CITATION
Reference	Reference Text: 'Weeks, D. L., Corbette, C. F., & Stream, G. (2010). Beliefs of ambulatory care physicians about accuracy of patient medication records and technology-enhanced solutions to improve accuracy. Journal for Healthcare Quality, 32(5), 12-21. http://doi.org/10.1111/j.1945-1474.2010.00097.x'
Definition	Current Medications: Medications the patient is presently taking including all prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and cannabis/cannabidiol products with each medication's name, dosage, frequency and administered route. Route: Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical).
Guidance	This eCQM is an episode-based measure. An episode is defined as each eligible encounter during the measurement period. This measure is to be reported for every encounter during the measurement period. Eligible clinicians reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. By reporting the action described in this measure, the provider attests to having documented a list of current medications utilizing all immediate resources available at the time of the encounter. This list must include all known prescriptions, over-the-counter (OTC) products, herbals, vitamins, minerals, dietary (nutritional) supplements, cannabis/cannabidiol products AND must contain the medications' name, dosage, frequency and route of administration. This measure should also be reported if the eligible clinician documented the patient is not currently taking any medications. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	All visits occurring during the 12-month measurement period for patients aged 18 years and older
Denominator	Equals Initial Population
Denominator Exclusions	None
Numerator	Eligible clinician attests to documenting, updating, or reviewing the patient's current medications using all immediate resources available on the date of the encounter
Numerator Exclusions	Not Applicable

Denominator Exceptions	Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status)
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

Population Criteria

Initial Population

```
"Qualifying Encounter during Measurement Period" QualifyingEncounter
  where AgeInYearsAt(date from start of "Measurement Period")>= 18
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

None

Numerator

```
"Qualifying Encounter during Measurement Period" QualifyingEncounter
  with ( ["Procedure, Performed": "Documentation of current medications (procedure)"]
    union ["Intervention, Performed": "Documentation of current medications (procedure)"] ) MedicationsDocumented
    such that Global."NormalizeInterval" ( MedicationsDocumented.relevantDatetime, MedicationsDocumented.relevantPeriod ) during QualifyingEncounter.relevantPeriod
```

Numerator Exclusions

None

Denominator Exceptions

```
"Qualifying Encounter during Measurement Period" QualifyingEncounter
  with ( ["Procedure, Not Performed": "Documentation of current medications (procedure)"]
    union ["Intervention, Not Performed": "Documentation of current medications (procedure)"] ) MedicationsNotDocumented
    such that MedicationsNotDocumented.authorDatetime during QualifyingEncounter.relevantPeriod
      and MedicationsNotDocumented.negationRationale in "Medical Reason"
```

Stratification

None

Definitions

Denominator

```
"Initial Population"
```

Denominator Exceptions

```
"Qualifying Encounter during Measurement Period" QualifyingEncounter
  with ( ["Procedure, Not Performed": "Documentation of current medications (procedure)"]
    union ["Intervention, Not Performed": "Documentation of current medications (procedure)"] ) MedicationsNotDocumented
    such that MedicationsNotDocumented.authorDatetime during QualifyingEncounter.relevantPeriod
      and MedicationsNotDocumented.negationRationale in "Medical Reason"
```

Initial Population

```
"Qualifying Encounter during Measurement Period" QualifyingEncounter
  where AgeInYearsAt(date from start of "Measurement Period")>= 18
```

Numerator

```
"Qualifying Encounter during Measurement Period" QualifyingEncounter
  with ( ["Procedure, Performed": "Documentation of current medications (procedure)"]
    union ["Intervention, Performed": "Documentation of current medications (procedure)"] ) MedicationsDocumented
    such that Global."NormalizeInterval" ( MedicationsDocumented.relevantDatetime, MedicationsDocumented.relevantPeriod ) during QualifyingEncounter.relevantPeriod
```

Qualifying Encounter during Measurement Period

```
["Encounter, Performed": "Encounter to Document Medications"] ValidEncounter
  where ValidEncounter.relevantPeriod during "Measurement Period"
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Functions

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- code "Documentation of current medications (procedure)" ("SNOMEDCT Code (428191000124101)")
- valueset "Encounter to Document Medications" (2.16.840.1.113883.3.600.1.1834)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Medical Reason" (2.16.840.1.113883.3.526.3.1007)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Race" (2.16.840.1.114222.4.11.836)

Data Criteria (QDM Data Elements)

- "Encounter, Performed: Encounter to Document Medications" using "Encounter to Document Medications (2.16.840.1.113883.3.600.1.1834)"
- "Intervention, Not Performed: Documentation of current medications (procedure)" using "Documentation of current medications (procedure) (SNOMEDCT Code 428191000124101)"
- "Intervention, Performed: Documentation of current medications (procedure)" using "Documentation of current medications (procedure) (SNOMEDCT Code 428191000124101)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"
- "Procedure, Not Performed: Documentation of current medications (procedure)" using "Documentation of current medications (procedure) (SNOMEDCT Code 428191000124101)"
- "Procedure, Performed: Documentation of current medications (procedure)" using "Documentation of current medications (procedure) (SNOMEDCT Code 428191000124101)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	CLINICAL QUALITY MEASURE SET

eCQM Title	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan**
eCQM Identifier (Measure Authoring Tool)	69
eCQM Version Number	11.2.000
NQF Number	Not Applicable
GUID	9a031bb8-3d9b-11e1-8634-00237d5bf174
Measurement Period	January 1, 20XX through December 31, 20XX
Measure Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Developer	Mathematica
Endorsed By	None
Description	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the measurement period AND who had a follow-up plan documented if BMI was outside of normal parameters Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.
Copyright	CPT(R) contained in the Measure specifications is copyright 2004-2021 American Medical Association. LOINC(R) is copyright 2004-2021 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2021 International Health Terminology Standards Development Organisation. ICD-10 is copyright 2021 World Health Organization. All Rights Reserved. These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.
Disclaimer	THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Due to technical limitations, registered trademarks are indicated by (R) or [R] and unregistered trademarks are indicated by (TM) or [TM].
Measure Scoring	Proportion
Measure Type	Process
Stratification	None
Risk Adjustment	None
Rate Aggregation	None
Rationale	BMI Above Normal Parameters "Obesity is a chronic, multifactorial disease with complex psychological, environmental (social and cultural), genetic, physiologic, metabolic and behavioral causes and consequences. The prevalence of overweight and obese people is increasing worldwide at an alarming rate in both developing and developed countries. Environmental and behavioral changes brought about by economic development, modernization and urbanization have been linked to the rise in global obesity. The health consequences are becoming apparent" (Fitch et al., 2013). More than a third of U.S. adults have a body mass index [BMI] >= 30 kg/m2 and are at increased risk for diabetes, cardiovascular disease (CVD), and obstructive sleep apnea (Flegal et al., 2012; Ogden et al., 2015; Dong et al., 2020). Hales et al. (2017), reported that the prevalence of obesity among adults and youth in the United States was 39.8 percent and 18.5 percent respectively, from 2015-2016. Furthermore, the prevalence of obesity in adults increased to 42.4 percent in 2018, with the highest percentage among adults in the 40-59 age bracket compared with other age groups (Hales et al., 2020). Hales et al. (2020) also disaggregated the data according to race/ethnicity and noted that obesity prevalence was higher among non-Hispanic Black adults and Hispanic adults when compared with other races and ethnicities. Obesity prevalence was lowest among non-Hispanic Asian men and women. Among men, obesity prevalence was higher among Hispanic men compared with non-Hispanic Black men and non-Hispanic White men. Among women, the prevalence among non-Hispanic Black women was 56.9 percent, which was higher than all other race/ethnicities. In general, the prevalence of obesity in the U.S. remains higher than the Healthy People 2020 goals of 30.5 percent among adults (Hales et al., 2020). BMI continues to be a common and reasonably reliable measurement to identify overweight and obese adults who may be at an increased risk for future morbidity. Although good quality evidence supports obtaining a BMI, it is important to recognize it is not a perfect measurement. For example, BMI and its associated disease and mortality risk appear to vary among ethnic subgroups. Black/African Americans appear to have the lowest mortality risk at a BMI of 26.2-28.5 kg/m2 in Black women and 27.1-30.2 kg/m2 in Black men. In contrast, Asian populations may experience lowest mortality rates starting at a BMI of 23 to 24 kg/m2. The correlation between BMI and diabetes risk also varies by ethnicity (LeBlanc et al., 2011, pp. 2-3). BMI is not a direct measure of adiposity and as a consequence, it can over or underestimate adiposity. However, overall, BMI is a derived value that correlates well with total body fat and markers of secondary complications, e.g., hypertension and dyslipidemia (Barlow & the Expert Committee, 2007). It is important to enhance beneficiary access to appropriate treatments for obesity, which could result in decreased healthcare costs and lower obesity rates. Behavioral weight management treatment has been identified as an effective first-line treatment for obesity with an average initial weight loss of 8-10 percent. This percentage weight loss is associated with a significant risk reduction for diabetes and CVD (Wadden, Butryn & Wilson, 2007). Evidence also shows that when provided 14 or more high-intensity behavioral intervention sessions of face-to-face individual or group treatment across 6 months, participants lose up to 8 percent of their weight during that time and experience improvements in heart disease risk factors and quality of life (Wadden, Tronieri, & Butryn, 2020). There is also evidence that high-intensity behavioral counseling is effective, whether delivered in-person, by phone, or electronically (Tronieri et al., 2019). Moreover, Intensive Behavioral Therapy (IBT) for obesity provided by Registered Dietitian Nutritionists for 6-12 months shows significant mean weight loss of up to 10 percent of body weight, maintained over one year's time (Raynor & Champagne, 2016). Despite the evidence that supports weight management counseling, the rate of use in primary care for patients with obesity decreased by 10 percent from 39.9 percent in 1995-1996 to 29.9 percent in 2007-2008 (Kraschnewski et al., 2013). Weight management counseling during primary care visits further declined from 33 percent to 21 percent between 2008-2009 and 2012-2013. This suggests that obesity management in primary care remains suboptimal (Fitzpatrick & Stevens, 2017). Therefore, screening for BMI and follow-up is critical and will help in reaching the quality goals of population health and cost reduction. However, due to concerns for other underlying conditions (such as bone health) or nutrition-related deficiencies, providers are cautioned to use their best clinical judgment when considering weight management programs for overweight patients, especially the elderly (National Heart, Lung, and Blood Institute [NHLBI] Obesity Education Initiative, 1998, p. 91). BMI Below Normal Parameters On the other end of the body weight spectrum is underweight (BMI < 18.5 kg/m2), which is equally detrimental to population health. When compared to normal weight individuals (BMI 18.5-25 kg/m2), underweight individuals have significantly higher death rates with a Hazard Ratio of 2.27 and 95 percent confidence intervals (CI) = 1.78, 2.90 (Borrell & Samuel, 2014). Poor nutrition or underlying health conditions can result in underweight (Fryar & Ogden, 2012). The National Health and Nutrition Examination Survey (NHANES) results from 2007-2010 indicate that women are more likely to be underweight than men (Centers for Disease Control and Prevention, 2012). However, all patients should be equally

	screened for underweight and followed up with nutritional counseling to reduce mortality and morbidity associated with underweight. All adults should be screened annually using a BMI measurement. BMI measurements >= 25 kg/m2 should be used to initiate further evaluation of overweight or obesity after taking into account age, gender, ethnicity, fluid status, and muscularity; therefore, clinical evaluation and judgment must be used when BMI is employed as the anthropometric indicator of excess adiposity, particularly in athletes and those with sarcopenia (Garvey et al., 2016 AACE/ACE Guidelines, 2016, pp. 12-13) (Grade A). Overweight and Underweight Categories: Underweight < 18.5; Normal weight 18.5-24.9; Overweight 25-29.9; Obese class I 30-34.9; Obese class II 35-39.9; Obese class III >= 40 (Garvey et al., 2016 AACE/ACE Guidelines, 2016, p. 15). BMI cutoff point value of >= 23 kg/m2 should be used in the screening and confirmation of excess adiposity in Asian adults (Garvey et al., 2016 AACE/ACE Guidelines, 2016, p. 13) (Grade B). Lifestyle/Behavioral Therapy for Overweight and Obesity should include behavioral interventions that enhance adherence to prescriptions for a reduced-calorie meal plan and increased physical activity (behavioral interventions can include: self-monitoring of weight, food intake, and physical activity; clear and reasonable goal-setting; education pertaining to obesity, nutrition, and physical activity; face-to-face and group meetings; stimulus control; systematic approaches for problem solving; stress reduction; cognitive restructuring [i.e., cognitive behavioral therapy], motivational interviewing; behavioral contracting; psychological counseling; and mobilization of social support structures) (Garvey et al., 2016 AACE/ACE Guidelines, 2016, p. 22) (Grade A). Behavioral lifestyle intervention should be tailored to a patient's ethnic, cultural, socioeconomic, and educational background (Garvey et al., 2016 AACE/ACE Guidelines, 2016, p. 22) (Grade B).
Clinical Recommendation Statement	The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians offer or refer adults with a BMI of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions (USPSTF, 2018) (Grade B). Interventions: - Effective intensive behavioral interventions were designed to help participants achieve or maintain weight loss of at least five percent through a combination of dietary changes and increased physical activity - Most interventions lasted for one to two years, and the majority had at least 12 sessions in the first year - Most behavioral interventions focused on problem solving to identify barriers, self-monitoring of weight, peer support, and relapse prevention - Interventions also provided tools to support weight loss or weight loss maintenance (e.g., pedometers, food scales, or exercise videos) (USPSTF, 2018) Nutritional safety for the elderly should be considered when recommending weight reduction. "A clinical decision to forego obesity treatment in older adults should be guided by an evaluation of the potential benefits of weight reduction for day-to-day functioning and reduction of the risk of future cardiovascular events, as well as the patient's motivation for weight reduction. Care must be taken to ensure that any weight reduction program minimizes the likelihood of adverse effects on bone health or other aspects of nutritional status" (NHLBI Obesity Education Initiative, 1998, p. 91) (Evidence Category D). In addition, weight reduction prescriptions in older persons should be accompanied by proper nutritional counseling and regular body weight monitoring (NHLBI Obesity Education Initiative, 1998, p. 91). The possibility that a standard approach to weight loss will work differently in diverse patient populations must be considered when setting expectations about treatment outcomes (NHLBI Obesity Education Initiative, 1998, p. 97) (Evidence Category B).
Improvement Notation	Higher score indicates better quality
	Reference Type: CITATION
Reference	Reference Text: 'Barlow, S. E., & the Expert Committee. (2007). Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. Pediatrics, 120(Suppl. 4), S164-S192. doi:10.1542/peds.2007-2329C'
	Reference Type: CITATION
Reference	Reference Text: 'Borrell, L. N., & Samuel, L. (2014). Body mass index categories and mortality risk in U.S. adults: The effect of overweight and obesity on advancing death. American Journal of Public Health, 104(3), 512-519. doi:10.2105/AJPH.2013.301597'
	Reference Type: CITATION
Reference	Reference Text: 'Centers for Disease Control and Prevention (CDC). (2012). National Health and Nutrition Examination Survey (NHANES). Prevalence of underweight among adults aged 20 and over: United States, 1960–1962 Through 2011–2012. Retrieved from https://www.cdc.gov/nchs/data/hestat/underweight_adult_11_12/underweight_adult_11_12.htm'
	Reference Type: CITATION
Reference	Reference Text: 'Diehr, P., O'Meara, E. S., Fitzpatrick A., Newman, A. B., Kuller, L., Burke, G. (2008). Weight, mortality, years of healthy life, and active life expectancy in older adults. Journal of the American Geriatrics Society, 56(1), 76-83. https://doi.org/10.1111/j.1532-5415.2007.01500.x'
	Reference Type: CITATION
Reference	Reference Text: 'Dong, Z., Xu, X., Wang, C., Cartledge, S., Maddison, R., & Mohammed Shariful Islam, S. (2020). Association of overweight and obesity with obstructive sleep apnoea: A systematic review and meta-analysis. Obesity Medicine, 17. doi:https://doi.org/10.1016/j.obmed.2020.100185'
	Reference Type: CITATION
Reference	Reference Text: 'Donini, L. M., Savina, C., Gennaro, E., De Felice, M. R., Rosano, A., Pandolfo, M. M., Del Balzo, V., … Chumlea, W. C. et al. (2012). A systematic review of the literature concerning the relationship between obesity and mortality in the elderly. The Journal of Nutrition, Health & Aging, 16(1), 89-98. doi:10.1007/s12603-011-0073-x'
	Reference Type: CITATION
Reference	Reference Text: 'Fitch, A., Everling, L., Fox, C.,Goldberg, J., Heim, C., Johnson, K., …Webb, B. (2013, May). Prevention and management of obesity for adults. Bloomington, MN: Institute for Clinical Systems Improvement.'
	Reference Type: CITATION
Reference	Reference Text: 'Fitzpatrick, S. L., & Stevens, V. J. (2017). Adult obesity management in primary care, 2008-2013. Preventive medicine, 99, 128–133. https://doi.org/10.1016/j.ypmed.2017.02.020'
	Reference Type: CITATION
Reference	Reference Text: 'Flegal, K. M., Carroll, M. D., Kit, B. K., & Ogden, C. L. (2012). Prevalence of obesity and trends in the distribution of body mass index among U. S. adults, 1999-2010. JAMA, 307(5), 491-497. doi.10.1001/jama.2012.39'
Reference	Reference Type: CITATION
	Reference Text: 'Fryar, C. D., & Ogden, C. L. (2012). Prevalence of underweight among adults aged 20 and over: United States, 1960-1962 through 2007-2010. Hyattsville, MD: NCHS, Division of Health and Nutrition Examination

	Surveys. Retrieved from http://www.cdc.gov/nchs/data/hestat/underweight_adult_07_10/underweight_adult_07_10.pdf'
	Reference Type: CITATION
Reference	Reference Text: 'Garvey, W. T., Mechanick, J. I., Brett, E. M., Garber, A. J., Hurley, D. L., Jastrebodd. A. M., …and Reviewers of the AACE/ACE Obesity Clinical Practice Guidelines. (2016). American Association of Clinical Endocrinologists and American College of Endocrinology Comprehensive clinical practice guidelines for medical care of patients with obesity. Endocrine Practice, 22(Suppl. 3), 1-203. https://doi.org/10.4158/EP161365.GL'
	Reference Type: CITATION
Reference	Reference Text: 'Hales, C. M., Carroll, M. D., Fryar, C. D., et al. (2017). Prevalence of obesity among adults and youth: United States, 2015-2016. NCHS Data Brief No. 288. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db288.htm'
	Reference Type: CITATION
Reference	Reference Text: 'Hales, C. M., Carroll, M. D., Fryar, C. D., & Ogden, C.L. (2020). Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017-2018. NCHS Data Brief No. 360. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db360.htm'
	Reference Type: CITATION
Reference	Reference Text: 'Holme, I., & Tonstad, S. (2015). Survival in elderly men in relation to midlife and current BMI. Age and Ageing, 44(3), 434-439'
	Reference Type: CITATION
Reference	Reference Text: 'Kraschnewski, J. L., Sciamanna, C. N., Stuckey, H. L., Chuang, C. H., Lehman, E. B., Hwang, K. O., Sherwood, L. L., & Nembhard, H. B. (2013). A silent response to the obesity epidemic: decline in US physician weight counseling. Medical care, 51(2), 186–192. https://doi.org/10.1097/MLR.0b013e3182726c33'
	Reference Type: CITATION
Reference	Reference Text: 'LeBlanc, E., O'Connor, E., Whitlock, E. P., et al. (2011). Screening for and management of obesity and overweight in adults (Evidence Report No. 89; AHRQ Publication No. 11-05159-EF-1). Rockville, MD: Agency for Healthcare Research and Quality'
	Reference Type: CITATION
Reference	Reference Text: 'NHLBI Obesity Education Initiative. (1998). Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults (Report No. 98-4083). Bethesda, MD: NHLBI'
	Reference Type: CITATION
Reference	Reference Text: 'Ogden, C.L., Carroll, M.D., Fryar, C.D., Flegal, K.M. (2015). Prevalence of obesity among adults and youth: United States, 2011–2014. NCHS data brief, no 219. Hyattsville, MD: National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db219.pdf'
	Reference Type: CITATION
Reference	Reference Text: 'Raynor, H. A., & Champagne, C. M. (2016). Position of the Academy of Nutrition and Dietetics: Interventions for the treatment of overweight and obesity in adults. Journal of the Academy of Nutrition and Dietetics, 116(1), 129-147. doi:10.1016/jand.2015.10.031'
	Reference Type: CITATION
Reference	Reference Text: 'Tronieri, J. S., Wadden, T. A., Chao, A. M., & Tsai, A. G. (2019). Primary Care Interventions for Obesity: Review of the Evidence. Current obesity reports, 8(2), 128–136. https://doi.org/10.1007/s13679-019-00341-5'
	Reference Type: CITATION
Reference	Reference Text: 'U.S. Preventive Services Task Force (USPSTF). (2018). Behavioral weight loss interventions to prevent obesity-related morbidity and mortality in adults: U.S. Preventive Services Task Force recommendation statement. JAMA, 320(11), 1163–1171. doi:10.1001/jama.2018.13022'
	Reference Type: CITATION
Reference	Reference Text: 'Wadden, T. A, Butryn, M. L., Wilson, C. (2007). Lifestyle modification for the management of obesity. Gastroenterology, 132 (6), 2226-2238. doi: 10.1053/j.gastro.2007.03.051'
	Reference Type: CITATION
Reference	Reference Text: 'Wadden, T. A., Tronieri, J. S., & Butryn, M. L. (2020). Lifestyle modification approaches for the treatment of obesity in adults. American Psychologist, 75(2), 235–251'
Definition	Normal BMI Parameters: Age 18 years and older BMI >= 18.5 and < 25 kg/m2 BMI- Body mass index (BMI) is a number calculated using the Quetelet index: weight divided by height squared (W/H2) and is commonly used to classify weight categories. BMI can be calculated using: Metric Units: BMI = Weight (kg) / (Height (m) x Height (m)) OR English Units: BMI = Weight (lbs.) / (Height (in) x Height (in)) x 703 Follow-Up Plan - Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include, but is not limited to: documentation of education, referral (for example a Registered Dietitian Nutritionist (RDN), occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon) for lifestyle/behavioral therapy, pharmacological interventions, dietary supplements, exercise counseling and/or nutrition counseling
Guidance	BMI Measurement Guidance: * Height and Weight - An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured during the measurement period. Self-reported values cannot be used. * The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider. * If the documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the measurement period. * If more than one BMI is reported during the measurement period, and any of the documented BMI assessments is outside of normal parameters, documentation of an appropriate follow-up plan will be used to determine if performance has been met. * Review the exclusions and exceptions criteria to determine those patients that BMI measurement may not be appropriate or necessary. Follow-Up Plan Guidance: * The documented follow-up plan must be based on the documented BMI, outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above or below normal parameters." See the Definition section for examples of follow-up plan treatments.

	Variation has been noted in studies exploring optimal BMI ranges for the elderly (see Donini et al., [2012]; Holme & Tonstad [2015]; Diehr et al. [2008]). Notably however, all these studies have arrived at ranges that differ from the standard range for ages 18 and older, which is >=18.5 and < 25 kg/m2. For instance, both Donini et al. (2012) and Holme and Tonstad (2015) reported findings that suggest that higher BMI (higher than the upper end of 25kg/m2) in the elderly may be beneficial. Similarly, worse outcomes have been associated with being underweight (at a threshold higher than 18.5 kg/m2) at age 65 (Diehr et al. 2008). Because of optimal BMI range variation recommendations from these studies, no specific optimal BMI range for the elderly is used. However, it may be appropriate to exempt certain patients from a follow-up plan by applying the exception criteria. See Denominator Exception section for examples. This eCQM is a patient-based measure. This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying encounter and the measure-specific denominator coding. Telehealth encounters are not eligible for this measure because the measure requires a clinical action that cannot be conducted via telehealth. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	All patients aged 18 and older on the date of the encounter with at least one eligible encounter during the measurement period
Denominator	Equals Initial Population
Denominator Exclusions	Patients who are pregnant at any time during the measurement period. Patients receiving palliative or hospice care at any time during the measurement period.
Numerator	Patients with a documented BMI during the encounter or during the measurement period, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the measurement period
Numerator Exclusions	Not Applicable
Denominator Exceptions	Patients with a documented medical reason for not documenting BMI or for not documenting a follow-up plan for a BMI outside normal parameters (e.g., elderly patients 65 years of age or older for whom weight reduction/weight gain would complicate other underlying health conditions such as illness or physical disability, mental illness, dementia, confusion, or nutritional deficiency such as vitamin/mineral deficiency; patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status). Patients who refuse measurement of height and/or weight.
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity, and sex

Table of Contents

Population Criteria

Initial Population

```
exists "Qualifying Encounter during Measurement Period" QualifyingEncounter
  where "AgeInYearsAt"(date from start of QualifyingEncounter.relevantPeriod)>= 18
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or PalliativeCare."Palliative Care in the Measurement Period"
  or exists "Pregnancy"
```

Numerator

```
exists "High BMI and Follow up Provided"
  or exists "Low BMI and Follow up Provided"
  or "Has Normal BMI"
```

Numerator Exclusions

None

Denominator Exceptions

```
exists "Medical Reason for Not Documenting a Follow up Plan for Low or High BMI"
  or exists "Medical Reason or Patient Reason for Not Performing BMI Exam"
```

Stratification

None

Definitions

BMI during Measurement Period

```
( ["Physical Exam, Performed": "Body mass index (BMI) [Ratio]"] BMI
    where Global."NormalizeInterval" ( BMI.relevantDatetime, BMI.relevantPeriod ) during "Measurement Period"
      and BMI.result > 0 'kg/m2'
    sort by start of Global."NormalizeInterval" ( relevantDatetime, relevantPeriod ) ascending
)
```

Denominator

```
"Initial Population"
```

Denominator Exceptions

```
exists "Medical Reason for Not Documenting a Follow up Plan for Low or High BMI"
  or exists "Medical Reason or Patient Reason for Not Performing BMI Exam"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or PalliativeCare."Palliative Care in the Measurement Period"
  or exists "Pregnancy"
```

Documented High BMI during Measurement Period

```
["Physical Exam, Performed": "Body mass index (BMI) [Ratio]"] BMI
  where Global."NormalizeInterval" ( BMI.relevantDatetime, BMI.relevantPeriod ) during "Measurement Period"
    and BMI.result >= 25 'kg/m2'
```

Documented Low BMI during Measurement Period

```
["Physical Exam, Performed": "Body mass index (BMI) [Ratio]"] BMI
  where Global."NormalizeInterval" ( BMI.relevantDatetime, BMI.relevantPeriod ) during "Measurement Period"
    and BMI.result < 18.5 'kg/m2'
```

Has Normal BMI

```
exists ( "BMI during Measurement Period" BMI
    where BMI.result included in Interval[18.5 'kg/m2', 24.9 'kg/m2']
)
  and not ( exists "Documented High BMI during Measurement Period"
      or exists "Documented Low BMI during Measurement Period"
  )
```

High BMI and Follow up Provided

```
( "Documented High BMI during Measurement Period" HighBMI
    with ( "High BMI Interventions Ordered"
      union "High BMI Interventions Performed" ) HighBMIInterventions
      such that ( Coalesce(start of Global."NormalizeInterval"(HighBMIInterventions.relevantDatetime, HighBMIInterventions.relevantPeriod),
HighBMIInterventions.authorDatetime)during "Measurement Period" )
)
```

High BMI Interventions Ordered

```
( ( ["Intervention, Order": "Follow Up for Above Normal BMI"]
    union ["Intervention, Order": "Referrals Where Weight Assessment May Occur"]
    union ["Medication, Order": "Medications for Above Normal BMI"] ) HighInterventionsOrdered
    where HighInterventionsOrdered.reason in "Overweight or Obese"
      or ( exists ["Diagnosis": "Overweight or Obese"] OverweightObese
          where OverweightObese.prevalencePeriod starts before or on day of HighInterventionsOrdered.authorDatetime
            and not ( OverweightObese.prevalencePeriod ends before day of HighInterventionsOrdered.authorDatetime )
            and HighInterventionsOrdered.authorDatetime during "Measurement Period"
      )
)
```

High BMI Interventions Performed

```
( ["Intervention, Performed": "Follow Up for Above Normal BMI"] HighInterventionsPerformed
    where HighInterventionsPerformed.reason in "Overweight or Obese"
      or ( exists ["Diagnosis": "Overweight or Obese"] OverweightObese
          where OverweightObese.prevalencePeriod starts before or on day of Global."NormalizeInterval" ( HighInterventionsPerformed.relevantDatetime,
HighInterventionsPerformed.relevantPeriod )
            and not ( OverweightObese.prevalencePeriod ends before day of Global."NormalizeInterval" ( HighInterventionsPerformed.relevantDatetime,
HighInterventionsPerformed.relevantPeriod ) )
            and Global."NormalizeInterval" ( HighInterventionsPerformed.relevantDatetime, HighInterventionsPerformed.relevantPeriod ) during "Measurement Period"
      )
)
```

Hospice.Has Hospice Services

```
exists ( ["Encounter, Performed": "Encounter Inpatient"] InpatientEncounter
    where ( InpatientEncounter.dischargeDisposition ~ "Discharge to home for hospice care (procedure)"
       or InpatientEncounter.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)"
    )
      and InpatientEncounter.relevantPeriod ends during day of "Measurement Period"
)
  or exists ( ["Encounter, Performed": "Hospice Encounter"] HospiceEncounter
      where HospiceEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Assessment, Performed": "Hospice care [Minimum Data Set]"] HospiceAssessment
      where HospiceAssessment.result ~ "Yes (qualifier value)"
        and Global."NormalizeInterval" ( HospiceAssessment.relevantDatetime, HospiceAssessment.relevantPeriod ) overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Order": "Hospice Care Ambulatory"] HospiceOrder
      where HospiceOrder.authorDatetime during day of "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Hospice Care Ambulatory"] HospicePerformed
      where Global."NormalizeInterval" ( HospicePerformed.relevantDatetime, HospicePerformed.relevantPeriod ) overlaps "Measurement Period"
  )
```

Initial Population

```
exists "Qualifying Encounter during Measurement Period" QualifyingEncounter
  where "AgeInYearsAt"(date from start of QualifyingEncounter.relevantPeriod)>= 18
```

Low BMI and Follow up Provided

```
( "Documented Low BMI during Measurement Period" LowBMI
    with ( "Low BMI Interventions Ordered"
      union "Low BMI Interventions Performed" ) LowBMIInterventions
      such that ( Coalesce(start of Global."NormalizeInterval"(LowBMIInterventions.relevantDatetime, LowBMIInterventions.relevantPeriod),
LowBMIInterventions.authorDatetime)during "Measurement Period" )
)
```

Low BMI Interventions Ordered

```
( ( ["Intervention, Order": "Follow Up for Below Normal BMI"]
    union ["Intervention, Order": "Referrals Where Weight Assessment May Occur"]
    union ["Medication, Order": "Medications for Below Normal BMI"] ) LowInterventionsOrdered
    where LowInterventionsOrdered.reason in "Underweight"
      or ( exists ["Diagnosis": "Underweight"] Underweight
          where Underweight.prevalencePeriod starts before or on day of LowInterventionsOrdered.authorDatetime
            and not ( Underweight.prevalencePeriod ends before day of LowInterventionsOrdered.authorDatetime )
            and LowInterventionsOrdered.authorDatetime during "Measurement Period"
      )
)
```

Low BMI Interventions Performed

```
( ["Intervention, Performed": "Follow Up for Below Normal BMI"] LowInterventionsPerformed
    where LowInterventionsPerformed.reason in "Underweight"
      or ( exists ["Diagnosis": "Underweight"] Underweight
          where Underweight.prevalencePeriod starts before or on day of Global."NormalizeInterval" ( LowInterventionsPerformed.relevantDatetime,
LowInterventionsPerformed.relevantPeriod )
            and not ( Underweight.prevalencePeriod ends before day of Global."NormalizeInterval" ( LowInterventionsPerformed.relevantDatetime,
LowInterventionsPerformed.relevantPeriod ) )
            and Global."NormalizeInterval" ( LowInterventionsPerformed.relevantDatetime, LowInterventionsPerformed.relevantPeriod ) during "Measurement Period"
      )
)
```

Medical Reason for Not Documenting a Follow up Plan for Low or High BMI

```
( ["Intervention, Not Ordered": "Referrals Where Weight Assessment May Occur"]
  union ["Intervention, Not Ordered": "Follow Up for Above Normal BMI"]
  union ["Intervention, Not Performed": "Follow Up for Above Normal BMI"]
  union ["Intervention, Not Ordered": "Follow Up for Below Normal BMI"]
  union ["Intervention, Not Performed": "Follow Up for Below Normal BMI"]
  union ["Medication, Not Ordered": "Medications for Above Normal BMI"]
  union ["Medication, Not Ordered": "Medications for Below Normal BMI"] ) NoBMIFollowUp
  with "Qualifying Encounter during Measurement Period" QualifyingEncounter
    such that NoBMIFollowUp.authorDatetime same day as start of QualifyingEncounter.relevantPeriod
  where NoBMIFollowUp.negationRationale in "Medical Reason"
```

Medical Reason or Patient Reason for Not Performing BMI Exam

```
["Physical Exam, Not Performed": "Body mass index (BMI) [Ratio]"] NoBMI
  with "Qualifying Encounter during Measurement Period" QualifyingEncounter
    such that Global."NormalizeInterval" ( NoBMI.authorDatetime, NoBMI.relevantPeriod ) ends same day as start of QualifyingEncounter.relevantPeriod
  where ( NoBMI.negationRationale in "Medical Reason"
     or NoBMI.negationRationale in "Patient Declined"
  )
```

Numerator

```
exists "High BMI and Follow up Provided"
  or exists "Low BMI and Follow up Provided"
  or "Has Normal BMI"
```

PalliativeCare.Palliative Care in the Measurement Period

```
exists ( ["Assessment, Performed": "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)"] PalliativeAssessment
    where Global."NormalizeInterval"(PalliativeAssessment.relevantDatetime, PalliativeAssessment.relevantPeriod) overlaps "Measurement Period"
)
or exists (["Diagnosis": "Encounter for palliative care"] PalliativeDiagnosis
where PalliativeDiagnosis.prevalencePeriod overlaps "Measurement Period")
  or exists ( ["Encounter, Performed": "Palliative Care Encounter"] PalliativeEncounter
      where PalliativeEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Palliative Care Intervention"] PalliativeIntervention
      where Global."NormalizeInterval"(PalliativeIntervention.relevantDatetime, PalliativeIntervention.relevantPeriod) overlaps "Measurement Period"
  )
```

Pregnancy

```
["Diagnosis": "Pregnancy or Other Related Diagnoses"] PregnancyDiagnosis
  with "Qualifying Encounter during Measurement Period" QualifyingEncounter
    such that PregnancyDiagnosis.prevalencePeriod overlaps "Measurement Period"
```

Qualifying Encounter during Measurement Period

```
["Encounter, Performed": "Encounter to Evaluate BMI"] BMIEncounter
  where BMIEncounter.relevantPeriod during "Measurement Period"
    and BMIEncounter.class !~ "virtual"
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- code "Body mass index (BMI) [Ratio]" ("LOINC Code (39156-5)")
- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Encounter for palliative care" ("ICD10CM Code (Z51.5)")
- code "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")
- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "virtual" ("ActCode Code (VR)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Encounter to Evaluate BMI" (2.16.840.1.113883.3.600.1.1751)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Follow Up for Above Normal BMI" (2.16.840.1.113883.3.600.1.1525)
- valueset "Follow Up for Below Normal BMI" (2.16.840.1.113883.3.600.1.1528)
- valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Medical Reason" (2.16.840.1.113883.3.526.3.1007)
- valueset "Medications for Above Normal BMI" (2.16.840.1.113883.3.526.3.1561)
- valueset "Medications for Below Normal BMI" (2.16.840.1.113883.3.526.3.1562)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Overweight or Obese" (2.16.840.1.113762.1.4.1047.502)
- valueset "Palliative Care Encounter" (2.16.840.1.113883.3.464.1003.101.12.1090)
- valueset "Palliative Care Intervention" (2.16.840.1.113883.3.464.1003.198.12.1135)
- valueset "Patient Declined" (2.16.840.1.113883.3.526.3.1582)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Pregnancy or Other Related Diagnoses" (2.16.840.1.113883.3.600.1.1623)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Referrals Where Weight Assessment May Occur" (2.16.840.1.113883.3.600.1.1527)
- valueset "Underweight" (2.16.840.1.113883.3.526.3.1563)

Data Criteria (QDM Data Elements)

- "Assessment, Performed: Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal) (LOINC Code 71007-9)"
- "Assessment, Performed: Hospice care [Minimum Data Set]" using "Hospice care [Minimum Data Set] (LOINC Code 45755-6)"
- "Diagnosis: Encounter for palliative care" using "Encounter for palliative care (ICD10CM Code Z51.5)"
- "Diagnosis: Overweight or Obese" using "Overweight or Obese (2.16.840.1.113762.1.4.1047.502)"
- "Diagnosis: Pregnancy or Other Related Diagnoses" using "Pregnancy or Other Related Diagnoses (2.16.840.1.113883.3.600.1.1623)"
- "Diagnosis: Underweight" using "Underweight (2.16.840.1.113883.3.526.3.1563)"
- "Encounter, Performed: Encounter Inpatient" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "Encounter, Performed: Encounter to Evaluate BMI" using "Encounter to Evaluate BMI (2.16.840.1.113883.3.600.1.1751)"
- "Encounter, Performed: Hospice Encounter" using "Hospice Encounter (2.16.840.1.113883.3.464.1003.1003)"
- "Encounter, Performed: Palliative Care Encounter" using "Palliative Care Encounter (2.16.840.1.113883.3.464.1003.101.12.1090)"
- "Intervention, Not Ordered: Follow Up for Above Normal BMI" using "Follow Up for Above Normal BMI (2.16.840.1.113883.3.600.1.1525)"
- "Intervention, Not Ordered: Follow Up for Below Normal BMI" using "Follow Up for Below Normal BMI (2.16.840.1.113883.3.600.1.1528)"
- "Intervention, Not Ordered: Referrals Where Weight Assessment May Occur" using "Referrals Where Weight Assessment May Occur (2.16.840.1.113883.3.600.1.1527)"
- "Intervention, Not Performed: Follow Up for Above Normal BMI" using "Follow Up for Above Normal BMI (2.16.840.1.113883.3.600.1.1525)"
- "Intervention, Not Performed: Follow Up for Below Normal BMI" using "Follow Up for Below Normal BMI (2.16.840.1.113883.3.600.1.1528)"
- "Intervention, Order: Follow Up for Above Normal BMI" using "Follow Up for Above Normal BMI (2.16.840.1.113883.3.600.1.1525)"
- "Intervention, Order: Follow Up for Below Normal BMI" using "Follow Up for Below Normal BMI (2.16.840.1.113883.3.600.1.1528)"
- "Intervention, Order: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Order: Referrals Where Weight Assessment May Occur" using "Referrals Where Weight Assessment May Occur (2.16.840.1.113883.3.600.1.1527)"
- "Intervention, Performed: Follow Up for Above Normal BMI" using "Follow Up for Above Normal BMI (2.16.840.1.113883.3.600.1.1525)"
- "Intervention, Performed: Follow Up for Below Normal BMI" using "Follow Up for Below Normal BMI (2.16.840.1.113883.3.600.1.1528)"
- "Intervention, Performed: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Palliative Care Intervention" using "Palliative Care Intervention (2.16.840.1.113883.3.464.1003.198.12.1135)"
- "Medication, Not Ordered: Medications for Above Normal BMI" using "Medications for Above Normal BMI (2.16.840.1.113883.3.526.3.1561)"
- "Medication, Not Ordered: Medications for Below Normal BMI" using "Medications for Below Normal BMI (2.16.840.1.113883.3.526.3.1562)"
- "Medication, Order: Medications for Above Normal BMI" using "Medications for Above Normal BMI (2.16.840.1.113883.3.526.3.1561)"
- "Medication, Order: Medications for Below Normal BMI" using "Medications for Below Normal BMI (2.16.840.1.113883.3.526.3.1562)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"
- "Physical Exam, Not Performed: Body mass index (BMI) [Ratio]" using "Body mass index (BMI) [Ratio] (LOINC Code 39156-5)"
- "Physical Exam, Performed: Body mass index (BMI) [Ratio]" using "Body mass index (BMI) [Ratio] (LOINC Code 39156-5)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)**
eCQM Identifier (Measure Authoring Tool)	122
eCQM Version Number	11.0.000
NQF Number	Not Applicable
GUID	f2986519-5a4e-4149-a8f2-af0a1dc7f6bc
Measurement Period	January 1, 20XX through December 31, 20XX
Measure Steward	National Committee for Quality Assurance
Measure Developer	National Committee for Quality Assurance
Endorsed By	None
Description	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
Copyright	This Physician Performance Measure (Measure) and related data specifications are owned and were developed by the National Committee for Quality Assurance (NCQA). NCQA is not responsible for any use of the Measure. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in the Measure. The Measure can be reproduced and distributed, without modification, for noncommercial purposes (e.g., use by healthcare providers in connection with their practices) without obtaining approval from NCQA. Commercial use is defined as the sale, licensing, or distribution of the Measure for commercial gain, or incorporation of the Measure into a product or service that is sold, licensed or distributed for commercial gain. All commercial uses or requests for modification must be approved by NCQA and are subject to a license at the discretion of NCQA. (C) 2012-2021 National Committee for Quality Assurance. All Rights Reserved. Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. NCQA disclaims all liability for use or accuracy of any third party codes contained in the specifications. CPT(R) contained in the Measure specifications is copyright 2004-2021 American Medical Association. LOINC(R) copyright 2004-2021 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2021 International Health Terminology Standards Development Organisation. ICD-10 copyright 2021 World Health Organization. All Rights Reserved.
Disclaimer	The performance Measure is not a clinical guideline and does not establish a standard of medical care, and has not been tested for all potential applications. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Due to technical limitations, registered trademarks are indicated by (R) or [R] and unregistered trademarks are indicated by (TM) or [TM].
Measure Scoring	Proportion
Measure Type	Intermediate Clinical Outcome
Stratification	None
Risk Adjustment	None
Rate Aggregation	None
Rationale	Diabetes is the seventh leading cause of death in the United States. In 2017, diabetes affected approximately 34 million Americans (10.5 percent of the U.S. population) and killed approximately 84,000 people (Centers for Disease Control and Prevention [CDC], 2020a). Diabetes is a long-lasting disease marked by high blood glucose levels, resulting from the body's inability to produce or use insulin properly (CDC, 2020b). People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney damage, amputation of feet or legs, and premature death (CDC, 2021). In 2017, diabetes cost the U.S. an estimated $327 billion: $237 billion in direct medical costs and $90 billion in reduced productivity. This is a 34 percent increase from the estimated $245 billion spent on diabetes in 2012 (American Diabetes Association [ADA], 2018). Controlling A1c blood levels helps reduce the risk of microvascular complications (eye, kidney and nerve diseases) (ADA, 2021).
Clinical Recommendation Statement	American Diabetes Association (2021): - An A1C goal for many nonpregnant adults of <7% (53 mmol/mol) without significant hypocalcemia is appropriate. (Level of evidence: A) - On the basis of provider judgement and patient preference, achievement of lower A1C levels than the goal of 7% may be acceptable, and even beneficial, if it can be achieved safely without significant hypoglycemia or other adverse effects of treatment. (Level of evidence: C) - Less stringent A1C goals (such as <8% [64 mmol/mol]) may be appropriate for patients with limited life expectancy, where the harms of treatment are greater than the benefits. (Level of evidence: B)
Improvement Notation	Lower score indicates better quality
Reference	Reference Type: CITATION Reference Text: 'American Diabetes Association. (2018). Economic Costs of Diabetes in the U.S. in 2017. Diabetes Care, 41, 917-928. Retrieved from http://care.diabetesjournals.org/content/early/2018/03/20/dci18-0007'
Reference	Reference Type: CITATION Reference Text: 'American Diabetes Association. (2021). 6. Glycemic Targets: Standards of Medical Care in Diabetes–2021. Diabetes Care 2021; 44(Suppl. 1):S73–S84. https://doi.org/10.2337/dc21-S006'
Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. (2021). Diabetes Report Card 2019. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services. Retrieved from https://www.cdc.gov/diabetes/library/reports/reportcard.html'
Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. (2020a). National Diabetes Statistics Report, 2020. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services. Retrieved from https://www.cdc.gov/diabetes/data/statistics-report/index.html'
Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. (2020b). Diabetes Basics. Retrieved from https://www.cdc.gov/diabetes/basics/diabetes.html'
Definition	None

	If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance.
Guidance	This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	Patients 18-75 years of age by the end of the measurement period, with diabetes with a visit during the measurement period
Denominator	Equals Initial Population
Denominator Exclusions	Exclude patients who are in hospice care for any part of the measurement period. Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of during the measurement period. Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: - Advanced illness with two outpatient encounters during the measurement period or the year prior - OR advanced illness with one inpatient encounter during the measurement period or the year prior - OR taking dementia medications during the measurement period or the year prior Exclude patients receiving palliative care for any part of the measurement period.
Numerator	Patients whose most recent HbA1c level (performed during the measurement period) is >9.0% or is missing, or was not performed during the measurement period
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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Population Criteria

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
)in Interval[18, 75]
  and exists ( "Qualifying Encounters" )
  and exists ( ["Diagnosis": "Diabetes"] Diabetes
      where Diabetes.prevalencePeriod overlaps "Measurement Period"
  )
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or AIFrailLTCF."Is Age 66 or Older with Advanced Illness and Frailty"
  or AIFrailLTCF."Is Age 66 or Older Living Long Term in a Nursing Home"
  or PalliativeCare."Palliative Care in the Measurement Period"
```

Numerator

```
"Has Most Recent HbA1c Without Result"
  or "Has Most Recent Elevated HbA1c"
  or "Has No Record Of HbA1c"
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

AIFrailLTCF.Has Criteria Indicating Frailty

```
exists ( ["Device, Order": "Frailty Device"] FrailtyDeviceOrder
    where FrailtyDeviceOrder.authorDatetime during day of "Measurement Period"
)
  or exists ( ["Assessment, Performed": "Medical equipment used"] EquipmentUsed
      where EquipmentUsed.result in "Frailty Device"
        and Global."NormalizeInterval" ( EquipmentUsed.relevantDatetime, EquipmentUsed.relevantPeriod ) ends during day of "Measurement Period"
  )
```

```
or exists ( ["Diagnosis": "Frailty Diagnosis"] FrailtyDiagnosis
    where FrailtyDiagnosis.prevalencePeriod overlaps "Measurement Period"
)
or exists ( ["Encounter, Performed": "Frailty Encounter"] FrailtyEncounter
    where FrailtyEncounter.relevantPeriod overlaps "Measurement Period"
)
or exists ( ["Symptom": "Frailty Symptom"] FrailtySymptom
    where FrailtySymptom.prevalencePeriod overlaps "Measurement Period"
)
```

AIFrailLTCF.Has Dementia Medications in Year Before or During Measurement Period

```
exists (["Medication, Active": "Dementia Medications"] DementiaMedication
  where Global."NormalizeInterval" ( DementiaMedication.relevantDatetime, DementiaMedication.relevantPeriod ) overlaps Interval[start of "Measurement Period" - 1 year,
  end of "Measurement Period"])
```

AIFrailLTCF.Has Inpatient Encounter with Advanced Illness

```
exists( ["Encounter, Performed": "Acute Inpatient"] InpatientEncounter
  where exists ( InpatientEncounter.diagnoses Diagnosis
      where Diagnosis.code in "Advanced Illness"
  )
    and InpatientEncounter.relevantPeriod starts during day of Interval[start of "Measurement Period" - 1 year,
    end of "Measurement Period"])
```

AIFrailLTCF.Has Two Outpatient Encounters with Advanced Illness on Different Dates of Service

```
exists (
from
  "Outpatient Encounters with Advanced Illness" OutpatientEncounter1,
  "Outpatient Encounters with Advanced Illness" OutpatientEncounter2
  where OutpatientEncounter2.relevantPeriod ends 1 day or more after day of
  end of OutpatientEncounter1.relevantPeriod
  return OutpatientEncounter1
  )
```

AIFrailLTCF.Is Age 66 or Older Living Long Term in a Nursing Home

```
( AgeInYearsAt(date from
    end of "Measurement Period"
  )>= 66
)
  and ( ( Last(["Assessment, Performed": "Housing status"] HousingStatus
        where Global."NormalizeInterval"(HousingStatus.relevantDatetime, HousingStatus.relevantPeriod)ends on or before
        end of "Measurement Period"
        sort by
        end of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)asc
    )) LastHousingStatus
      where LastHousingStatus.result ~ "Lives in a nursing home (finding)"
  ) is not null
```

AIFrailLTCF.Is Age 66 or Older with Advanced Illness and Frailty

```
( AgeInYearsAt(date from
    end of "Measurement Period"
  )>= 66
    and "Has Criteria Indicating Frailty"
    and ( "Has Two Outpatient Encounters with Advanced Illness on Different Dates of Service"
        or "Has Inpatient Encounter with Advanced Illness"
        or "Has Dementia Medications in Year Before or During Measurement Period"
    )
)
```

AIFrailLTCF.Outpatient Encounters with Advanced Illness

```
( ["Encounter, Performed": "Outpatient"]
  union ["Encounter, Performed": "Observation"]
  union ["Encounter, Performed": "Emergency Department Visit"]
  union ["Encounter, Performed": "Nonacute Inpatient"] ) OutpatientEncounter
  where exists ( OutpatientEncounter.diagnoses Diagnosis
      where Diagnosis.code in "Advanced Illness"
  )
    and OutpatientEncounter.relevantPeriod starts during day of Interval[start of "Measurement Period" - 1 year,
    end of "Measurement Period"]
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or AIFrailLTCF."Is Age 66 or Older with Advanced Illness and Frailty"
  or AIFrailLTCF."Is Age 66 or Older Living Long Term in a Nursing Home"
  or PalliativeCare."Palliative Care in the Measurement Period"
```

Has Most Recent Elevated HbA1c

```
"Most Recent HbA1c".result > 9 '%'
```

Has Most Recent HbA1c Without Result

```
"Most Recent HbA1c" is not null
  and "Most Recent HbA1c".result is null
```

Has No Record Of HbA1c

```
not exists ["Laboratory Test, Performed": "HbA1c Laboratory Test"] NoHbA1c
  where Global."LatestOf" ( NoHbA1c.relevantDatetime, NoHbA1c.relevantPeriod ) during day of "Measurement Period"
```

Hospice.Has Hospice Services

```
exists ( ["Encounter, Performed": "Encounter Inpatient"] InpatientEncounter
    where ( InpatientEncounter.dischargeDisposition ~ "Discharge to home for hospice care (procedure)"
        or InpatientEncounter.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)"
```

```
    )
      and InpatientEncounter.relevantPeriod ends during day of "Measurement Period"
)
  or exists ( ["Encounter, Performed": "Hospice Encounter"] HospiceEncounter
      where HospiceEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Assessment, Performed": "Hospice care [Minimum Data Set]"] HospiceAssessment
      where HospiceAssessment.result ~ "Yes (qualifier value)"
        and Global."NormalizeInterval" ( HospiceAssessment.relevantDatetime, HospiceAssessment.relevantPeriod ) overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Order": "Hospice Care Ambulatory"] HospiceOrder
      where HospiceOrder.authorDatetime during day of "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Hospice Care Ambulatory"] HospicePerformed
      where Global."NormalizeInterval" ( HospicePerformed.relevantDatetime, HospicePerformed.relevantPeriod ) overlaps "Measurement Period"
  )
```

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
)in Interval[18, 75]
  and exists ( "Qualifying Encounters" )
  and exists ( ["Diagnosis": "Diabetes"] Diabetes
      where Diabetes.prevalencePeriod overlaps "Measurement Period"
  )
```

Most Recent HbA1c

```
Last(["Laboratory Test, Performed": "HbA1c Laboratory Test"] RecentHbA1c
    where Global."LatestOf"(RecentHbA1c.relevantDatetime, RecentHbA1c.relevantPeriod)during day of "Measurement Period"
    sort by start of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)
)
```

Numerator

```
"Has Most Recent HbA1c Without Result"
  or "Has Most Recent Elevated HbA1c"
  or "Has No Record Of HbA1c"
```

PalliativeCare.Palliative Care in the Measurement Period

```
exists ( ["Assessment, Performed": "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)"] PalliativeAssessment
    where Global."NormalizeInterval"(PalliativeAssessment.relevantDatetime, PalliativeAssessment.relevantPeriod) overlaps "Measurement Period"
)
or exists (["Diagnosis": "Encounter for palliative care"] PalliativeDiagnosis
where PalliativeDiagnosis.prevalencePeriod overlaps "Measurement Period")
  or exists ( ["Encounter, Performed": "Palliative Care Encounter"] PalliativeEncounter
      where PalliativeEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Palliative Care Intervention"] PalliativeIntervention
      where Global."NormalizeInterval"(PalliativeIntervention.relevantDatetime, PalliativeIntervention.relevantPeriod) overlaps "Measurement Period"
  )
```

Qualifying Encounters

```
( ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Annual Wellness Visit"]
  union ["Encounter, Performed": "Preventive Care Services Established Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Preventive Care Services Initial Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Home Healthcare Services"]
  union ["Encounter, Performed": "Nutrition Services"]
  union ["Encounter, Performed": "Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes"]
  union ["Encounter, Performed": "Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes"]
  union ["Encounter, Performed": "Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes"]
  union ["Encounter, Performed": "Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis,
medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes"]
  union ["Encounter, Performed": "Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis,
medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes"]
  union ["Encounter, Performed": "Telephone Visits"] ) ValidEncounters
  where ValidEncounters.relevantPeriod during day of "Measurement Period"
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

Global.HasEnd(period Interval<DateTime>)

```
not (
  end of period is null
    or
    end of period = maximum DateTime
)
```

Global.Latest(period Interval<DateTime>)

```
if ( HasEnd(period)) then
end of period
  else start of period
```

Global.LatestOf(pointInTime DateTime, period Interval<DateTime>)

```
Latest(NormalizeInterval(pointInTime, period))
```

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Encounter for palliative care" ("ICD10CM Code (Z51.5)")
- code "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")
- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "Housing status" ("LOINC Code (71802-3)")
- code "Lives in a nursing home (finding)" ("SNOMEDCT Code (160734000)")
- code "Medical equipment used" ("LOINC Code (98181-1)")
- code "Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes" ("HCPCS Code (G0271)")
- code "Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes" ("CPT Code (97804)")
- code "Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes" ("CPT Code (97802)")
- code "Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes" ("CPT Code (97803)")
- code "Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes" ("HCPCS Code (G0270)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- valueset "Acute Inpatient" (2.16.840.1.113883.3.464.1003.101.12.1083)
- valueset "Advanced Illness" (2.16.840.1.113883.3.464.1003.110.12.1082)
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Dementia Medications" (2.16.840.1.113883.3.464.1003.196.12.1510)
- valueset "Diabetes" (2.16.840.1.113883.3.464.1003.103.12.1001)
- valueset "Emergency Department Visit" (2.16.840.1.113883.3.464.1003.101.12.1010)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Frailty Device" (2.16.840.1.113883.3.464.1003.118.12.1300)
- valueset "Frailty Diagnosis" (2.16.840.1.113883.3.464.1003.113.12.1074)
- valueset "Frailty Encounter" (2.16.840.1.113883.3.464.1003.101.12.1088)
- valueset "Frailty Symptom" (2.16.840.1.113883.3.464.1003.113.12.1075)
- valueset "HbA1c Laboratory Test" (2.16.840.1.113883.3.464.1003.198.12.1013)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Nonacute Inpatient" (2.16.840.1.113883.3.464.1003.101.12.1084)
- valueset "Nutrition Services" (2.16.840.1.113883.3.464.1003.1006)
- valueset "Observation" (2.16.840.1.113883.3.464.1003.101.12.1086)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Outpatient" (2.16.840.1.113883.3.464.1003.101.12.1087)
- valueset "Palliative Care Encounter" (2.16.840.1.113883.3.464.1003.101.12.1090)
- valueset "Palliative Care Intervention" (2.16.840.1.113883.3.464.1003.198.12.1135)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Preventive Care Services Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Telephone Visits" (2.16.840.1.113883.3.464.1003.101.12.1080)

Data Criteria (QDM Data Elements)

- "Assessment, Performed: Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal) (LOINC Code 71007-9)"
- "Assessment, Performed: Hospice care [Minimum Data Set]" using "Hospice care [Minimum Data Set] (LOINC Code 45755-6)"
- "Assessment, Performed: Housing status" using "Housing status (LOINC Code 71802-3)"
- "Assessment, Performed: Medical equipment used" using "Medical equipment used (LOINC Code 98181-1)"
- "Device, Order: Frailty Device" using "Frailty Device (2.16.840.1.113883.3.464.1003.118.12.1300)"
- "Diagnosis: Diabetes" using "Diabetes (2.16.840.1.113883.3.464.1003.103.12.1001)"
- "Diagnosis: Encounter for palliative care" using "Encounter for palliative care (ICD10CM Code Z51.5)"
- "Diagnosis: Frailty Diagnosis" using "Frailty Diagnosis (2.16.840.1.113883.3.464.1003.113.12.1074)"
- "Encounter, Performed: Acute Inpatient" using "Acute Inpatient (2.16.840.1.113883.3.464.1003.101.12.1083)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Emergency Department Visit" using "Emergency Department Visit (2.16.840.1.113883.3.464.1003.101.12.1010)"
- "Encounter, Performed: Encounter Inpatient" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "Encounter, Performed: Frailty Encounter" using "Frailty Encounter (2.16.840.1.113883.3.464.1003.101.12.1088)"
- "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Hospice Encounter" using "Hospice Encounter (2.16.840.1.113883.3.464.1003.1003)"
- "Encounter, Performed: Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes" using "Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes (HCPCS Code G0271)"
- "Encounter, Performed: Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes" using "Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes (CPT Code 97804)"
- "Encounter, Performed: Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes" using "Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes (CPT Code 97802)"
- "Encounter, Performed: Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes" using "Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes (CPT Code 97803)"
- "Encounter, Performed: Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes" using "Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes (HCPCS Code G0270)"
- "Encounter, Performed: Nonacute Inpatient" using "Nonacute Inpatient (2.16.840.1.113883.3.464.1003.101.12.1084)"
- "Encounter, Performed: Nutrition Services" using "Nutrition Services (2.16.840.1.113883.3.464.1003.1006)"
- "Encounter, Performed: Observation" using "Observation (2.16.840.1.113883.3.464.1003.101.12.1086)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Outpatient" using "Outpatient (2.16.840.1.113883.3.464.1003.101.12.1087)"
- "Encounter, Performed: Palliative Care Encounter" using "Palliative Care Encounter (2.16.840.1.113883.3.464.1003.101.12.1090)"
- "Encounter, Performed: Preventive Care Services Established Office Visit, 18 and Up" using "Preventive Care Services Established Office Visit, 18 and Up (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 (2.16.840.1.113883.3.464.1003.101.12.1023)"

- "Encounter, Performed: Telephone Visits" using "Telephone Visits (2.16.840.1.113883.3.464.1003.101.12.1080)"
- "Intervention, Order: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Palliative Care Intervention" using "Palliative Care Intervention (2.16.840.1.113883.3.464.1003.198.12.1135)"
- "Laboratory Test, Performed: HbA1c Laboratory Test" using "HbA1c Laboratory Test (2.16.840.1.113883.3.464.1003.198.12.1013)"
- "Medication, Active: Dementia Medications" using "Dementia Medications (2.16.840.1.113883.3.464.1003.196.12.1510)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"
- "Symptom: Frailty Symptom" using "Frailty Symptom (2.16.840.1.113883.3.464.1003.113.12.1075)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	**Diabetes: Eye Exam**
eCQM Identifier (Measure Authoring Tool)	131
eCQM Version Number	11.0.000
NQF Number	Not Applicable
GUID	d90bdab4-b9d2-4329-9993-5c34e2c0dc66
Measurement Period	January 1, 20XX through December 31, 20XX
Measure Steward	National Committee for Quality Assurance
Measure Developer	National Committee for Quality Assurance
Endorsed By	None
Description	Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period
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Measure Scoring	Proportion
Measure Type	Process
Stratification	None
Risk Adjustment	None
Rate Aggregation	None
Rationale	Diabetes is the seventh leading cause of death in the United States. In 2017, diabetes affected approximately 34 million Americans (10.5 percent of the U.S. population) and killed approximately 84,000 people (Centers for Disease Control and Prevention [CDC], 2020a). Diabetes is a long-lasting disease marked by high blood glucose levels, resulting from the body's inability to produce or use insulin properly (CDC, 2020b). People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney damage, amputation of feet or legs, and premature death (CDC, 2021). In 2017, diabetes cost the U.S. an estimated $327 billion: $237 billion in direct medical costs and $90 billion in reduced productivity. This is a 34 percent increase from the estimated $245 billion spent on diabetes in 2012 (American Diabetes Association, 2018). Diabetic retinopathy is progressive damage to the small blood vessels in the retina that may result in loss of vision. It is the leading cause of blindness in adults between 20-74 years of age. Approximately 4.1 million adults are affected by diabetic retinopathy (CDC, 2020c).
Clinical Recommendation Statement	American Diabetes Association (2021): - Adults with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (Level of evidence: B) - Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist at the time of the diabetes diagnosis. (Level of evidence: B) -If there is no evidence of retinopathy for one or more annual eye exam and glycemia is well controlled, then screening every 1–2 years may be considered. If any level of diabetic retinopathy is present, subsequent dilated retinal examinations should be repeated at least annually by an ophthalmologist or optometrist. If retinopathy is progressing or sight threatening, then examinations will be required more frequently. (Level of evidence: B)
Improvement Notation	Higher score indicates better quality
Reference	Reference Type: CITATION Reference Text: 'American Diabetes Association. (2018). Economic Costs of Diabetes in the U.S. in 2017. Diabetes Care, 41, 917-928. Retrieved from http://care.diabetesjournals.org/content/early/2018/03/20/dci18-0007'
Reference	Reference Type: CITATION Reference Text: 'American Diabetes Association. (2021). 11. Microvascular Complications and Foot Care: Standards of Medical Care in Diabetes–2021. Diabetes Care 2021; 44(Suppl. 1):S151–S167. https://doi.org/10.2337/dc21-S011'
Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. (2020a). National Diabetes Statistics Report, 2020. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services. Retrieved from https://www.cdc.gov/diabetes/data/statistics-report/index.html'
Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. (2020b). Diabetes Basics. Retrieved from https://www.cdc.gov/diabetes/basics/diabetes.html'
Reference	Reference Type: CITATION

	Reference Text: 'Centers for Disease Control and Prevention. (2020c). Common Eye Disorders and Diseases. Retrieved from https://www.cdc.gov/visionhealth/basics/ced/index.html' Reference Type: CITATION
Reference	Reference Text: 'Centers for Disease Control and Prevention. (2021). Diabetes Report Card 2019. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services. Retrieved from https://www.cdc.gov/diabetes/library/reports/reportcard.html'
Definition	None The eye exam must be performed by an ophthalmologist or optometrist, or there must be evidence that fundus photography results were read by a system that provides an artificial intelligence (AI) interpretation.
Guidance	This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	Patients 18-75 years of age by the end of the measurement period, with diabetes with a visit during the measurement period
Denominator	Equals Initial Population
Denominator Exclusions	Exclude patients who are in hospice care for any part of the measurement period. Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period. Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: - Advanced illness with two outpatient encounters during the measurement period or the year prior - OR advanced illness with one inpatient encounter during the measurement period or the year prior - OR taking dementia medications during the measurement period or the year prior Exclude patients receiving palliative care for any part of the measurement period.
Numerator	Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: •Diabetic with a diagnosis of retinopathy in any part of the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period •Diabetic with no diagnosis of retinopathy in any part of the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period or the year prior to the measurement period
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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Population Criteria

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
)in Interval[18, 75]
  and exists ( "Qualifying Encounters" )
  and exists ( ["Diagnosis": "Diabetes"] Diabetes
      where Diabetes.prevalencePeriod overlaps "Measurement Period"
  )
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or AIFrailLTCF."Is Age 66 or Older with Advanced Illness and Frailty"
  or AIFrailLTCF."Is Age 66 or Older Living Long Term in a Nursing Home"
  or PalliativeCare."Palliative Care in the Measurement Period"
```

Numerator

```
( "Diabetic Retinopathy Overlapping Measurement Period"
    and exists ( "Retinal Exam in Measurement Period" )
)
  or ( not ( "Diabetic Retinopathy Overlapping Measurement Period" )
      and exists ( "Retinal Exam in Measurement Period or Year Prior" )
  )
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

AIFrailLTCF.Has Criteria Indicating Frailty

```
exists ( ["Device, Order": "Frailty Device"] FrailtyDeviceOrder
    where FrailtyDeviceOrder.authorDatetime during day of "Measurement Period"
)
  or exists ( ["Assessment, Performed": "Medical equipment used"] EquipmentUsed
      where EquipmentUsed.result in "Frailty Device"
        and Global."NormalizeInterval" ( EquipmentUsed.relevantDatetime, EquipmentUsed.relevantPeriod ) ends during day of "Measurement Period"
  )
  or exists ( ["Diagnosis": "Frailty Diagnosis"] FrailtyDiagnosis
      where FrailtyDiagnosis.prevalencePeriod overlaps "Measurement Period"
  )
  or exists ( ["Encounter, Performed": "Frailty Encounter"] FrailtyEncounter
      where FrailtyEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Symptom": "Frailty Symptom"] FrailtySymptom
      where FrailtySymptom.prevalencePeriod overlaps "Measurement Period"
  )
```

AIFrailLTCF.Has Dementia Medications in Year Before or During Measurement Period

```
exists (["Medication, Active": "Dementia Medications"] DementiaMedication
  where Global."NormalizeInterval" ( DementiaMedication.relevantDatetime, DementiaMedication.relevantPeriod ) overlaps Interval[start of "Measurement Period" - 1 year,
  end of "Measurement Period"])
```

AIFrailLTCF.Has Inpatient Encounter with Advanced Illness

```
exists( ["Encounter, Performed": "Acute Inpatient"] InpatientEncounter
  where exists ( InpatientEncounter.diagnoses Diagnosis
      where Diagnosis.code in "Advanced Illness"
  )
    and InpatientEncounter.relevantPeriod starts during day of Interval[start of "Measurement Period" - 1 year,
    end of "Measurement Period"])
```

AIFrailLTCF.Has Two Outpatient Encounters with Advanced Illness on Different Dates of Service

```
exists (
from
  "Outpatient Encounters with Advanced Illness" OutpatientEncounter1,
  "Outpatient Encounters with Advanced Illness" OutpatientEncounter2
  where OutpatientEncounter2.relevantPeriod ends 1 day or more after day of
  end of OutpatientEncounter1.relevantPeriod
  return OutpatientEncounter1
  )
```

AIFrailLTCF.Is Age 66 or Older Living Long Term in a Nursing Home

```
( AgeInYearsAt(date from
    end of "Measurement Period"
  )>= 66
)
  and ( ( Last(["Assessment, Performed": "Housing status"] HousingStatus
        where Global."NormalizeInterval"(HousingStatus.relevantDatetime, HousingStatus.relevantPeriod)ends on or before
        end of "Measurement Period"
        sort by
        end of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)asc
    )) LastHousingStatus
      where LastHousingStatus.result ~ "Lives in a nursing home (finding)"
  ) is not null
```

AIFrailLTCF.Is Age 66 or Older with Advanced Illness and Frailty

```
( AgeInYearsAt(date from
    end of "Measurement Period"
  )>= 66
    and "Has Criteria Indicating Frailty"
    and ( "Has Two Outpatient Encounters with Advanced Illness on Different Dates of Service"
        or "Has Inpatient Encounter with Advanced Illness"
        or "Has Dementia Medications in Year Before or During Measurement Period"
    )
)
```

AIFrailLTCF.Outpatient Encounters with Advanced Illness

```
( ["Encounter, Performed": "Outpatient"]
  union ["Encounter, Performed": "Observation"]
  union ["Encounter, Performed": "Emergency Department Visit"]
  union ["Encounter, Performed": "Nonacute Inpatient"] ) OutpatientEncounter
  where exists ( OutpatientEncounter.diagnoses Diagnosis
      where Diagnosis.code in "Advanced Illness"
  )
    and OutpatientEncounter.relevantPeriod starts during day of Interval[start of "Measurement Period" - 1 year,
    end of "Measurement Period"]
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or AIFrailLTCF."Is Age 66 or Older with Advanced Illness and Frailty"
  or AIFrailLTCF."Is Age 66 or Older Living Long Term in a Nursing Home"
  or PalliativeCare."Palliative Care in the Measurement Period"
```

Diabetic Retinopathy Overlapping Measurement Period

```
exists ( ["Diagnosis": "Diabetic Retinopathy"] Retinopathy
    where Retinopathy.prevalencePeriod overlaps "Measurement Period"
)
```

Hospice.Has Hospice Services

```
exists ( ["Encounter, Performed": "Encounter Inpatient"] InpatientEncounter
    where ( InpatientEncounter.dischargeDisposition ~ "Discharge to home for hospice care (procedure)"
        or InpatientEncounter.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)"
    )
      and InpatientEncounter.relevantPeriod ends during day of "Measurement Period"
)
  or exists ( ["Encounter, Performed": "Hospice Encounter"] HospiceEncounter
      where HospiceEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Assessment, Performed": "Hospice care [Minimum Data Set]"] HospiceAssessment
      where HospiceAssessment.result ~ "Yes (qualifier value)"
        and Global."NormalizeInterval" ( HospiceAssessment.relevantDatetime, HospiceAssessment.relevantPeriod ) overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Order": "Hospice Care Ambulatory"] HospiceOrder
      where HospiceOrder.authorDatetime during day of "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Hospice Care Ambulatory"] HospicePerformed
      where Global."NormalizeInterval" ( HospicePerformed.relevantDatetime, HospicePerformed.relevantPeriod ) overlaps "Measurement Period"
  )
```

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
)in Interval[18, 75]
  and exists ( "Qualifying Encounters" )
  and exists ( ["Diagnosis": "Diabetes"] Diabetes
      where Diabetes.prevalencePeriod overlaps "Measurement Period"
  )
```

Numerator

```
( "Diabetic Retinopathy Overlapping Measurement Period"
    and exists ( "Retinal Exam in Measurement Period" )
)
  or ( not ( "Diabetic Retinopathy Overlapping Measurement Period" )
      and exists ( "Retinal Exam in Measurement Period or Year Prior" )
  )
```

PalliativeCare.Palliative Care in the Measurement Period

```
exists ( ["Assessment, Performed": "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)"] PalliativeAssessment
    where Global."NormalizeInterval"(PalliativeAssessment.relevantDatetime, PalliativeAssessment.relevantPeriod) overlaps "Measurement Period"
)
or exists (["Diagnosis": "Encounter for palliative care"] PalliativeDiagnosis
where PalliativeDiagnosis.prevalencePeriod overlaps "Measurement Period")
  or exists ( ["Encounter, Performed": "Palliative Care Encounter"] PalliativeEncounter
      where PalliativeEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Palliative Care Intervention"] PalliativeIntervention
      where Global."NormalizeInterval"(PalliativeIntervention.relevantDatetime, PalliativeIntervention.relevantPeriod) overlaps "Measurement Period"
  )
```

Qualifying Encounters

```
( ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Annual Wellness Visit"]
  union ["Encounter, Performed": "Preventive Care Services Established Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Preventive Care Services Initial Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Home Healthcare Services"]
  union ["Encounter, Performed": "Ophthalmological Services"]
  union ["Encounter, Performed": "Telephone Visits"] ) ValidEncounters
  where ValidEncounters.relevantPeriod during day of "Measurement Period"
```

Retinal Exam in Measurement Period

```
["Physical Exam, Performed": "Retinal or Dilated Eye Exam"] RetinalExam
  where Global."NormalizeInterval" ( RetinalExam.relevantDatetime, RetinalExam.relevantPeriod ) during day of "Measurement Period"
```

Retinal Exam in Measurement Period or Year Prior

```
["Physical Exam, Performed": "Retinal or Dilated Eye Exam"] RetinalExam
  where Global."NormalizeInterval" ( RetinalExam.relevantDatetime, RetinalExam.relevantPeriod ) during day of Interval[start of "Measurement Period" - 1 year,
  end of "Measurement Period"]
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
```

```
else null as Interval<DateTime>
```

Terminology

- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Encounter for palliative care" ("ICD10CM Code (Z51.5)")
- code "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")
- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "Housing status" ("LOINC Code (71802-3)")
- code "Lives in a nursing home (finding)" ("SNOMEDCT Code (160734000)")
- code "Medical equipment used" ("LOINC Code (98181-1)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- valueset "Acute Inpatient" (2.16.840.1.113883.3.464.1003.101.12.1083)
- valueset "Advanced Illness" (2.16.840.1.113883.3.464.1003.110.12.1082)
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Dementia Medications" (2.16.840.1.113883.3.464.1003.196.12.1510)
- valueset "Diabetes" (2.16.840.1.113883.3.464.1003.103.12.1001)
- valueset "Diabetic Retinopathy" (2.16.840.1.113883.3.526.3.327)
- valueset "Emergency Department Visit" (2.16.840.1.113883.3.464.1003.101.12.1010)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Frailty Device" (2.16.840.1.113883.3.464.1003.118.12.1300)
- valueset "Frailty Diagnosis" (2.16.840.1.113883.3.464.1003.113.12.1074)
- valueset "Frailty Encounter" (2.16.840.1.113883.3.464.1003.101.12.1088)
- valueset "Frailty Symptom" (2.16.840.1.113883.3.464.1003.113.12.1075)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Nonacute Inpatient" (2.16.840.1.113883.3.464.1003.101.12.1084)
- valueset "Observation" (2.16.840.1.113883.3.464.1003.101.12.1086)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Outpatient" (2.16.840.1.113883.3.464.1003.101.12.1087)
- valueset "Palliative Care Encounter" (2.16.840.1.113883.3.464.1003.101.12.1090)
- valueset "Palliative Care Intervention" (2.16.840.1.113883.3.464.1003.198.12.1135)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Preventive Care Services Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Retinal or Dilated Eye Exam" (2.16.840.1.113883.3.464.1003.115.12.1088)
- valueset "Telephone Visits" (2.16.840.1.113883.3.464.1003.101.12.1080)

Data Criteria (QDM Data Elements)

- "Assessment, Performed: Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal) (LOINC Code 71007-9)"
- "Assessment, Performed: Hospice care [Minimum Data Set]" using "Hospice care [Minimum Data Set] (LOINC Code 45755-6)"
- "Assessment, Performed: Housing status" using "Housing status (LOINC Code 71802-3)"
- "Assessment, Performed: Medical equipment used" using "Medical equipment used (LOINC Code 98181-1)"
- "Device, Order: Frailty Device" using "Frailty Device (2.16.840.1.113883.3.464.1003.118.12.1300)"
- "Diagnosis: Diabetes" using "Diabetes (2.16.840.1.113883.3.464.1003.103.12.1001)"
- "Diagnosis: Diabetic Retinopathy" using "Diabetic Retinopathy (2.16.840.1.113883.3.526.3.327)"
- "Diagnosis: Encounter for palliative care" using "Encounter for palliative care (ICD10CM Code Z51.5)"
- "Diagnosis: Frailty Diagnosis" using "Frailty Diagnosis (2.16.840.1.113883.3.464.1003.113.12.1074)"
- "Encounter, Performed: Acute Inpatient" using "Acute Inpatient (2.16.840.1.113883.3.464.1003.101.12.1083)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Emergency Department Visit" using "Emergency Department Visit (2.16.840.1.113883.3.464.1003.101.12.1010)"
- "Encounter, Performed: Encounter Inpatient" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "Encounter, Performed: Frailty Encounter" using "Frailty Encounter (2.16.840.1.113883.3.464.1003.101.12.1088)"
- "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Hospice Encounter" using "Hospice Encounter (2.16.840.1.113883.3.464.1003.1003)"
- "Encounter, Performed: Nonacute Inpatient" using "Nonacute Inpatient (2.16.840.1.113883.3.464.1003.101.12.1084)"
- "Encounter, Performed: Observation" using "Observation (2.16.840.1.113883.3.464.1003.101.12.1086)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Ophthalmological Services" using "Ophthalmological Services (2.16.840.1.113883.3.526.3.1285)"
- "Encounter, Performed: Outpatient" using "Outpatient (2.16.840.1.113883.3.464.1003.101.12.1087)"
- "Encounter, Performed: Palliative Care Encounter" using "Palliative Care Encounter (2.16.840.1.113883.3.464.1003.101.12.1090)"
- "Encounter, Performed: Preventive Care Services Established Office Visit, 18 and Up" using "Preventive Care Services Established Office Visit, 18 and Up (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 (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Encounter, Performed: Telephone Visits" using "Telephone Visits (2.16.840.1.113883.3.464.1003.101.12.1080)"
- "Intervention, Order: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Palliative Care Intervention" using "Palliative Care Intervention (2.16.840.1.113883.3.464.1003.198.12.1135)"
- "Medication, Active: Dementia Medications" using "Dementia Medications (2.16.840.1.113883.3.464.1003.196.12.1510)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"
- "Physical Exam, Performed: Retinal or Dilated Eye Exam" using "Retinal or Dilated Eye Exam (2.16.840.1.113883.3.464.1003.115.12.1088)"
- "Symptom: Frailty Symptom" using "Frailty Symptom (2.16.840.1.113883.3.464.1003.113.12.1075)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	**Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery**
eCQM Identifier (Measure Authoring Tool)	133
eCQM Version Number	11.0.000
NQF Number	0565e
GUID	39e0424a-1727-4629-89e2-c46c2fbb3f5f
Measurement Period	January 1, 20XX through December 31, 20XX
Measure Steward	American Academy of Ophthalmology
Measure Developer	American Academy of Ophthalmology
Measure Developer	American Medical Association (AMA)
Measure Developer	PCPI(R) Foundation (PCPI[R])
Endorsed By	National Quality Forum
Description	Percentage of cataract surgeries for patients aged 18 and older with a diagnosis of uncomplicated cataract and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following the cataract surgery
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Measure Scoring	Proportion
Measure Type	Outcome
Stratification	None
Risk Adjustment	None
Rate Aggregation	None
Rationale	In the United States, cataracts affect more than 24 million adults over 40 years (National Eye Institute, 2019). According to the American Academy of Ophthalmology (2016), cataract surgery has a substantial beneficial impact on visual function and on quality of life. 1. Scientific basis for measuring visual acuity outcomes after cataract surgery The only reason to perform cataract surgery (other than for a limited set of medical indications) is to improve a patient's vision and associated functioning. The use of a 20/40 visual acuity threshold is based on several considerations. First, it is the level for unrestricted operation of a motor vehicle in the US. Second, it has been consistently used by the FDA in its assessment for approval of intraocular lens (IOL) and other vision devices. Third, it is the literature standard to denote success in cataract surgery. Fourth, work by West et al. in the Salisbury Eye Study suggests that 20/40 is a useful threshold for 50th percentile functioning for several vision-related tasks. Most patients achieve excellent visual acuity after cataract surgery (20/40 or better). This outcome is achieved consistently through careful attention through the accurate measurement of axial length and corneal power and the appropriate selection of an IOL power calculation formula. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this after surgery in eyes without comorbid ocular conditions that would impact the success of the surgery would reflect care that should be assessed for opportunities for improvement. The exclusion of patients with other ocular and systemic conditions known to increase the risk of an adverse outcome reflects the findings of the two published prediction rule papers for cataract surgery outcomes, by Mangione et al. (1995) and Steinberg et al. (1994). In both papers, the presence of comorbid glaucoma and macular degeneration negatively impacted the likelihood of successful outcomes of surgery. Further, as noted in the prior indicator, exclusion of eyes with ocular conditions that could impact the success of the surgery would NOT eliminate the large majority of eyes undergoing surgery while also minimizing the potential adverse selection that might otherwise occur relative to those patients with the most complex situations who might benefit the most from having surgery to maximize their remaining vision. 2. Evidence of a gap in care Cataract surgery successfully restores vision in the majority of people who have the procedure. Data from a study of 368,256 cataract surgeries show that corrected visual acuity (CDVA) of 0.5 (20/40) or better was achieved in 94.3% and CDVA of 1.0 (20/20) or better was achieved in 61.3% of cases (Lundstrom, Barry, Henry, Rosen & Stenevi, 2013). Additionally, data from a UK multi-center Cataract National Dataset found a postoperative visual acuity of 6/12 (20/40) or better was achieved for 94.7% of eyes with no co-pathologies and in 79.9% of eyes with one or more co-pathologies (Jaycock et al., 2009). A rate of 85.5-94.7% of patients achieving a 20/40 or better visual acuity in the context of approximately 3 million cataract surgeries in the US annually would mean that between 160,000 to 435,000 individuals would not achieve a 20/40 or better visual acuity which suggests an opportunity for improvement.

Clinical Recommendation Statement	This is an outcome measure. As such, there is no statement in the guideline specific to this measurement topic.
Improvement Notation	Higher score indicates better quality
Reference	Reference Type: CITATION Reference Text: 'American Academy of Ophthalmology. (2016). Cataract in the adult eye Preferred Practice Pattern. San Francisco, CA: American Academy of Ophthalmology.'
Reference	Reference Type: CITATION Reference Text: 'Jaycock, P., Johnston, R. L., Taylor, H., Adams, M., Tole, D. M., Galloway, P., … UK EPR user group (2009). The Cataract National Dataset electronic multi-centre audit of 55,567 operations: Updating benchmark standards of care in the United Kingdom and internationally. Eye, 23(1), 38-49. doi:10.1038/sj.eye.6703015'
Reference	Reference Type: CITATION Reference Text: 'Lundstrom, M., Barry, P., Henry, Y., Rosen, P., & Stenevi, U. (2013). Visual outcome of cataract surgery; Study from the European Registry of Quality Outcomes for Cataract and Refractive Surgery. Journal of Cataract & Refractive Surgery, 39(5), 673-679. doi:10.1016/j.jcrs.2012.11.026'
Reference	Reference Type: CITATION Reference Text: 'Mangione, C. M., Orav, J., Lawrence, M. G., Phillips, R.S., Seddon, J.M., & Goldman, L. (1995). Prediction of visual function after cataract surgery: A prospectively validated model. Archives of Ophthalmology, 113(10), 1305-1311. doi:10.1001/archopht.1995.01100100093037'
Reference	Reference Type: CITATION Reference Text: 'National Eye Institute. (2019). Cataract data and statistics. Retrieved from https://nei.nih.gov/eyedata/cataract'
Reference	Reference Type: CITATION Reference Text: 'Steinberg, E. P., Tielsch, J. M., Schein, O. D., Javitt, J. C., Sharkey, P., Cassard, S. D., … Damiano, A. M. (1994). National study of cataract surgery outcomes: Variation in 4-month postoperative outcomes as reflected in multiple outcome measures. Ophthalmology, 101(6), 1131-1141. doi:10.1016/s0161-6420(94)31210-3'
Definition	None
Guidance	This eCQM is an episode-based measure. An episode for this measure is defined as each cataract surgery during the measurement period, including instances where more than one cataract procedure was performed during the measurement period. Every cataract surgery during the measurement period should be counted as a measurable denominator event for the measure calculation. Only procedures performed during January 1 - September 30 of the reporting period will be considered for this measure, in order to determine if 20/40 or better visual acuity has been achieved within the 90 days following the cataract procedure. Cataract procedures performed during October 1 - December 31 are excluded from the initial population. The measure, as written, does not specifically require documentation of laterality. Coding limitations in particular clinical terminologies do not currently allow for that level of specificity (ICD-10-CM includes laterality, but SNOMED-CT does not uniformly include this distinction). Therefore, at this time, it is not a requirement of this measure to indicate laterality of the diagnoses, findings or procedures. Available coding to capture the data elements specified in this measure has been provided. It is assumed that the eligible professional or eligible clinician will record laterality in the patient medical record, as quality care and clinical documentation should include laterality. This measure is to be reported by the clinician performing the cataract surgery procedure. Clinicians who provide only preoperative or postoperative management of cataract patients are not eligible for this measure. Telehealth encounters are not eligible for this measure because the measure does not contain telehealth-eligible encounter codes. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	All cataract surgeries for patients aged 18 years and older who did not meet any exclusion criteria
Denominator	Equals Initial Population
Denominator Exclusions	Cataract surgeries in patients with significant ocular conditions impacting the visual outcome of surgery
Numerator	Cataract surgeries with best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following cataract surgery
Numerator Exclusions	Not Applicable
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

Population Criteria

◢ Initial Population

"Cataract Surgery Between January and September of Measurement Period" CataractSurgeryPerformed
  where AgeInYearsAt(date from start of "Measurement Period")>= 18

◢ Denominator

"Initial Population"

Denominator Exclusions

```
"Cataract Surgery Between January and September of Measurement Period" CataractSurgeryPerformed
  with ( ["Diagnosis": "Acute and Subacute Iridocyclitis"]
    union ["Diagnosis": "Amblyopia"]
    union ["Diagnosis": "Burn Confined to Eye and Adnexa"]
    union ["Diagnosis": "Cataract Secondary to Ocular Disorders"]
    union ["Diagnosis": "Cataract, Congenital"]
    union ["Diagnosis": "Cataract, Mature or Hypermature"]
    union ["Diagnosis": "Cataract, Posterior Polar"]
    union ["Diagnosis": "Central Corneal Ulcer"]
    union ["Diagnosis": "Certain Types of Iridocyclitis"]
    union ["Diagnosis": "Choroidal Degenerations"]
    union ["Diagnosis": "Choroidal Detachment"]
    union ["Diagnosis": "Choroidal Hemorrhage and Rupture"]
    union ["Diagnosis": "Chronic Iridocyclitis"]
    union ["Diagnosis": "Cloudy Cornea"]
    union ["Diagnosis": "Corneal Edema"]
    union ["Diagnosis": "Corneal Opacity and Other Disorders of Cornea"]
    union ["Diagnosis": "Degeneration of Macula and Posterior Pole"]
    union ["Diagnosis": "Degenerative Disorders of Globe"]
    union ["Diagnosis": "Diabetic Macular Edema"]
    union ["Diagnosis": "Diabetic Retinopathy"]
    union ["Diagnosis": "Disorders of Optic Chiasm"]
    union ["Diagnosis": "Disorders of Visual Cortex"]
    union ["Diagnosis": "Disseminated Chorioretinitis and Disseminated Retinochoroiditis"]
    union ["Diagnosis": "Focal Chorioretinitis and Focal Retinochoroiditis"]
    union ["Diagnosis": "Glaucoma"]
    union ["Diagnosis": "Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes"]
    union ["Diagnosis": "Hereditary Choroidal Dystrophies"]
    union ["Diagnosis": "Hereditary Corneal Dystrophies"]
    union ["Diagnosis": "Hereditary Retinal Dystrophies"]
    union ["Diagnosis": "Hypotony of Eye"]
    union ["Diagnosis": "Injury to Optic Nerve and Pathways"]
    union ["Diagnosis": "Macular Scar of Posterior Polar"]
    union ["Diagnosis": "Morgagnian Cataract"]
    union ["Diagnosis": "Nystagmus and Other Irregular Eye Movements"]
    union ["Diagnosis": "Open Wound of Eyeball"]
    union ["Diagnosis": "Optic Atrophy"]
    union ["Diagnosis": "Optic Neuritis"]
    union ["Diagnosis": "Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis"]
    union ["Diagnosis": "Other Background Retinopathy and Retinal Vascular Changes"]
    union ["Diagnosis": "Other Disorders of Optic Nerve"]
    union ["Diagnosis": "Other Endophthalmitis"]
    union ["Diagnosis": "Other Proliferative Retinopathy"]
    union ["Diagnosis": "Pathologic Myopia"]
    union ["Diagnosis": "Posterior Lenticonus"]
    union ["Diagnosis": "Prior Penetrating Keratoplasty"]
    union ["Diagnosis": "Purulent Endophthalmitis"]
    union ["Diagnosis": "Retinal Detachment with Retinal Defect"]
    union ["Diagnosis": "Retinal Vascular Occlusion"]
    union ["Diagnosis": "Retrolental Fibroplasias"]
    union ["Diagnosis": "Scleritis"]
    union ["Diagnosis": "Separation of Retinal Layers"]
    union ["Diagnosis": "Traumatic Cataract"]
    union ["Diagnosis": "Uveitis"]
    union ["Diagnosis": "Vascular Disorders of Iris and Ciliary Body"]
    union ["Diagnosis": "Visual Field Defects"] ) ComorbidDiagnosis
    such that ComorbidDiagnosis.prevalencePeriod overlaps before Global."NormalizeInterval" ( CataractSurgeryPerformed.relevantDatetime,
CataractSurgeryPerformed.relevantPeriod )
```

Numerator

```
"Cataract Surgery Between January and September of Measurement Period" CataractSurgeryPerformed
  with ( ["Physical Exam, Performed": "Best corrected visual acuity (observable entity)"]
    union ["Physical Exam, Performed": "Best Corrected Visual Acuity Exam Using Snellen Chart"] ) VisualAcuityExamPerformed
    such that Global."NormalizeInterval" ( VisualAcuityExamPerformed.relevantDatetime, VisualAcuityExamPerformed.relevantPeriod ) 90 days or less after day of
    end of Global."NormalizeInterval" ( CataractSurgeryPerformed.relevantDatetime, CataractSurgeryPerformed.relevantPeriod )
      and VisualAcuityExamPerformed.result in "Visual Acuity 20/40 or Better"
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

Cataract Surgery Between January and September of Measurement Period

```
["Procedure, Performed": "Cataract Surgery"] CataractSurgery
  where Global."NormalizeInterval" ( CataractSurgery.relevantDatetime, CataractSurgery.relevantPeriod ) during "Measurement Period"
    and Global."NormalizeInterval" ( CataractSurgery.relevantDatetime, CataractSurgery.relevantPeriod ) starts 93 days or more before
    end of "Measurement Period"
```

Denominator

"Initial Population"

Denominator Exclusions

```
"Cataract Surgery Between January and September of Measurement Period" CataractSurgeryPerformed
  with ( ["Diagnosis": "Acute and Subacute Iridocyclitis"]
    union ["Diagnosis": "Amblyopia"]
    union ["Diagnosis": "Burn Confined to Eye and Adnexa"]
    union ["Diagnosis": "Cataract Secondary to Ocular Disorders"]
```

```
    union ["Diagnosis": "Cataract, Congenital"]
    union ["Diagnosis": "Cataract, Mature or Hypermature"]
    union ["Diagnosis": "Cataract, Posterior Polar"]
    union ["Diagnosis": "Central Corneal Ulcer"]
    union ["Diagnosis": "Certain Types of Iridocyclitis"]
    union ["Diagnosis": "Choroidal Degenerations"]
    union ["Diagnosis": "Choroidal Detachment"]
    union ["Diagnosis": "Choroidal Hemorrhage and Rupture"]
    union ["Diagnosis": "Chronic Iridocyclitis"]
    union ["Diagnosis": "Cloudy Cornea"]
    union ["Diagnosis": "Corneal Edema"]
    union ["Diagnosis": "Corneal Opacity and Other Disorders of Cornea"]
    union ["Diagnosis": "Degeneration of Macula and Posterior Pole"]
    union ["Diagnosis": "Degenerative Disorders of Globe"]
    union ["Diagnosis": "Diabetic Macular Edema"]
    union ["Diagnosis": "Diabetic Retinopathy"]
    union ["Diagnosis": "Disorders of Optic Chiasm"]
    union ["Diagnosis": "Disorders of Visual Cortex"]
    union ["Diagnosis": "Disseminated Chorioretinitis and Disseminated Retinochoroiditis"]
    union ["Diagnosis": "Focal Chorioretinitis and Focal Retinochoroiditis"]
    union ["Diagnosis": "Glaucoma"]
    union ["Diagnosis": "Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes"]
    union ["Diagnosis": "Hereditary Choroidal Dystrophies"]
    union ["Diagnosis": "Hereditary Corneal Dystrophies"]
    union ["Diagnosis": "Hereditary Retinal Dystrophies"]
    union ["Diagnosis": "Hypotony of Eye"]
    union ["Diagnosis": "Injury to Optic Nerve and Pathways"]
    union ["Diagnosis": "Macular Scar of Posterior Polar"]
    union ["Diagnosis": "Morgagnian Cataract"]
    union ["Diagnosis": "Nystagmus and Other Irregular Eye Movements"]
    union ["Diagnosis": "Open Wound of Eyeball"]
    union ["Diagnosis": "Optic Atrophy"]
    union ["Diagnosis": "Optic Neuritis"]
    union ["Diagnosis": "Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis"]
    union ["Diagnosis": "Other Background Retinopathy and Retinal Vascular Changes"]
    union ["Diagnosis": "Other Disorders of Optic Nerve"]
    union ["Diagnosis": "Other Endophthalmitis"]
    union ["Diagnosis": "Other Proliferative Retinopathy"]
    union ["Diagnosis": "Pathologic Myopia"]
    union ["Diagnosis": "Posterior Lenticonus"]
    union ["Diagnosis": "Prior Penetrating Keratoplasty"]
    union ["Diagnosis": "Purulent Endophthalmitis"]
    union ["Diagnosis": "Retinal Detachment with Retinal Defect"]
    union ["Diagnosis": "Retinal Vascular Occlusion"]
    union ["Diagnosis": "Retrolental Fibroplasias"]
    union ["Diagnosis": "Scleritis"]
    union ["Diagnosis": "Separation of Retinal Layers"]
    union ["Diagnosis": "Traumatic Cataract"]
    union ["Diagnosis": "Uveitis"]
    union ["Diagnosis": "Vascular Disorders of Iris and Ciliary Body"]
    union ["Diagnosis": "Visual Field Defects"] ) ComorbidDiagnosis
    such that ComorbidDiagnosis.prevalencePeriod overlaps before Global."NormalizeInterval" ( CataractSurgeryPerformed.relevantDatetime,
CataractSurgeryPerformed.relevantPeriod )
```

Initial Population

```
"Cataract Surgery Between January and September of Measurement Period" CataractSurgeryPerformed
  where AgeInYearsAt(date from start of "Measurement Period")>= 18
```

Numerator

```
"Cataract Surgery Between January and September of Measurement Period" CataractSurgeryPerformed
  with ( ["Physical Exam, Performed": "Best corrected visual acuity (observable entity)"]
    union ["Physical Exam, Performed": "Best Corrected Visual Acuity Exam Using Snellen Chart"] ) VisualAcuityExamPerformed
    such that Global."NormalizeInterval" ( VisualAcuityExamPerformed.relevantDatetime, VisualAcuityExamPerformed.relevantPeriod ) 90 days or less after day of
    end of Global."NormalizeInterval" ( CataractSurgeryPerformed.relevantDatetime, CataractSurgeryPerformed.relevantPeriod )
      and VisualAcuityExamPerformed.result in "Visual Acuity 20/40 or Better"
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- code "Best corrected visual acuity (observable entity)" ("SNOMEDCT Code (419775003)")
- valueset "Acute and Subacute Iridocyclitis" (2.16.840.1.113883.3.526.3.1241)
- valueset "Amblyopia" (2.16.840.1.113883.3.526.3.1448)
- valueset "Best Corrected Visual Acuity Exam Using Snellen Chart" (2.16.840.1.113883.3.526.3.1560)
- valueset "Burn Confined to Eye and Adnexa" (2.16.840.1.113883.3.526.3.1409)
- valueset "Cataract Secondary to Ocular Disorders" (2.16.840.1.113883.3.526.3.1410)
- valueset "Cataract Surgery" (2.16.840.1.113883.3.526.3.1411)
- valueset "Cataract, Congenital" (2.16.840.1.113883.3.526.3.1412)
- valueset "Cataract, Mature or Hypermature" (2.16.840.1.113883.3.526.3.1413)
- valueset "Cataract, Posterior Polar" (2.16.840.1.113883.3.526.3.1414)

- valueset "Central Corneal Ulcer" (2.16.840.1.113883.3.526.3.1428)
- valueset "Certain Types of Iridocyclitis" (2.16.840.1.113883.3.526.3.1415)
- valueset "Choroidal Degenerations" (2.16.840.1.113883.3.526.3.1450)
- valueset "Choroidal Detachment" (2.16.840.1.113883.3.526.3.1451)
- valueset "Choroidal Hemorrhage and Rupture" (2.16.840.1.113883.3.526.3.1452)
- valueset "Chronic Iridocyclitis" (2.16.840.1.113883.3.526.3.1416)
- valueset "Cloudy Cornea" (2.16.840.1.113883.3.526.3.1417)
- valueset "Corneal Edema" (2.16.840.1.113883.3.526.3.1418)
- valueset "Corneal Opacity and Other Disorders of Cornea" (2.16.840.1.113883.3.526.3.1419)
- valueset "Degeneration of Macula and Posterior Pole" (2.16.840.1.113883.3.526.3.1453)
- valueset "Degenerative Disorders of Globe" (2.16.840.1.113883.3.526.3.1454)
- valueset "Diabetic Macular Edema" (2.16.840.1.113883.3.526.3.1455)
- valueset "Diabetic Retinopathy" (2.16.840.1.113883.3.526.3.327)
- valueset "Disorders of Optic Chiasm" (2.16.840.1.113883.3.526.3.1457)
- valueset "Disorders of Visual Cortex" (2.16.840.1.113883.3.526.3.1458)
- valueset "Disseminated Chorioretinitis and Disseminated Retinochoroiditis" (2.16.840.1.113883.3.526.3.1459)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Focal Chorioretinitis and Focal Retinochoroiditis" (2.16.840.1.113883.3.526.3.1460)
- valueset "Glaucoma" (2.16.840.1.113883.3.526.3.1423)
- valueset "Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes" (2.16.840.1.113883.3.526.3.1461)
- valueset "Hereditary Choroidal Dystrophies" (2.16.840.1.113883.3.526.3.1462)
- valueset "Hereditary Corneal Dystrophies" (2.16.840.1.113883.3.526.3.1424)
- valueset "Hereditary Retinal Dystrophies" (2.16.840.1.113883.3.526.3.1463)
- valueset "Hypotony of Eye" (2.16.840.1.113883.3.526.3.1426)
- valueset "Injury to Optic Nerve and Pathways" (2.16.840.1.113883.3.526.3.1427)
- valueset "Macular Scar of Posterior Polar" (2.16.840.1.113883.3.526.3.1559)
- valueset "Morgagnian Cataract" (2.16.840.1.113883.3.526.3.1558)
- valueset "Nystagmus and Other Irregular Eye Movements" (2.16.840.1.113883.3.526.3.1465)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Open Wound of Eyeball" (2.16.840.1.113883.3.526.3.1430)
- valueset "Optic Atrophy" (2.16.840.1.113883.3.526.3.1466)
- valueset "Optic Neuritis" (2.16.840.1.113883.3.526.3.1467)
- valueset "Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis" (2.16.840.1.113883.3.526.3.1468)
- valueset "Other Background Retinopathy and Retinal Vascular Changes" (2.16.840.1.113883.3.526.3.1469)
- valueset "Other Disorders of Optic Nerve" (2.16.840.1.113883.3.526.3.1471)
- valueset "Other Endophthalmitis" (2.16.840.1.113883.3.526.3.1473)
- valueset "Other Proliferative Retinopathy" (2.16.840.1.113883.3.526.3.1480)
- valueset "Pathologic Myopia" (2.16.840.1.113883.3.526.3.1432)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Posterior Lenticonus" (2.16.840.1.113883.3.526.3.1433)
- valueset "Prior Penetrating Keratoplasty" (2.16.840.1.113883.3.526.3.1475)
- valueset "Purulent Endophthalmitis" (2.16.840.1.113883.3.526.3.1477)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Retinal Detachment with Retinal Defect" (2.16.840.1.113883.3.526.3.1478)
- valueset "Retinal Vascular Occlusion" (2.16.840.1.113883.3.526.3.1479)
- valueset "Retrolental Fibroplasias" (2.16.840.1.113883.3.526.3.1438)
- valueset "Scleritis" (2.16.840.1.113762.1.4.1226.1)
- valueset "Separation of Retinal Layers" (2.16.840.1.113883.3.526.3.1482)
- valueset "Traumatic Cataract" (2.16.840.1.113883.3.526.3.1443)
- valueset "Uveitis" (2.16.840.1.113883.3.526.3.1444)
- valueset "Vascular Disorders of Iris and Ciliary Body" (2.16.840.1.113883.3.526.3.1445)
- valueset "Visual Acuity 20/40 or Better" (2.16.840.1.113883.3.526.3.1483)
- valueset "Visual Field Defects" (2.16.840.1.113883.3.526.3.1446)

Data Criteria (QDM Data Elements)

- "Diagnosis: Acute and Subacute Iridocyclitis" using "Acute and Subacute Iridocyclitis (2.16.840.1.113883.3.526.3.1241)"
- "Diagnosis: Amblyopia" using "Amblyopia (2.16.840.1.113883.3.526.3.1448)"
- "Diagnosis: Burn Confined to Eye and Adnexa" using "Burn Confined to Eye and Adnexa (2.16.840.1.113883.3.526.3.1409)"
- "Diagnosis: Cataract Secondary to Ocular Disorders" using "Cataract Secondary to Ocular Disorders (2.16.840.1.113883.3.526.3.1410)"
- "Diagnosis: Cataract, Congenital" using "Cataract, Congenital (2.16.840.1.113883.3.526.3.1412)"
- "Diagnosis: Cataract, Mature or Hypermature" using "Cataract, Mature or Hypermature (2.16.840.1.113883.3.526.3.1413)"
- "Diagnosis: Cataract, Posterior Polar" using "Cataract, Posterior Polar (2.16.840.1.113883.3.526.3.1414)"
- "Diagnosis: Central Corneal Ulcer" using "Central Corneal Ulcer (2.16.840.1.113883.3.526.3.1428)"
- "Diagnosis: Certain Types of Iridocyclitis" using "Certain Types of Iridocyclitis (2.16.840.1.113883.3.526.3.1415)"
- "Diagnosis: Choroidal Degenerations" using "Choroidal Degenerations (2.16.840.1.113883.3.526.3.1450)"
- "Diagnosis: Choroidal Detachment" using "Choroidal Detachment (2.16.840.1.113883.3.526.3.1451)"
- "Diagnosis: Choroidal Hemorrhage and Rupture" using "Choroidal Hemorrhage and Rupture (2.16.840.1.113883.3.526.3.1452)"
- "Diagnosis: Chronic Iridocyclitis" using "Chronic Iridocyclitis (2.16.840.1.113883.3.526.3.1416)"
- "Diagnosis: Cloudy Cornea" using "Cloudy Cornea (2.16.840.1.113883.3.526.3.1417)"
- "Diagnosis: Corneal Edema" using "Corneal Edema (2.16.840.1.113883.3.526.3.1418)"
- "Diagnosis: Corneal Opacity and Other Disorders of Cornea" using "Corneal Opacity and Other Disorders of Cornea (2.16.840.1.113883.3.526.3.1419)"
- "Diagnosis: Degeneration of Macula and Posterior Pole" using "Degeneration of Macula and Posterior Pole (2.16.840.1.113883.3.526.3.1453)"
- "Diagnosis: Degenerative Disorders of Globe" using "Degenerative Disorders of Globe (2.16.840.1.113883.3.526.3.1454)"
- "Diagnosis: Diabetic Macular Edema" using "Diabetic Macular Edema (2.16.840.1.113883.3.526.3.1455)"
- "Diagnosis: Diabetic Retinopathy" using "Diabetic Retinopathy (2.16.840.1.113883.3.526.3.327)"
- "Diagnosis: Disorders of Optic Chiasm" using "Disorders of Optic Chiasm (2.16.840.1.113883.3.526.3.1457)"
- "Diagnosis: Disorders of Visual Cortex" using "Disorders of Visual Cortex (2.16.840.1.113883.3.526.3.1458)"
- "Diagnosis: Disseminated Chorioretinitis and Disseminated Retinochoroiditis" using "Disseminated Chorioretinitis and Disseminated Retinochoroiditis (2.16.840.1.113883.3.526.3.1459)"
- "Diagnosis: Focal Chorioretinitis and Focal Retinochoroiditis" using "Focal Chorioretinitis and Focal Retinochoroiditis (2.16.840.1.113883.3.526.3.1460)"
- "Diagnosis: Glaucoma" using "Glaucoma (2.16.840.1.113883.3.526.3.1423)"
- "Diagnosis: Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes" using "Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes (2.16.840.1.113883.3.526.3.1461)"
- "Diagnosis: Hereditary Choroidal Dystrophies" using "Hereditary Choroidal Dystrophies (2.16.840.1.113883.3.526.3.1462)"
- "Diagnosis: Hereditary Corneal Dystrophies" using "Hereditary Corneal Dystrophies (2.16.840.1.113883.3.526.3.1424)"
- "Diagnosis: Hereditary Retinal Dystrophies" using "Hereditary Retinal Dystrophies (2.16.840.1.113883.3.526.3.1463)"
- "Diagnosis: Hypotony of Eye" using "Hypotony of Eye (2.16.840.1.113883.3.526.3.1426)"
- "Diagnosis: Injury to Optic Nerve and Pathways" using "Injury to Optic Nerve and Pathways (2.16.840.1.113883.3.526.3.1427)"
- "Diagnosis: Macular Scar of Posterior Polar" using "Macular Scar of Posterior Polar (2.16.840.1.113883.3.526.3.1559)"
- "Diagnosis: Morgagnian Cataract" using "Morgagnian Cataract (2.16.840.1.113883.3.526.3.1558)"
- "Diagnosis: Nystagmus and Other Irregular Eye Movements" using "Nystagmus and Other Irregular Eye Movements (2.16.840.1.113883.3.526.3.1465)"
- "Diagnosis: Open Wound of Eyeball" using "Open Wound of Eyeball (2.16.840.1.113883.3.526.3.1430)"
- "Diagnosis: Optic Atrophy" using "Optic Atrophy (2.16.840.1.113883.3.526.3.1466)"
- "Diagnosis: Optic Neuritis" using "Optic Neuritis (2.16.840.1.113883.3.526.3.1467)"
- "Diagnosis: Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis" using "Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis (2.16.840.1.113883.3.526.3.1468)"
- "Diagnosis: Other Background Retinopathy and Retinal Vascular Changes" using "Other Background Retinopathy and Retinal Vascular Changes (2.16.840.1.113883.3.526.3.1469)"
- "Diagnosis: Other Disorders of Optic Nerve" using "Other Disorders of Optic Nerve (2.16.840.1.113883.3.526.3.1471)"
- "Diagnosis: Other Endophthalmitis" using "Other Endophthalmitis (2.16.840.1.113883.3.526.3.1473)"
- "Diagnosis: Other Proliferative Retinopathy" using "Other Proliferative Retinopathy (2.16.840.1.113883.3.526.3.1480)"
- "Diagnosis: Pathologic Myopia" using "Pathologic Myopia (2.16.840.1.113883.3.526.3.1432)"
- "Diagnosis: Posterior Lenticonus" using "Posterior Lenticonus (2.16.840.1.113883.3.526.3.1433)"
- "Diagnosis: Prior Penetrating Keratoplasty" using "Prior Penetrating Keratoplasty (2.16.840.1.113883.3.526.3.1475)"
- "Diagnosis: Purulent Endophthalmitis" using "Purulent Endophthalmitis (2.16.840.1.113883.3.526.3.1477)"

- "Diagnosis: Retinal Detachment with Retinal Defect" using "Retinal Detachment with Retinal Defect (2.16.840.1.113883.3.526.3.1478)"
- "Diagnosis: Retinal Vascular Occlusion" using "Retinal Vascular Occlusion (2.16.840.1.113883.3.526.3.1479)"
- "Diagnosis: Retrolental Fibroplasias" using "Retrolental Fibroplasias (2.16.840.1.113883.3.526.3.1438)"
- "Diagnosis: Scleritis" using "Scleritis (2.16.840.1.113762.1.4.1226.1)"
- "Diagnosis: Separation of Retinal Layers" using "Separation of Retinal Layers (2.16.840.1.113883.3.526.3.1482)"
- "Diagnosis: Traumatic Cataract" using "Traumatic Cataract (2.16.840.1.113883.3.526.3.1443)"
- "Diagnosis: Uveitis" using "Uveitis (2.16.840.1.113883.3.526.3.1444)"
- "Diagnosis: Vascular Disorders of Iris and Ciliary Body" using "Vascular Disorders of Iris and Ciliary Body (2.16.840.1.113883.3.526.3.1445)"
- "Diagnosis: Visual Field Defects" using "Visual Field Defects (2.16.840.1.113883.3.526.3.1446)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"
- "Physical Exam, Performed: Best corrected visual acuity (observable entity)" using "Best corrected visual acuity (observable entity) (SNOMEDCT Code 419775003)"
- "Physical Exam, Performed: Best Corrected Visual Acuity Exam Using Snellen Chart" using "Best Corrected Visual Acuity Exam Using Snellen Chart (2.16.840.1.113883.3.526.3.1560)"
- "Procedure, Performed: Cataract Surgery" using "Cataract Surgery (2.16.840.1.113883.3.526.3.1411)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**
eCQM Identifier (Measure Authoring Tool)	138
eCQM Version Number	11.0.000
NQF Number	0028e
GUID	e35791df-5b25-41bb-b260-673337bc44a8
Measurement Period	January 1, 20XX through December 31, 20XX
Measure Steward	National Committee for Quality Assurance
Measure Developer	National Committee for Quality Assurance
Measure Developer	American Medical Association (AMA)
Measure Developer	PCPI(R) Foundation (PCPI[R])
Endorsed By	National Quality Forum
Description	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period b. Percentage of patients aged 18 years and older who were identified as a tobacco user during the measurement period who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user
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Measure Scoring	Proportion
Measure Type	Process
Stratification	None
Risk Adjustment	None
Rate Aggregation	None
Rationale	This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop using tobacco lower their risk for heart disease, lung disease, and stroke.
Clinical Recommendation Statement	The US Preventive Services Task Force (USPSTF) recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2021). The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2021). The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women (Grade I Statement) (U.S. Preventive Services Task Force, 2021). The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of electronic cigarettes (e-cigarettes) for tobacco cessation in adults, including pregnant persons. The USPSTF recommends that clinicians direct patients who use tobacco to other tobacco cessation interventions with proven effectiveness and established safety (Grade I Statement) (U.S. Preventive Services Task Force, 2021).
Improvement Notation	Higher score indicates better quality
Reference	Reference Type: CITATION Reference Text: 'US Preventive Services Task Force. (2021). Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons. US Preventive Services Task Force Recommendation Statement. JAMA, 325(3), 265-279. doi:10.1001/jama.2020.25019'
Definition	Tobacco Use - use of any tobacco product The 2021 USPSTF recommendation references the US Food and Drug Administration definition of tobacco which includes "any product made or derived from tobacco intended for human consumption (except products that meet the definition of drugs), including, but not limited to, cigarettes, cigars (including cigarillos and little cigars), dissolvables, hookah tobacco, nicotine gels, pipe tobacco, roll-your-own tobacco, smokeless tobacco products (including dip, snuff, snus, and chewing tobacco), vapes, electronic cigarettes (e-cigarettes), hookah pens, and other electronic nicotine delivery systems."

Guidance	The 2021 USPSTF recommendation describes smoking as generally referring to "the inhaling and exhaling of smoke produced by combustible tobacco products such as cigarettes, cigars, and pipes." The 2021 USPSTF recommendation describes vaping as "the inhaling and exhaling of aerosols produced by e-cigarettes." In addition, it states, "vaping products (i.e., e-cigarettes) usually contain nicotine, which is the addictive ingredient in tobacco. Substances other than tobacco can also be used to smoke or vape. While the 2015 USPSTF recommendation statement used the term 'electronic nicotine delivery systems' or 'ENDS,' the USPSTF recognizes that the field has shifted to using the term 'e-cigarettes' (or 'e-cigs') and uses the term e-cigarettes in the current recommendation statement. e-Cigarettes can come in many shapes and sizes, but generally they heat a liquid that contains nicotine (the addictive drug in tobacco) to produce an aerosol (or 'vapor') that is inhaled ('vaped') by users." Tobacco Cessation Intervention - Includes brief counseling (3 minutes or less), and/or pharmacotherapy - Note: Concepts aligned with brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) are included in the value set for the numerator. Other concepts such as written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies are not included in the value set and do not qualify for the numerator. Counseling also may be of longer duration or be performed more frequently, as evidence shows that higher-intensity interventions are associated with higher tobacco cessation rates (U.S. Preventive Services Task Force, 2021). The requirement of two or more visits is to establish that the eligible clinician has an existing relationship with the patient for certain types of encounters. To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the measurement period. If a patient has multiple tobacco use screenings during the measurement period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements. If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy. As noted above in the 2021 USPSTF recommendation statement, the current evidence is insufficient to recommend electronic cigarettes (e-cigarettes) for tobacco cessation. However, as noted above in the Definition section, the 2021 USPSTF recommendation also references the US Food and Drug Administration definition of tobacco, which includes e-cigarettes, hookah pens and other electronic nicotine delivery systems. Therefore, the measure does consider the use of e-cigarettes and other electronic nicotine delivery systems to be tobacco use. If a patient's tobacco use status is unknown, the patient does not meet the screening requirement and does not meet the numerator for populations 1 or 3. Instances where tobacco use status of "unknown" include: 1) the patient was not screened; or 2) the patient was screened and the patient (or caregiver) was unable to provide a definitive answer. In order to promote a team-based approach to patient care, the tobacco cessation intervention can be performed by another healthcare provider; therefore, the tobacco use screening and tobacco cessation intervention do not need to be performed by the same provider or clinician. This measure contains three reporting rates which aim to identify patients who were screened for tobacco use (rate/population 1), patients who were identified as tobacco users and who received a tobacco cessation intervention (rate/population 2), and a comprehensive look at the overall performance on tobacco screening and cessation intervention (rate/population 3). By separating this measure into various reporting rates, the eligible clinician will be able to better ascertain where gaps in performance exist, and identify opportunities for improvement. The overall rate (rate/population 3) can be utilized to compare performance to published versions of this measure prior to the 2018 performance year, when the measure had a single performance rate. For accountability reporting in the CMS MIPS program, the rate for population 2 is used for performance. The denominator of population criteria 2 is a subset of the resulting numerator for population criteria 1, as population criteria 2 is limited to assessing if patients identified as tobacco users received an appropriate tobacco cessation intervention. For all patients, population criteria 1 and 3 are applicable, but population criteria 2 will only be applicable for those patients who are identified as tobacco users. Therefore, data for every patient that meets the initial population criteria will only be submitted for population 1 and 3, whereas data submitted for population 2 will be for a subset of patients who meet the initial population criteria, as the denominator has been further limited to those who were identified as tobacco users. This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Denominator	Population 1: Equals Initial Population Population 2: Equals Initial Population who were screened for tobacco use during the measurement period and identified as a tobacco user Population 3: Equals Initial Population
Denominator Exclusions	Exclude patients who are in hospice care for any part of the measurement period
Numerator	Population 1: Patients who were screened for tobacco use at least once during the measurement period Population 2: Patients who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period Population 3: Patients who were screened for tobacco use at least once during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user
Numerator Exclusions	Not Applicable
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

- Risk Adjustment Variables

Population Criteria

Population Criteria 1

Initial Population

```
AgeInYearsAt(date from start of "Measurement Period")>= 18
  and ( Count("Qualifying Visit During Measurement Period")>= 2
     or exists "Preventive Visit During Measurement Period"
  )
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
```

Numerator

```
"Most Recent Tobacco Use Screening Indicates Tobacco Non User" is not null
  or "Most Recent Tobacco Use Screening Indicates Tobacco User" is not null
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Population Criteria 2

Initial Population

```
AgeInYearsAt(date from start of "Measurement Period")>= 18
  and ( Count("Qualifying Visit During Measurement Period")>= 2
     or exists "Preventive Visit During Measurement Period"
  )
```

Denominator

```
"Initial Population"
  and "Most Recent Tobacco Use Screening Indicates Tobacco User" is not null
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
```

Numerator

```
exists "Tobacco Cessation Counseling Given"
  or exists "Tobacco Cessation Pharmacotherapy Ordered"
  or exists "Active Pharmacotherapy for Tobacco Cessation"
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Population Criteria 3

Initial Population

```
AgeInYearsAt(date from start of "Measurement Period")>= 18
  and ( Count("Qualifying Visit During Measurement Period")>= 2
     or exists "Preventive Visit During Measurement Period"
  )
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
```

Numerator

```
"Most Recent Tobacco Use Screening Indicates Tobacco Non User" is not null
  or ( "Most Recent Tobacco Use Screening Indicates Tobacco User" is not null
     and ( exists "Tobacco Cessation Counseling Given"
        or exists "Tobacco Cessation Pharmacotherapy Ordered"
        or exists "Active Pharmacotherapy for Tobacco Cessation"
```

```
    )
  )
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

Active Pharmacotherapy for Tobacco Cessation

```
["Medication, Active": "Tobacco Use Cessation Pharmacotherapy"] TakingCessationPharmacotherapy
  where Global."NormalizeInterval" ( TakingCessationPharmacotherapy.relevantDatetime, TakingCessationPharmacotherapy.relevantPeriod ) during day of Interval[start of
"Measurement Period" - 6 months,
  end of "Measurement Period"]
```

Denominator 1

```
"Initial Population"
```

Denominator 2

```
"Initial Population"
  and "Most Recent Tobacco Use Screening Indicates Tobacco User" is not null
```

Denominator 3

```
"Initial Population"
```

Denominator Exclusion

```
Hospice."Has Hospice Services"
```

Hospice.Has Hospice Services

```
exists ( ["Encounter, Performed": "Encounter Inpatient"] InpatientEncounter
    where ( InpatientEncounter.dischargeDisposition ~ "Discharge to home for hospice care (procedure)"
        or InpatientEncounter.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)"
    )
      and InpatientEncounter.relevantPeriod ends during day of "Measurement Period"
)
  or exists ( ["Encounter, Performed": "Hospice Encounter"] HospiceEncounter
      where HospiceEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Assessment, Performed": "Hospice care [Minimum Data Set]"] HospiceAssessment
      where HospiceAssessment.result ~ "Yes (qualifier value)"
        and Global."NormalizeInterval" ( HospiceAssessment.relevantDatetime, HospiceAssessment.relevantPeriod ) overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Order": "Hospice Care Ambulatory"] HospiceOrder
      where HospiceOrder.authorDatetime during day of "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Hospice Care Ambulatory"] HospicePerformed
      where Global."NormalizeInterval" ( HospicePerformed.relevantDatetime, HospicePerformed.relevantPeriod ) overlaps "Measurement Period"
  )
```

Initial Population

```
AgeInYearsAt(date from start of "Measurement Period")>= 18
  and ( Count("Qualifying Visit During Measurement Period")>= 2
      or exists "Preventive Visit During Measurement Period"
  )
```

Most Recent Tobacco Use Screening Indicates Tobacco Non User

```
( Last(["Assessment, Performed": "Tobacco Use Screening"] TobaccoUseScreening
    where Global."NormalizeInterval"(TobaccoUseScreening.relevantDatetime, TobaccoUseScreening.relevantPeriod)during "Measurement Period"
    sort by start of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)
)) MostRecentTobaccoUseScreening
  where MostRecentTobaccoUseScreening.result in "Tobacco Non User"
```

Most Recent Tobacco Use Screening Indicates Tobacco User

```
( Last(["Assessment, Performed": "Tobacco Use Screening"] TobaccoUseScreening
    where Global."NormalizeInterval"(TobaccoUseScreening.relevantDatetime, TobaccoUseScreening.relevantPeriod)during "Measurement Period"
    sort by start of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)
)) MostRecentTobaccoUseScreening
  where MostRecentTobaccoUseScreening.result in "Tobacco User"
```

Numerator 1

```
"Most Recent Tobacco Use Screening Indicates Tobacco Non User" is not null
  or "Most Recent Tobacco Use Screening Indicates Tobacco User" is not null
```

Numerator 2

```
exists "Tobacco Cessation Counseling Given"
  or exists "Tobacco Cessation Pharmacotherapy Ordered"
  or exists "Active Pharmacotherapy for Tobacco Cessation"
```

Numerator 3

```
"Most Recent Tobacco Use Screening Indicates Tobacco Non User" is not null
  or ( "Most Recent Tobacco Use Screening Indicates Tobacco User" is not null
      and ( exists "Tobacco Cessation Counseling Given"
          or exists "Tobacco Cessation Pharmacotherapy Ordered"
          or exists "Active Pharmacotherapy for Tobacco Cessation"
```

```
    )
  )
```

Preventive Visit During Measurement Period

```
( ["Encounter, Performed": "Annual Wellness Visit"]
  union ["Encounter, Performed": "Preventive Care Services Established Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Preventive Care Services Group Counseling"]
  union ["Encounter, Performed": "Unlisted preventive medicine service"]
  union ["Encounter, Performed": "Preventive Care Services Individual Counseling"]
  union ["Encounter, Performed": "Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was
performed during a postoperative period for a reason(s) related to the original procedure"]
  union ["Encounter, Performed": "Nutrition Services"]
  union ["Encounter, Performed": "Preventive Care Services Initial Office Visit, 18 and Up"] ) PreventiveEncounter
  where PreventiveEncounter.relevantPeriod during day of "Measurement Period"
```

Qualifying Visit During Measurement Period

```
( ["Encounter, Performed": "Health behavior intervention, individual, face-to-face; initial 30 minutes"]
  union ["Encounter, Performed": "Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)"]
  union ["Encounter, Performed": "Home Healthcare Services"]
  union ["Encounter, Performed": "Occupational Therapy Evaluation"]
  union ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Ophthalmological Services"]
  union ["Encounter, Performed": "Physical Therapy Evaluation"]
  union ["Encounter, Performed": "Psych Visit Diagnostic Evaluation"]
  union ["Encounter, Performed": "Psych Visit Psychotherapy"]
  union ["Encounter, Performed": "Psychoanalysis"]
  union ["Encounter, Performed": "Speech and Hearing Evaluation"]
  union ["Encounter, Performed": "Telephone Visits"]
  union ["Encounter, Performed": "Online Assessments"] ) OfficeBasedEncounter
  where OfficeBasedEncounter.relevantPeriod during day of "Measurement Period"
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Tobacco Cessation Counseling Given

```
( ["Intervention, Performed": "Tobacco Use Cessation Counseling"] TobaccoCessationCounseling
    where Global."NormalizeInterval" ( TobaccoCessationCounseling.relevantDatetime, TobaccoCessationCounseling.relevantPeriod ) during day of Interval[start of
"Measurement Period" - 6 months,
    end of "Measurement Period"]
)
  union ( ["Diagnosis": "Tobacco abuse counseling"] TobaccoCounseling
      where ( TobaccoCounseling.prevalencePeriod ) starts during day of Interval[start of "Measurement Period" - 6 months,
      end of "Measurement Period"]
  )
```

Tobacco Cessation Pharmacotherapy Ordered

```
["Medication, Order": "Tobacco Use Cessation Pharmacotherapy"] CessationPharmacotherapyOrdered
  where CessationPharmacotherapyOrdered.authorDatetime during day of Interval[start of "Measurement Period" - 6 months,
  end of "Measurement Period"]
```

Functions

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)" ("CPT Code (96156)")
- code "Health behavior intervention, individual, face-to-face; initial 30 minutes" ("CPT Code (96158)")
- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure" ("CPT Code (99024)")
- code "Tobacco abuse counseling" ("ICD10CM Code (Z71.6)")
- code "Unlisted preventive medicine service" ("CPT Code (99429)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Nutrition Services" (2.16.840.1.113883.3.464.1003.1006)
- valueset "Occupational Therapy Evaluation" (2.16.840.1.113883.3.526.3.1011)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Online Assessments" (2.16.840.1.113883.3.464.1003.101.12.1089)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Physical Therapy Evaluation" (2.16.840.1.113883.3.526.3.1022)
- valueset "Preventive Care Services Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services Group Counseling" (2.16.840.1.113883.3.464.1003.101.12.1027)
- valueset "Preventive Care Services Individual Counseling" (2.16.840.1.113883.3.464.1003.101.12.1026)
- valueset "Preventive Care Services Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)

- valueset "Psych Visit Diagnostic Evaluation" (2.16.840.1.113883.3.526.3.1492)
- valueset "Psych Visit Psychotherapy" (2.16.840.1.113883.3.526.3.1496)
- valueset "Psychoanalysis" (2.16.840.1.113883.3.526.3.1141)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Speech and Hearing Evaluation" (2.16.840.1.113883.3.526.3.1530)
- valueset "Telephone Visits" (2.16.840.1.113883.3.464.1003.101.12.1080)
- valueset "Tobacco Non User" (2.16.840.1.113883.3.526.3.1189)
- valueset "Tobacco Use Cessation Counseling" (2.16.840.1.113883.3.526.3.509)
- valueset "Tobacco Use Cessation Pharmacotherapy" (2.16.840.1.113883.3.526.3.1190)
- valueset "Tobacco Use Screening" (2.16.840.1.113883.3.526.3.1278)
- valueset "Tobacco User" (2.16.840.1.113883.3.526.3.1170)

Data Criteria (QDM Data Elements)

- "Assessment, Performed: Hospice care [Minimum Data Set]" using "Hospice care [Minimum Data Set] (LOINC Code 45755-6)"
- "Assessment, Performed: Tobacco Use Screening" using "Tobacco Use Screening (2.16.840.1.113883.3.526.3.1278)"
- "Diagnosis: Tobacco abuse counseling" using "Tobacco abuse counseling (ICD10CM Code Z71.6)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Encounter Inpatient" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "Encounter, Performed: Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)" using "Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making) (CPT Code 96156)"
- "Encounter, Performed: Health behavior intervention, individual, face-to-face; initial 30 minutes" using "Health behavior intervention, individual, face-to-face; initial 30 minutes (CPT Code 96158)"
- "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Hospice Encounter" using "Hospice Encounter (2.16.840.1.113883.3.464.1003.1003)"
- "Encounter, Performed: Nutrition Services" using "Nutrition Services (2.16.840.1.113883.3.464.1003.1006)"
- "Encounter, Performed: Occupational Therapy Evaluation" using "Occupational Therapy Evaluation (2.16.840.1.113883.3.526.3.1011)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Online Assessments" using "Online Assessments (2.16.840.1.113883.3.464.1003.101.12.1089)"
- "Encounter, Performed: Ophthalmological Services" using "Ophthalmological Services (2.16.840.1.113883.3.526.3.1285)"
- "Encounter, Performed: Physical Therapy Evaluation" using "Physical Therapy Evaluation (2.16.840.1.113883.3.526.3.1022)"
- "Encounter, Performed: Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure" using "Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure (CPT Code 99024)"
- "Encounter, Performed: Preventive Care Services Established Office Visit, 18 and Up" using "Preventive Care Services Established Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1025)"
- "Encounter, Performed: Preventive Care Services Group Counseling" using "Preventive Care Services Group Counseling (2.16.840.1.113883.3.464.1003.101.12.1027)"
- "Encounter, Performed: Preventive Care Services Individual Counseling" using "Preventive Care Services Individual Counseling (2.16.840.1.113883.3.464.1003.101.12.1026)"
- "Encounter, Performed: Preventive Care Services Initial Office Visit, 18 and Up" using "Preventive Care Services Initial Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Encounter, Performed: Psych Visit Diagnostic Evaluation" using "Psych Visit Diagnostic Evaluation (2.16.840.1.113883.3.526.3.1492)"
- "Encounter, Performed: Psych Visit Psychotherapy" using "Psych Visit Psychotherapy (2.16.840.1.113883.3.526.3.1496)"
- "Encounter, Performed: Psychoanalysis" using "Psychoanalysis (2.16.840.1.113883.3.526.3.1141)"
- "Encounter, Performed: Speech and Hearing Evaluation" using "Speech and Hearing Evaluation (2.16.840.1.113883.3.526.3.1530)"
- "Encounter, Performed: Telephone Visits" using "Telephone Visits (2.16.840.1.113883.3.464.1003.101.12.1080)"
- "Encounter, Performed: Unlisted preventive medicine service" using "Unlisted preventive medicine service (CPT Code 99429)"
- "Intervention, Order: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Tobacco Use Cessation Counseling" using "Tobacco Use Cessation Counseling (2.16.840.1.113883.3.526.3.509)"
- "Medication, Active: Tobacco Use Cessation Pharmacotherapy" using "Tobacco Use Cessation Pharmacotherapy (2.16.840.1.113883.3.526.3.1190)"
- "Medication, Order: Tobacco Use Cessation Pharmacotherapy" using "Tobacco Use Cessation Pharmacotherapy (2.16.840.1.113883.3.526.3.1190)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	**Falls: Screening for Future Fall Risk**		
eCQM Identifier (Measure Authoring Tool)	139	**eCQM Version Number**	11.0.000
NQF Number	Not Applicable	**GUID**	bc5b4a57-b964-4399-9d40-667c896f31ea
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	National Committee for Quality Assurance		
Measure Developer	National Committee for Quality Assurance		
Measure Developer	American Medical Association (AMA)		
Measure Developer	PCPI(R) Foundation (PCPI[R])		
Endorsed By	None		
Description	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period		
Copyright	This Physician Performance Measure (Measure) and related data specifications is owned and copyrighted by the National Committee for Quality Assurance (NCQA). NCQA makes no representations, warranties, or endorsement and NCQA has no liability to anyone who relies on or uses such measures or specifications. This Measure is not a clinical guideline and does not establish a standard of medical care, and has not been tested for all potential applications. The Measure, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measure for commercial gain, or incorporation of the Measure into a product or service that is sold, licensed or distributed for commercial gain. All commercial uses or requests for modification must be approved by NCQA and are subject to a license at the discretion of NCQA. (C) 2021 National Committee for Quality Assurance and PCPI(R) Foundation. All Rights Reserved. Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. NCQA disclaims all liability for use or accuracy of any third party codes contained in the specifications. CPT(R) contained in the Measure specifications is copyright 2004-2021 American Medical Association. LOINC(R) copyright 2004-2021 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2021 International Health Terminology Standards Development Organisation. ICD-10 copyright 2021 World Health Organization. All Rights Reserved.		
Disclaimer	The performance Measure is not a clinical guideline and does not establish a standard of medical care, and has not been tested for all potential applications. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Due to technical limitations, registered trademarks are indicated by (R) or [R] and unregistered trademarks are indicated by (TM) or [TM].		
Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	As the leading cause of both fatal and nonfatal injuries for older adults, falls are one of the most common and significant health issues facing people aged 65 years or older (Schneider, Shubert and Harmon, 2010). Moreover, the rate of falls increases with age (Dykes et al., 2010). Older adults are five times more likely to be hospitalized for fall-related injuries than any other cause-related injury. It is estimated that one in every three adults over 65 will fall each year (Centers for Disease Control and Prevention, 2015). In those over age 80, the rate of falls increases to fifty percent (Doherty et al., 2009). Falls are also associated with substantial cost and resource use, approaching $30,000 per fall hospitalization (Woolcott et al., 2011). Identifying at-risk patients is the most important part of management, as applying preventive measures in this vulnerable population can have a profound effect on public health (al-Aama, 2011). Family physicians have a pivotal role in screening older patients for risk of falls, and applying preventive strategies for patients at risk (al-Aama, 2011).		
Clinical Recommendation Statement	All older persons who are under the care of a heath professional (or their caregivers) should be asked at least once a year about falls. (American Geriatrics Society/British Geriatric Society/American Academy of Orthopaedic Surgeons, 2010) Older persons who present for medical attention because of a fall, report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should have a fall evaluation performed. This evaluation should be performed by a clinician with appropriate skills and experience, which may necessitate referral to a specialist (e.g., geriatrician). (AGS/BGS/AAOS, 2010)		
Improvement Notation	A higher score indicates better quality		
Reference	Reference Type: CITATION Reference Text: 'al-Aama, T. 2011. "Falls in the Elderly: Spectrum and Prevention." Can Fam Physician 57(7),771-6.'		
Reference	Reference Type: CITATION Reference Text: 'American Geriatrics Society and British Geriatric Society. (2010) Prevention of Falls in Older Persons Clinical Practice Guidelines. Accessed June 14, 2018. Available at https://www.archcare.org/sites/default/files/pdf/2010-prevention-of-falls-in-older-persons-ags-and-bgs-clinical-practice-guideline.pdf'		
Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. 2015. "Important Facts about Falls" (December 14, 2015) http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html'		
Reference	Reference Type: CITATION Reference Text: 'Doherty, M., and J. Crossen-Sills. 2009. "Fall Risk: Keep your Patients in Balance." The Nurse Practitioner: The American Journal of Primary Health Care 34(12),46-51.'		
Reference	Reference Type: CITATION Reference Text: 'Dykes, P.C., D.L. Carroll DL, A. Hurley A, S. Lipsitz S, A. Benoit A, F. Chang F, S. Meltzer S, R. Tsurikova R, L. Zuyov L, B. Middleton B. 2010. "Fall Prevention in Acute Care Hospitals: A Randomized Trial." JAMA. 2010;304(17),1912-1918.'		
Reference	Reference Type: CITATION		

	Reference Text: 'Schneider, E.C., T.E. Shubert, and K.J. Harmon. 2010. "Addressing the Escalating Public Health Issue of Falls Among Older Adults." NC Med J 71(6),547-52.' Reference Type: CITATION
Reference	Reference Text: 'Woolcott, J.C., K.M. Khan, S. Mitrovic, A.H. Anis, C.A. Marra. 2011. "The Cost of Fall Related Presentations to the ED: A Prospective, In-Person, Patient-Tracking Analysis of Health Resource Utilization." Osteporos Int [Epub ahead of print].'
Definition	Screening for Future Fall Risk: Assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure, however potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test. Fall: A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.
Guidance	This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	Patients aged 65 years and older at the start of the measurement period with a visit during the measurement period
Denominator	Equals Initial Population
Denominator Exclusions	Exclude patients who are in hospice care for any part of the measurement period
Numerator	Patients who were screened for future fall risk at least once within the measurement period
Numerator Exclusions	Not Applicable
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

Population Criteria

Initial Population

```
AgeInYearsAt(date from start of "Measurement Period")>= 65
  and exists "Qualifying Encounter"
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
```

Numerator

```
exists ( ["Assessment, Performed": "Falls Screening"] FallsScreening
    where Global."NormalizeInterval" ( FallsScreening.relevantDatetime, FallsScreening.relevantPeriod ) during day of "Measurement Period"
)
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
```

Hospice.Has Hospice Services

```
exists ( ["Encounter, Performed": "Encounter Inpatient"] InpatientEncounter
    where ( InpatientEncounter.dischargeDisposition ~ "Discharge to home for hospice care (procedure)"
        or InpatientEncounter.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)"
    )
      and InpatientEncounter.relevantPeriod ends during day of "Measurement Period"
```

```
)
  or exists ( ["Encounter, Performed": "Hospice Encounter"] HospiceEncounter
      where HospiceEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Assessment, Performed": "Hospice care [Minimum Data Set]"] HospiceAssessment
      where HospiceAssessment.result ~ "Yes (qualifier value)"
        and Global."NormalizeInterval" ( HospiceAssessment.relevantDatetime, HospiceAssessment.relevantPeriod ) overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Order": "Hospice Care Ambulatory"] HospiceOrder
      where HospiceOrder.authorDatetime during day of "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Hospice Care Ambulatory"] HospicePerformed
      where Global."NormalizeInterval" ( HospicePerformed.relevantDatetime, HospicePerformed.relevantPeriod ) overlaps "Measurement Period"
  )
```

Initial Population

```
AgeInYearsAt(date from start of "Measurement Period")>= 65
  and exists "Qualifying Encounter"
```

Numerator

```
exists ( ["Assessment, Performed": "Falls Screening"] FallsScreening
    where Global."NormalizeInterval" ( FallsScreening.relevantDatetime, FallsScreening.relevantPeriod ) during day of "Measurement Period"
)
```

Qualifying Encounter

```
( ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Annual Wellness Visit"]
  union ["Encounter, Performed": "Preventive Care Services Established Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Preventive Care Services Initial Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Home Healthcare Services"]
  union ["Encounter, Performed": "Ophthalmological Services"]
  union ["Encounter, Performed": "Preventive Care Services Individual Counseling"]
  union ["Encounter, Performed": "Discharge Services Nursing Facility"]
  union ["Encounter, Performed": "Nursing Facility Visit"]
  union ["Encounter, Performed": "Care Services in Long Term Residential Facility"]
  union ["Encounter, Performed": "Audiology Visit"]
  union ["Encounter, Performed": "Telephone Visits"]
  union ["Encounter, Performed": "Online Assessments"]
  union ["Encounter, Performed": "Physical Therapy Evaluation"]
  union ["Encounter, Performed": "Occupational Therapy Evaluation"] ) ValidEncounters
  where ValidEncounters.relevantPeriod during day of "Measurement Period"
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Audiology Visit" (2.16.840.1.113883.3.464.1003.101.12.1066)
- valueset "Care Services in Long Term Residential Facility" (2.16.840.1.113883.3.464.1003.101.12.1014)
- valueset "Discharge Services Nursing Facility" (2.16.840.1.113883.3.464.1003.101.12.1013)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Falls Screening" (2.16.840.1.113883.3.464.1003.118.12.1028)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Nursing Facility Visit" (2.16.840.1.113883.3.464.1003.101.12.1012)
- valueset "Occupational Therapy Evaluation" (2.16.840.1.113883.3.526.3.1011)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Online Assessments" (2.16.840.1.113883.3.464.1003.101.12.1089)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Physical Therapy Evaluation" (2.16.840.1.113883.3.526.3.1022)
- valueset "Preventive Care Services Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services Individual Counseling" (2.16.840.1.113883.3.464.1003.101.12.1026)
- valueset "Preventive Care Services Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Telephone Visits" (2.16.840.1.113883.3.464.1003.101.12.1080)

Data Criteria (QDM Data Elements)

- "Assessment, Performed: Falls Screening" using "Falls Screening (2.16.840.1.113883.3.464.1003.118.12.1028)"
- "Assessment, Performed: Hospice care [Minimum Data Set]" using "Hospice care [Minimum Data Set] (LOINC Code 45755-6)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"

- "Encounter, Performed: Audiology Visit" using "Audiology Visit (2.16.840.1.113883.3.464.1003.101.12.1066)"
- "Encounter, Performed: Care Services in Long Term Residential Facility" using "Care Services in Long Term Residential Facility (2.16.840.1.113883.3.464.1003.101.12.1014)"
- "Encounter, Performed: Discharge Services Nursing Facility" using "Discharge Services Nursing Facility (2.16.840.1.113883.3.464.1003.101.12.1013)"
- "Encounter, Performed: Encounter Inpatient" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Hospice Encounter" using "Hospice Encounter (2.16.840.1.113883.3.464.1003.1003)"
- "Encounter, Performed: Nursing Facility Visit" using "Nursing Facility Visit (2.16.840.1.113883.3.464.1003.101.12.1012)"
- "Encounter, Performed: Occupational Therapy Evaluation" using "Occupational Therapy Evaluation (2.16.840.1.113883.3.526.3.1011)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Online Assessments" using "Online Assessments (2.16.840.1.113883.3.464.1003.101.12.1089)"
- "Encounter, Performed: Ophthalmological Services" using "Ophthalmological Services (2.16.840.1.113883.3.526.3.1285)"
- "Encounter, Performed: Physical Therapy Evaluation" using "Physical Therapy Evaluation (2.16.840.1.113883.3.526.3.1022)"
- "Encounter, Performed: Preventive Care Services Established Office Visit, 18 and Up" using "Preventive Care Services Established Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1025)"
- "Encounter, Performed: Preventive Care Services Individual Counseling" using "Preventive Care Services Individual Counseling (2.16.840.1.113883.3.464.1003.101.12.1026)"
- "Encounter, Performed: Preventive Care Services Initial Office Visit, 18 and Up" using "Preventive Care Services Initial Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Encounter, Performed: Telephone Visits" using "Telephone Visits (2.16.840.1.113883.3.464.1003.101.12.1080)"
- "Intervention, Order: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	**Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care**		
eCQM Identifier (Measure Authoring Tool)	142	**eCQM Version Number**	11.0.000
NQF Number	Not Applicable	**GUID**	53d6d7c3-43fb-4d24-8099-17e74c022c05
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	American Academy of Ophthalmology		
Measure Developer	American Academy of Ophthalmology		
Measure Developer	American Medical Association (AMA)		
Measure Developer	PCPI(R) Foundation (PCPI[R])		
Endorsed By	None		
Description	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months		
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Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Diabetic retinopathy is a prevalent complication of diabetes, estimated to affect 28.5% of diabetic patients in the US (Zhang et al., 2010). Diabetic Retinopathy is a key indicator of systemic complications of diabetes (Zhang, 2010). Coordination of care between the eye care specialist and the physician managing a patient's ongoing diabetes care is essential in stemming the progression of vision loss. Communication from the eye care specialist to a primary care physician facilitates the exchange of information about the severity and progression of a patient's diabetic retinopathy, adherence to recommended ocular care, need for follow-up visits, and treatment plans (Storey et al., 2016). Data from the Diabetes Control and Complications Trial showed that diabetic treatment and maintenance of glucose control delays the onset and slows the progression of diabetic retinopathy (Aiello & DCCT/EDIC Research Group, 2014).		
Clinical Recommendation Statement	The ophthalmologist should refer patients with diabetes to a primary care physician for appropriate management of their systemic condition and should communicate examination results to the physician managing the patient's ongoing diabetes care (III; Good Quality; Strong Recommendation) (American Academy of Ophthalmology, 2017). Ophthalmologists should communicate the ophthalmologic findings and level of retinopathy with the primary care physician as well as the need for optimizing metabolic control (III; Good Quality; Strong Recommendation) (American Academy of Ophthalmology, 2017). Close partnership with the primary care physician is important to make sure that the care of the patient is optimized (III; Good Quality; Strong Recommendation) (American Academy of Ophthalmology, 2017).		
Improvement Notation	Higher score indicates better quality		
Reference	Reference Type: CITATION Reference Text: 'Aiello, L. P., & DCCT/EDIC Research Group (2014). Diabetic retinopathy and other ocular findings in the diabetes control and complications trial/epidemiology of diabetes interventions and complications study. Diabetes care, 37(1), 17–23. doi:10.2337/dc13-2251'		
Reference	Reference Type: CITATION Reference Text: 'American Academy of Ophthalmology. (2017). Diabetic retinopathy Preferred Practice Pattern. San Francisco, CA: American Academy of Ophthalmology.'		
Reference	Reference Type: CITATION Reference Text: 'Storey, P. P., Murchison, A. P., Pizzi, L. T., Hark, L. A., Dai, Y., Leiby, B. E., & Haller, J. A. Impact of physician communication on diabetic eye examination adherence: Results from a Retrospective Cohort Analysis. Retina. 2016 Jan;36(1),20-7. doi:10.1097/IAE.0000000000000652'		
Reference	Reference Type: CITATION Reference Text: 'Zhang, X., Saaddine, J. B., Chou, C. F., Cotch, M. F., Cheng, Y. J., Geiss, L. S., … Klein, R. (2010). Prevalence of diabetic retinopathy in the United States, 2005-2008. JAMA, 304(6), 649–656. doi:10.1001/jama.2010.1111'		

Definition	Communication - May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam. Findings - Includes level of severity of retinopathy (e.g., mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema. The measure, as written, does not specifically require documentation of laterality. Coding limitations in particular clinical terminologies do not currently allow for that level of specificity (ICD-10-CM includes laterality, but SNOMED-CT does not uniformly include this distinction). Therefore, at this time, it is not a requirement of this measure to indicate laterality of the diagnoses, findings or procedures. Available coding to capture the data elements specified in this measure has been provided. It is assumed that the eligible professional or eligible clinician will record laterality in the patient medical record, as quality care and clinical documentation should include laterality.
Guidance	The communication of results to the primary care physician providing ongoing care of a patient's diabetes should be completed soon after the dilated exam is performed. 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, eligible professionals or eligible clinicians who see patients towards the end of the reporting period (i.e., December in particular), should communicate the results of the dilated macular exam as soon as possible in order for those patients to be counted in the measure numerator. Communicating the results as soon as possible after the date of the exam will ensure the data are included in the submission to CMS. This eCQM is a patient-based measure. Telehealth encounters are not eligible for this measure because the measure requires a clinical action that cannot be conducted via telehealth. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	All patients aged 18 years and older with a diagnosis of diabetic retinopathy
Denominator	Equals Initial Population who had a dilated macular or fundus exam performed
Denominator Exclusions	None
Numerator	Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care
Numerator Exclusions	Not Applicable
Denominator Exceptions	Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes. Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

Population Criteria

Initial Population

```
AgeInYearsAt(date from start of "Measurement Period")>= 18
  and exists "Diabetic Retinopathy Encounter"
```

Denominator

```
"Initial Population"
  and exists "Macular Exam Performed"
```

Denominator Exclusions

None

Numerator

```
exists "Level of Severity of Retinopathy Findings Communicated"
  and ( exists "Macular Edema Absence Communicated"
      or exists "Macular Edema Presence Communicated"
  )
```

Numerator Exclusions

None

Denominator Exceptions

```
exists "Medical or Patient Reason for Not Communicating Level of Severity of Retinopathy"
  or exists "Medical or Patient Reason for Not Communicating Absence of Macular Edema"
  or exists "Medical or Patient Reason for Not Communicating Presence of Macular Edema"
```

Stratification

None

Definitions

Denominator

```
"Initial Population"
  and exists "Macular Exam Performed"
```

Denominator Exceptions

```
exists "Medical or Patient Reason for Not Communicating Level of Severity of Retinopathy"
  or exists "Medical or Patient Reason for Not Communicating Absence of Macular Edema"
  or exists "Medical or Patient Reason for Not Communicating Presence of Macular Edema"
```

Diabetic Retinopathy Encounter

```
"Qualifying Encounter During Measurement Period" ValidQualifyingEncounter
  with ["Diagnosis": "Diabetic Retinopathy"] DiabeticRetinopathy
    such that DiabeticRetinopathy.prevalencePeriod overlaps ValidQualifyingEncounter.relevantPeriod
```

Initial Population

```
AgeInYearsAt(date from start of "Measurement Period")>= 18
  and exists "Diabetic Retinopathy Encounter"
```

Level of Severity of Retinopathy Findings Communicated

```
["Communication, Performed": "Level of Severity of Retinopathy Findings"] LevelOfSeverityCommunicated
  with "Diabetic Retinopathy Encounter" EncounterDiabeticRetinopathy
    such that LevelOfSeverityCommunicated.sentDatetime after start of EncounterDiabeticRetinopathy.relevantPeriod
```

Macular Edema Absence Communicated

```
["Communication, Performed": "Macular edema absent (situation)"] MacularEdemaAbsentCommunicated
  with "Diabetic Retinopathy Encounter" EncounterDiabeticRetinopathy
    such that MacularEdemaAbsentCommunicated.sentDatetime after start of EncounterDiabeticRetinopathy.relevantPeriod
```

Macular Edema Presence Communicated

```
["Communication, Performed": "Macular Edema Findings Present"] MacularEdemaPresentCommunicated
  with "Diabetic Retinopathy Encounter" EncounterDiabeticRetinopathy
    such that MacularEdemaPresentCommunicated.sentDatetime after start of EncounterDiabeticRetinopathy.relevantPeriod
```

Macular Exam Performed

```
["Diagnostic Study, Performed": "Macular Exam"] MacularExam
  with "Diabetic Retinopathy Encounter" EncounterDiabeticRetinopathy
    such that Global."NormalizeInterval" ( MacularExam.relevantDatetime, MacularExam.relevantPeriod ) during EncounterDiabeticRetinopathy.relevantPeriod
  where MacularExam.result is not null
```

Medical or Patient Reason for Not Communicating Absence of Macular Edema

```
["Communication, Not Performed": "Macular edema absent (situation)"] MacularEdemaAbsentNotCommunicated
  with "Diabetic Retinopathy Encounter" EncounterDiabeticRetinopathy
    such that MacularEdemaAbsentNotCommunicated.authorDatetime during EncounterDiabeticRetinopathy.relevantPeriod
  where ( MacularEdemaAbsentNotCommunicated.negationRationale in "Medical Reason"
      or MacularEdemaAbsentNotCommunicated.negationRationale in "Patient Reason"
  )
```

Medical or Patient Reason for Not Communicating Level of Severity of Retinopathy

```
["Communication, Not Performed": "Level of Severity of Retinopathy Findings"] LevelOfSeverityNotCommunicated
  with "Diabetic Retinopathy Encounter" EncounterDiabeticRetinopathy
    such that LevelOfSeverityNotCommunicated.authorDatetime during EncounterDiabeticRetinopathy.relevantPeriod
  where ( LevelOfSeverityNotCommunicated.negationRationale in "Medical Reason"
      or LevelOfSeverityNotCommunicated.negationRationale in "Patient Reason"
  )
```

Medical or Patient Reason for Not Communicating Presence of Macular Edema

```
["Communication, Not Performed": "Macular Edema Findings Present"] MacularEdemaPresentNotCommunicated
  with "Diabetic Retinopathy Encounter" EncounterDiabeticRetinopathy
    such that MacularEdemaPresentNotCommunicated.authorDatetime during EncounterDiabeticRetinopathy.relevantPeriod
  where ( MacularEdemaPresentNotCommunicated.negationRationale in "Medical Reason"
      or MacularEdemaPresentNotCommunicated.negationRationale in "Patient Reason"
  )
```

Numerator

```
exists "Level of Severity of Retinopathy Findings Communicated"
  and ( exists "Macular Edema Absence Communicated"
      or exists "Macular Edema Presence Communicated"
  )
```

Qualifying Encounter During Measurement Period

```
( ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Ophthalmological Services"]
  union ["Encounter, Performed": "Outpatient Consultation"]
  union ["Encounter, Performed": "Care Services in Long-Term Residential Facility"]
  union ["Encounter, Performed": "Nursing Facility Visit"] ) QualifyingEncounter
  where QualifyingEncounter.relevantPeriod during "Measurement Period"
    and QualifyingEncounter.class !~ "virtual"
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Functions

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- code "Macular edema absent (situation)" ("SNOMEDCT Code (428341000124108)")
- code "virtual" ("ActCode Code (VR)")
- valueset "Care Services in Long-Term Residential Facility" (2.16.840.1.113883.3.464.1003.101.12.1014)
- valueset "Diabetic Retinopathy" (2.16.840.1.113883.3.526.3.327)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Level of Severity of Retinopathy Findings" (2.16.840.1.113883.3.526.3.1283)
- valueset "Macular Edema Findings Present" (2.16.840.1.113883.3.526.3.1320)
- valueset "Macular Exam" (2.16.840.1.113883.3.526.3.1251)
- valueset "Medical Reason" (2.16.840.1.113883.3.526.3.1007)
- valueset "Nursing Facility Visit" (2.16.840.1.113883.3.464.1003.101.12.1012)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Outpatient Consultation" (2.16.840.1.113883.3.464.1003.101.12.1008)
- valueset "Patient Reason" (2.16.840.1.113883.3.526.3.1008)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Race" (2.16.840.1.114222.4.11.836)

Data Criteria (QDM Data Elements)

- "Communication, Not Performed: Level of Severity of Retinopathy Findings" using "Level of Severity of Retinopathy Findings (2.16.840.1.113883.3.526.3.1283)"
- "Communication, Not Performed: Macular edema absent (situation)" using "Macular edema absent (situation) (SNOMEDCT Code 428341000124108)"
- "Communication, Not Performed: Macular Edema Findings Present" using "Macular Edema Findings Present (2.16.840.1.113883.3.526.3.1320)"
- "Communication, Performed: Level of Severity of Retinopathy Findings" using "Level of Severity of Retinopathy Findings (2.16.840.1.113883.3.526.3.1283)"
- "Communication, Performed: Macular edema absent (situation)" using "Macular edema absent (situation) (SNOMEDCT Code 428341000124108)"
- "Communication, Performed: Macular Edema Findings Present" using "Macular Edema Findings Present (2.16.840.1.113883.3.526.3.1320)"
- "Diagnosis: Diabetic Retinopathy" using "Diabetic Retinopathy (2.16.840.1.113883.3.526.3.327)"
- "Diagnostic Study, Performed: Macular Exam" using "Macular Exam (2.16.840.1.113883.3.526.3.1251)"
- "Encounter, Performed: Care Services in Long-Term Residential Facility" using "Care Services in Long-Term Residential Facility (2.16.840.1.113883.3.464.1003.101.12.1014)"
- "Encounter, Performed: Nursing Facility Visit" using "Nursing Facility Visit (2.16.840.1.113883.3.464.1003.101.12.1012)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Ophthalmological Services" using "Ophthalmological Services (2.16.840.1.113883.3.526.3.1285)"
- "Encounter, Performed: Outpatient Consultation" using "Outpatient Consultation (2.16.840.1.113883.3.464.1003.101.12.1008)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	**Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation**
eCQM Identifier (Measure Authoring Tool)	143
eCQM Version Number	11.0.000
NQF Number	0086e
GUID	db9d9f09-6b6a-4749-a8b2-8c1fdb018823
Measurement Period	January 1, 20XX through December 31, 20XX
Measure Steward	American Academy of Ophthalmology
Measure Developer	American Academy of Ophthalmology
Measure Developer	American Medical Association (AMA)
Measure Developer	PCPI(R) Foundation (PCPI[R])
Endorsed By	National Quality Forum
Description	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more visits within 12 months
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Measure Scoring	Proportion
Measure Type	Process
Stratification	None
Risk Adjustment	None
Rate Aggregation	None
Rationale	Glaucoma is a group of diseases that damage the eye's optic nerve and can result in vision loss and blindness. In 2011, 2.71 million persons in the U.S. had primary open-angle glaucoma (POAG) and in 2050, an estimated 7.32 million persons will have POAG (Vajaranant, Wu, Torres, & Varma, 2012). Furthermore, a study by Rein, Zhang, & Wirth (2006) estimated that the total financial burden of major visual disorders among U.S. residents aged 40 years or older was $35.4 billion in 2004: $16.2 billion in direct medical costs, $11.1 billion in other direct costs, and $8 billion in productivity losses. Of the direct medical costs, approximately $2.9 billion was attributable to glaucoma (Rein, Zhang, & Wirth, 2006). It is imperative that evidence-based care be delivered to all glaucoma patients. According to recent guidelines, optic nerve changes are one of the characteristics which reflect progression of glaucoma (the other characteristic is visual field). Examination of the optic nerve head (ONH) and retinal nerve fiber layer (RNFL) provides valuable structural information about optic nerve damage from glaucoma. Visible structural alterations of the ONH or RNFL may precede the onset of visual field defects. Careful study of the optic disc neural rim for small hemorrhages is important because these hemorrhages sometimes signal focal disc damage and visual field loss, and they may signify ongoing optic nerve damage in patients with glaucoma (American Academy of Ophthalmology, 2015). Despite evidence emphasizing the value of an optic nerve evaluation, there is a gap in documentation patterns of the optic nerve for both initial and follow-up care. This measure is intended to promote examination and documentation of the structure and function of the optic nerve, and to monitor and detect disease progression among patients diagnosed with POAG.
Clinical Recommendation Statement	Ophthalmic Evaluation The ophthalmic evaluation specifically focuses on the following elements in the comprehensive adult medical eye evaluation: Visual acuity measurement Pupil examination Anterior segment examination IOP measurement Gonioscopy Optic nerve head (ONH) and retinal nerve fiber layer (RNFL) examination Fundus examination (American Academy of Ophthalmology, 2015) The optic nerve should be carefully examined for the signs of glaucoma damage, and its appearance should be serially documented (I+, moderate quality, strong recommendation) (American Academy of Ophthalmology, 2015).
Improvement Notation	Higher score indicates better quality
Reference	Reference Type: CITATION Reference Text: 'American Academy of Ophthalmology (2015). Primary open-angle glaucoma Preferred Practice Pattern. San Francisco, CA: American Academy of Ophthalmology.'
Reference	Reference Type: CITATION

	Reference Text: 'Rein, D. B., Zhang, P., & Wirth, K. (2006). The economic burden of major adult visual disorders in the United States. Archives of Ophthalmology, 124(12), 1754-1760. doi:10.1001/archopht.124.12.1754'
	Reference Type: CITATION
Reference	Reference Text: 'Vajaranant, T. S., Wu, S., Torres, M., & Varma, R. (2012). The changing face of primary open-angle glaucoma in the United States: Demographic and geographic changes from 2011 to 2050. American Journal of Ophthalmology, 154(2). doi:10.1016/j.ajo.2012.02.024'
Definition	None
Guidance	Optic nerve head evaluation includes examination of the cup to disc ratio and identification of optic disc or retinal nerve abnormalities. Both of these components of the optic nerve head evaluation are examined using ophthalmoscopy. The measure, as written, does not specifically require documentation of laterality. Coding limitations in particular clinical terminologies do not currently allow for that level of specificity (ICD-10-CM includes laterality, but SNOMED-CT does not uniformly include this distinction). Therefore, at this time, it is not a requirement of this measure to indicate laterality of the diagnoses, findings or procedures. Available coding to capture the data elements specified in this measure has been provided. It is assumed that the eligible professional or eligible clinician will record laterality in the patient medical record, as quality care and clinical documentation should include laterality. This eCQM is a patient-based measure. Telehealth encounters are not eligible for this measure because the measure requires a clinical action that cannot be conducted via telehealth. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma
Denominator	Equals Initial Population
Denominator Exclusions	None
Numerator	Patients who have an optic nerve head evaluation during one or more visits within 12 months
Numerator Exclusions	Not Applicable
Denominator Exceptions	Documentation of medical reason(s) for not performing an optic nerve head evaluation
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

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Population Criteria

Initial Population

```
AgeInYearsAt(date from start of "Measurement Period")>= 18
  and exists "Primary Open Angle Glaucoma Encounter"
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

None

Numerator

```
exists "Cup to Disc Ratio Performed with Result"
  and exists "Optic Disc Exam Performed with Result"
```

Numerator Exclusions

None

Denominator Exceptions

```
exists "Medical Reason for Not Performing Cup to Disc Ratio"
  or exists "Medical Reason for Not Performing Optic Disc Exam"
```

Stratification

None

Definitions

Cup to Disc Ratio Performed with Result

```
["Diagnostic Study, Performed": "Cup to Disc Ratio"] CupToDiscExamPerformed
  with "Primary Open Angle Glaucoma Encounter" EncounterWithPOAG
    such that Global."NormalizeInterval" ( CupToDiscExamPerformed.relevantDatetime, CupToDiscExamPerformed.relevantPeriod ) during
```

```
EncounterWithPOAG.relevantPeriod
  where CupToDiscExamPerformed.result is not null
```

Denominator

```
"Initial Population"
```

Denominator Exceptions

```
exists "Medical Reason for Not Performing Cup to Disc Ratio"
  or exists "Medical Reason for Not Performing Optic Disc Exam"
```

Initial Population

```
AgeInYearsAt(date from start of "Measurement Period")>= 18
  and exists "Primary Open Angle Glaucoma Encounter"
```

Medical Reason for Not Performing Cup to Disc Ratio

```
["Diagnostic Study, Not Performed": "Cup to Disc Ratio"] CupToDiscExamNotPerformed
  with "Primary Open Angle Glaucoma Encounter" EncounterWithPOAG
    such that CupToDiscExamNotPerformed.authorDatetime during EncounterWithPOAG.relevantPeriod
  where CupToDiscExamNotPerformed.negationRationale in "Medical Reason"
```

Medical Reason for Not Performing Optic Disc Exam

```
["Diagnostic Study, Not Performed": "Optic Disc Exam for Structural Abnormalities"] OpticDiscExamNotPerformed
  with "Primary Open Angle Glaucoma Encounter" EncounterWithPOAG
    such that OpticDiscExamNotPerformed.authorDatetime during EncounterWithPOAG.relevantPeriod
  where OpticDiscExamNotPerformed.negationRationale in "Medical Reason"
```

Numerator

```
exists "Cup to Disc Ratio Performed with Result"
  and exists "Optic Disc Exam Performed with Result"
```

Optic Disc Exam Performed with Result

```
["Diagnostic Study, Performed": "Optic Disc Exam for Structural Abnormalities"] OpticDiscExamPerformed
  with "Primary Open Angle Glaucoma Encounter" EncounterWithPOAG
    such that Global."NormalizeInterval" ( OpticDiscExamPerformed.relevantDatetime, OpticDiscExamPerformed.relevantPeriod ) during EncounterWithPOAG.relevantPeriod
  where OpticDiscExamPerformed.result is not null
```

Primary Open Angle Glaucoma Encounter

```
"Qualifying Encounter During Measurement Period" ValidQualifyingEncounter
  with ["Diagnosis": "Primary Open-Angle Glaucoma"] PrimaryOpenAngleGlaucoma
    such that PrimaryOpenAngleGlaucoma.prevalencePeriod overlaps ValidQualifyingEncounter.relevantPeriod
```

Qualifying Encounter During Measurement Period

```
( ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Ophthalmological Services"]
  union ["Encounter, Performed": "Outpatient Consultation"]
  union ["Encounter, Performed": "Nursing Facility Visit"]
  union ["Encounter, Performed": "Care Services in Long-Term Residential Facility"] ) QualifyingEncounter
  where QualifyingEncounter.relevantPeriod during "Measurement Period"
    and QualifyingEncounter.class !~ "virtual"
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- code "virtual" ("ActCode Code (VR)")
- valueset "Care Services in Long-Term Residential Facility" (2.16.840.1.113883.3.464.1003.101.12.1014)
- valueset "Cup to Disc Ratio" (2.16.840.1.113883.3.526.3.1333)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Medical Reason" (2.16.840.1.113883.3.526.3.1007)
- valueset "Nursing Facility Visit" (2.16.840.1.113883.3.464.1003.101.12.1012)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Optic Disc Exam for Structural Abnormalities" (2.16.840.1.113883.3.526.3.1334)
- valueset "Outpatient Consultation" (2.16.840.1.113883.3.464.1003.101.12.1008)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Primary Open-Angle Glaucoma" (2.16.840.1.113883.3.526.3.326)
- valueset "Race" (2.16.840.1.114222.4.11.836)

Data Criteria (QDM Data Elements)

- "Diagnosis: Primary Open-Angle Glaucoma" using "Primary Open-Angle Glaucoma (2.16.840.1.113883.3.526.3.326)"
- "Diagnostic Study, Not Performed: Cup to Disc Ratio" using "Cup to Disc Ratio (2.16.840.1.113883.3.526.3.1333)"
- "Diagnostic Study, Not Performed: Optic Disc Exam for Structural Abnormalities" using "Optic Disc Exam for Structural Abnormalities (2.16.840.1.113883.3.526.3.1334)"
- "Diagnostic Study, Performed: Cup to Disc Ratio" using "Cup to Disc Ratio (2.16.840.1.113883.3.526.3.1333)"
- "Diagnostic Study, Performed: Optic Disc Exam for Structural Abnormalities" using "Optic Disc Exam for Structural Abnormalities (2.16.840.1.113883.3.526.3.1334)"
- "Encounter, Performed: Care Services in Long-Term Residential Facility" using "Care Services in Long-Term Residential Facility (2.16.840.1.113883.3.464.1003.101.12.1014)"
- "Encounter, Performed: Nursing Facility Visit" using "Nursing Facility Visit (2.16.840.1.113883.3.464.1003.101.12.1012)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Ophthalmological Services" using "Ophthalmological Services (2.16.840.1.113883.3.526.3.1285)"
- "Encounter, Performed: Outpatient Consultation" using "Outpatient Consultation (2.16.840.1.113883.3.464.1003.101.12.1008)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	**Use of High-Risk Medications in Older Adults**		
eCQM Identifier (Measure Authoring Tool)	156	**eCQM Version Number**	11.1.000
NQF Number	Not Applicable	**GUID**	a3837ff8-1abc-4ba9-800e-fd4e7953adbd
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	National Committee for Quality Assurance		
Measure Developer	National Committee for Quality Assurance		
Endorsed By	None		
Description	Percentage of patients 65 years of age and older who were ordered at least two high-risk medications from the same drug class. Three rates are reported. 1. Percentage of patients 65 years of age and older who were ordered at least two high-risk medications from the same drug class. 2. Percentage of patients 65 years of age and older who were ordered at least two high-risk medications from the same drug class, except for appropriate diagnoses. 3. Total rate (the sum of the two numerators divided by the denominator, deduplicating for patients in both numerators).		
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Disclaimer	The performance Measure is not a clinical guideline and does not establish a standard of medical care, and has not been tested for all potential applications. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Due to technical limitations, registered trademarks are indicated by (R) or [R] and unregistered trademarks are indicated by (TM) or [TM].		
Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Certain medications (MacKinnon & Hepler, 2003) are associated with increased risk of harm from drug side-effects and drug toxicity and pose a concern for patient safety. There is clinical consensus that these drugs pose increased risks in older adults (Kaufman, Brodin, & Sarafian, 2005). Potentially inappropriate medication use in older adults has been connected to significantly longer hospital stay lengths and increased hospitalization costs (Hagstrom et al., 2015) as well as increased risk of death (Lau et al., 2004). Use of specific high-risk medications such as hypnotics, including benzodiazepine receptor agonists, and nonsteroidal anti-inflammatory drugs (NSAIDS) can result in increased risk of delirium, falls, fractures, gastrointestinal bleeding and acute kidney injury (Merel et al., 2017). Long-term use of benzodiazepines in older adults has been associated with increased risk of dementia (Zhong et al., 2015; Takada et al., 2016). Additionally, the use of antipsychotics can lead to increased risk of stroke and greater cognitive decline in older adults with dementia (Tampi et al., 2016). Older adults receiving inappropriate medications are more likely to report poorer health status at follow-up, compared to those who receive appropriate medications (Fu, Liu, & Christensen, 2004). A study of the prevalence of potentially inappropriate medication use in older adults found that 40 percent of individuals 65 and older filled at least one prescription for a potentially inappropriate medication and 13 percent filled two or more (Fick et al., 2008). While some adverse drug events (ADEs) are unavoidable, studies estimate that between 30 and 80 percent of ADEs in older adults are preventable (MacKinnon & Hepler, 2003). More recently with the onset of the COVID-19 pandemic, several studies have shown an increase in anxiety, insomnia and depression rates, which could result in an increase in the use of high-risk medications in order to treat these conditions (Agrawal, 2020). Reducing the number of inappropriate prescriptions can lead to improved patient safety and significant cost savings. Conservative estimates of extra costs due to potentially inappropriate medications in older adults average $7.2 billion a year (Fu et al., 2007). Medication use by older adults will likely increase further as the U.S. population ages, new drugs are developed, and new therapeutic and preventive uses for medications are discovered (Rothberg et al., 2008). The annual direct costs of preventable ADEs in the Medicare population have been estimated to exceed $800 million (Institute of Medicine, 2007). By the year 2030, nearly one in five U.S. residents is expected to be aged 65 years or older; this age group is projected to more than double from 38.7 million in 2008 to more than 88.5 million in 2050. Likewise, the population aged 85 years or older is expected to increase almost four-fold, from 5.4 million to 19 million between 2008 and 2050. As the older adult population continues to grow, the number of older adults who present with multiple medical conditions for which several medications are prescribed will likely continue to increase, resulting in polypharmacy concerns (Gray & Gardner, 2009).		
Clinical Recommendation Statement	The measure is based on recommendations from the American Geriatrics Society Beers Criteria[R] for Potentially Inappropriate Medication Use in Older Adults (2019 Update). The criteria were developed through key clinical expert consensus processes by Beers in 1997, Zhan in 2001, and an updated process by Fick et al. in 2003, 2012, 2015, and 2019. The Beers Criteria identifies lists of drugs that are potentially inappropriate for all older adults, except for those with certain conditions for which some high-risk medications may be warranted, and drugs that are potentially inappropriate in older adults based on various high-risk factors such as dosage, days supply and underlying diseases or conditions. NCQA's Geriatric Measurement Advisory Panel recommended a subset of drugs that should be used with caution in older adults for inclusion in the measure based upon the recommendations in the Beers Criteria.		
Improvement Notation	Lower score indicates better quality		
Reference	Reference Type: CITATION Reference Text: 'Agrawal, R. (2020). Careful Prescribing of Benzodiazepines during COVID-19 Pandemic: A Review. Journal of Mental Health & Clinical Psychology 4(4). Retrieved from https://www.mentalhealthjournal.org/articles/careful-prescribing-of-benzodiazepines-during-covid-19-pandemic-a-review.html'		
Reference	Reference Type: CITATION Reference Text: 'American Geriatrics Society 2015 Beers Criteria Update Expert Panel. (2015). American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Journal of the		

	American Geriatrics Society, 63(11), 2227-2246.'
	Reference Type: CITATION
Reference	Reference Text: 'Beers, M. H. (1997). Explicit criteria for determining potentially inappropriate medication use by the elderly. Archives of Internal Medicine, 157, 1531-1536.'
	Reference Type: CITATION
Reference	Reference Text: 'Campanelli, C. M. (2012). American Geriatrics Society updated Beers criteria for potentially inappropriate medication use in older adults: The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. Journal of the American Geriatrics Society, 60(4), 616.'
	Reference Type: CITATION
Reference	Reference Text: 'Fick, D. M., Cooper J. W., Wade, W. E., et al. (2003). Updating the Beers criteria for potentially inappropriate medication use in older adults. Archives of Internal Medicine, 163(22), 2716-2724.'
	Reference Type: CITATION
Reference	Reference Text: 'Fick, D. M., Mion, L. C., Beers, M. H., et al. (2008). Health outcomes associated with potentially inappropriate medication use in older adults. Research in Nursing & Health, 31(1), 42-51.'
	Reference Type: CITATION
Reference	Reference Text: 'Fu, A. Z., Liu, G. G., & Christensen, D. B. (2004). Inappropriate medication use and health outcomes in the elderly. Journal of the American Geriatrics Society, 52(11), 1934-1939.'
	Reference Type: CITATION
Reference	Reference Text: 'Gray, C. L., & Gardner, C. (2009). Adverse drug events in the elderly: An ongoing problem. Journal of Managed Care & Specialty Pharmacy, 15(7), 568-571.'
	Reference Type: CITATION
Reference	Reference Text: 'Hagstrom, K., Nailor, M., Lindberg, M., Hobbs, L., & Sobieraj, D. M. 2015. Association Between Potentially Inappropriate Medication Use in Elderly Adults and Hospital-Related Outcomes. Journal of the American Geriatrics Society, 63(1), 185-186.'
	Reference Type: CITATION
Reference	Reference Text: 'Institute of Medicine, Committee on Identifying and Preventing Medication Errors. (2007). Preventing medication errors. Aspden, P., Wolcott, J. A., Bootman, J. L., & Cronenwatt, L. R. (eds.). Washington, DC: National Academy Press.'
	Reference Type: CITATION
Reference	Reference Text: 'Kaufman, M. B., Brodin, K. A., & Sarafian, A. (2005, April/May). Effect of prescriber education on the use of medications contraindicated in older adults in a managed Medicare population. Journal of Managed Care & Specialty Pharmacy, 11(3), 211-219.'
	Reference Type: CITATION
Reference	Reference Text: 'Lau, D.T., J.D., Kasper, D.E., Potter, A. Lyles. (2004). Potentially Inappropriate Medication Prescriptions Among Elderly Nursing Home Residents: Their Scope and Associated Resident and Facility Characteristics. Health Services Research, 39(5), 1257-1276.'
	Reference Type: CITATION
Reference	Reference Text: 'MacKinnon, N. J., & Hepler, C. D. (2003). Indicators of preventable drug-related morbidity in older adults: Use within a managed care organization. Journal of Managed Care & Specialty Pharmacy, 9(2), 134-141.'
	Reference Type: CITATION
Reference	Reference Text: 'Merel, S.E., and D.S. Paauw. (2017). Common Drug Side Effects and Drug-Drug Interactions in Elderly Adults in Primary Care. Journal of the American Geriatrics Society, 65(7), 1578-1585.'
	Reference Type: CITATION
Reference	Reference Text: 'Rothberg, M. B., Perkow, P. S., Liu, F., et al. (2008). Potentially inappropriate medication use in hospitalized elders. Journal of Hospital Medicine, 3(2), 91-102.'
	Reference Type: CITATION
Reference	Reference Text: 'Takada, M., M. Fujimoto, and K. Hosomi. (2016). Association between benzodiazepine use and dementia: data mining of different medical databases. International Journal of Medical Sciences, 13(11), 825-834.'
	Reference Type: CITATION
Reference	Reference Text: 'Tampi, R.R., D.J. Tampi, S. Balachandran, and S. Srinivasan. (2016). Antipsychotic use in dementia: a systematic review of benefits and risks from meta-analyses. Therapeutic Advances in Chronic Disease, 7(5), 229-245.'
	Reference Type: CITATION
Reference	Reference Text: 'Zhan, C., Sangl, J., Bierman, A. S., et al. (2001). Potentially inappropriate medication use in the community-dwelling elderly. JAMA, 286(22), 2823-2868.'
	Reference Type: CITATION
Reference	Reference Text: 'Zhong, G., Y. Wang, Y. Zhang, and Y. Zhao. (2015). Association between benzodiazepine use and dementia: a meta-analysis. PLoS One, 10(5).'
	Reference Type: CITATION
Reference	Reference Text: '2019 American Geriatrics Society Beers Criteria Update Expert Panel. (2019). American Geriatrics Society 2019 Updated AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Journal of the American Geriatrics Society, 67(4), 674-694.'
	Index Prescription Start Date (IPSD). The start date of the earliest prescription ordered for a high-risk medication during the measurement period.
Definition	A high-risk medication is identified by any one of the following: a. A prescription for medications classified as high risk at any dose and for any duration. b. A prescription for medications classified as high risk at any dose with greater than a 90 day supply. c. A prescription for medications classified as high risk exceeding average daily dose criteria.
	An order is identified by either a prescription order or a prescription refill.
Guidance	The intent of the measure is to assess if the patient has been ordered at least two high-risk medication prescriptions from the same drug class on different days.
	The intent of the measure is to assess if the reporting provider ordered the high-risk medication(s). If the patient had a high-risk medication previously prescribed by another provider, they would not be counted towards the numerator unless the reporting provider also ordered a high-risk medication from the same drug class for them.

	Calculate average daily dose for each prescription event. To calculate average daily dose, multiply the quantity of pills prescribed by the dose of each pill and divide by the days supply. For example, a prescription for the 30-days supply of digoxin containing 15 pills, 0.25 mg each pill, has an average daily dose of 0.125 mg. To calculate average daily dose for elixirs and concentrates, multiply the volume prescribed by daily dose and divide by the days supply. Do not round when calculating average daily dose. This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	Patients 65 years and older at the end of the measurement period who had a visit during the measurement period
Denominator	Equals Initial Population
Denominator Exclusions	Exclude patients who are in hospice care for any part of the measurement period. Exclude patients receiving palliative care for any part of the measurement period.
Numerator	Rate 1: Patients with at least two orders of high-risk medications from the same drug class on different days. a. At least two orders of high-risk medications from the same drug class. b. At least two orders of high-risk medications from the same drug class with summed days supply greater than 90 days. c. At least two orders of high-risk medications from the same drug class each exceeding average daily dose criteria. Rate 2: Patients with at least two orders of high-risk medications from the same drug class (i.e., antipsychotics and benzodiazepines) on different days. Total rate (the sum of the two previous numerators, deduplicated).
Numerator Exclusions	Rate 2: For patients with two or more antipsychotic prescriptions ordered, exclude patients who have a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder on or between January 1 of the year prior to the measurement period and the IPSD for antipsychotics. For patients with two or more benzodiazepine prescriptions ordered, exclude patients who have a diagnosis of seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, or severe generalized anxiety disorder on or between January 1 of the year prior to the measurement period and the IPSD for benzodiazepines.
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

Population Criteria

Population Criteria 1

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
)>= 65
  and exists ( "Qualifying Encounters" )
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or PalliativeCare."Palliative Care in the Measurement Period"
```

Numerator

```
exists ( "Same High Risk Medications Ordered on Different Days" )
  or ( "Two High Risk Medications with Prolonged Duration" )
  or ( "High Risk Medications with Average Daily Dose Criteria" )
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Population Criteria 2

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
)>= 65
  and exists ( "Qualifying Encounters" )
```

Denominator

"Initial Population"

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or PalliativeCare."Palliative Care in the Measurement Period"
```

Numerator

```
( "More than One Antipsychotic Order" )
  or ( "More than One Benzodiazepine Order" )
```

Numerator Exclusions

```
( "More than One Antipsychotic Order"
    and not ( "More than One Benzodiazepine Order" )
    and ( exists ( ( ["Diagnosis": "Schizophrenia"]
         union ["Diagnosis": "Bipolar Disorder"]
         union ["Diagnosis": "Other Bipolar Disorder"] ) AntipsychoticTreatedDiagnoses
         where AntipsychoticTreatedDiagnoses.prevalencePeriod overlaps Interval[start of "Measurement Period" - 1 year, "Antipsychotic Index Prescription Start Date"]
     )
    )
)
  or ( "More than One Benzodiazepine Order"
     and not ( "More than One Antipsychotic Order" )
     and ( exists ( ( ["Diagnosis": "Seizure Disorder"]
          union ["Diagnosis": "REM Sleep Behavior Disorder"]
          union ["Diagnosis": "Benzodiazepine Withdrawal"]
          union ["Diagnosis": "Alcohol Withdrawal"]
          union ["Diagnosis": "Generalized Anxiety Disorder"] ) BenzodiazepineTreatedDiagnoses
          where BenzodiazepineTreatedDiagnoses.prevalencePeriod overlaps Interval[start of "Measurement Period" - 1 year, "Benzodiazepine Index Prescription Start
Date"]
       )
     )
  )
  or ( "More than One Benzodiazepine Order"
     and ( "More than One Antipsychotic Order" )
     and ( exists ( ( ["Diagnosis": "Seizure Disorder"]
          union ["Diagnosis": "REM Sleep Behavior Disorder"]
          union ["Diagnosis": "Benzodiazepine Withdrawal"]
          union ["Diagnosis": "Alcohol Withdrawal"]
          union ["Diagnosis": "Generalized Anxiety Disorder"] ) BenzodiazepineTreatedDiagnoses
          where BenzodiazepineTreatedDiagnoses.prevalencePeriod overlaps Interval[start of "Measurement Period" - 1 year, "Benzodiazepine Index Prescription Start
Date"]
       )
     )
     and ( exists ( ( ["Diagnosis": "Schizophrenia"]
          union ["Diagnosis": "Bipolar Disorder"]
          union ["Diagnosis": "Other Bipolar Disorder"] ) AntipsychoticTreatedDiagnoses
          where AntipsychoticTreatedDiagnoses.prevalencePeriod overlaps Interval[start of "Measurement Period" - 1 year, "Antipsychotic Index Prescription Start Date"]
       )
     )
  )
```

Denominator Exceptions

None

Stratification

None

Population Criteria 3

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
)>= 65
  and exists ( "Qualifying Encounters" )
```

Denominator

"Initial Population"

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or PalliativeCare."Palliative Care in the Measurement Period"
```

Numerator

```
( "Numerator 2"
    and not "Numerator Exclusion"
)
  or ( "Numerator 1"
     and not "Numerator 2"
  )
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

Antipsychotic Index Prescription Start Date

"First Antipsychotic Medication Ordered"

Benzodiazepine Index Prescription Start Date

"First Benzodiazepine Medication Ordered"

Denominator

"Initial Population"

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or PalliativeCare."Palliative Care in the Measurement Period"
```

First Antipsychotic Medication Ordered

```
First(["Medication, Order": "Antipsychotics"] AntipsychoticMedication
    where AntipsychoticMedication.authorDatetime during "Measurement Period"
    return AntipsychoticMedication.authorDatetime
    sort asc
)
```

First Benzodiazepine Medication Ordered

```
First(["Medication, Order": "Benzodiazepines"] BenzodiazepineMedication
    where BenzodiazepineMedication.authorDatetime during "Measurement Period"
    return BenzodiazepineMedication.authorDatetime
    sort asc
)
```

High Risk Medications with Average Daily Dose Criteria

```
exists ( "More Than One Order"(["Medication, Order": "Reserpine"] ReserpineOrdered
      where "Average Daily Dose"(ReserpineOrdered)> 0.1 'mg/d'
  )
)
  or exists ( "More Than One Order"(["Medication, Order": "Digoxin"] DigoxinOrdered
      where "Average Daily Dose"(DigoxinOrdered)> 0.125 'mg/d'
    )
  )
  or exists ( "More Than One Order"(["Medication, Order": "Doxepin"] DoxepinOrdered
      where "Average Daily Dose"(DoxepinOrdered)> 6 'mg/d'
    )
  )
```

Hospice.Has Hospice Services

```
exists ( ["Encounter, Performed": "Encounter Inpatient"] InpatientEncounter
    where ( InpatientEncounter.dischargeDisposition ~ "Discharge to home for hospice care (procedure)"
      or InpatientEncounter.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)"
    )
      and InpatientEncounter.relevantPeriod ends during day of "Measurement Period"
)
  or exists ( ["Encounter, Performed": "Hospice Encounter"] HospiceEncounter
      where HospiceEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Assessment, Performed": "Hospice care [Minimum Data Set]"] HospiceAssessment
      where HospiceAssessment.result ~ "Yes (qualifier value)"
        and Global."NormalizeInterval" ( HospiceAssessment.relevantDatetime, HospiceAssessment.relevantPeriod ) overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Order": "Hospice Care Ambulatory"] HospiceOrder
      where HospiceOrder.authorDatetime during day of "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Hospice Care Ambulatory"] HospicePerformed
      where Global."NormalizeInterval" ( HospicePerformed.relevantDatetime, HospicePerformed.relevantPeriod ) overlaps "Measurement Period"
  )
```

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
)>= 65
  and exists ( "Qualifying Encounters" )
```

More than One Antipsychotic Order

```
exists ( "More Than One Order"(["Medication, Order": "Antipsychotics"]))
```

More than One Benzodiazepine Order

```
exists ( "More Than One Order"(["Medication, Order": "Benzodiazepines"]))
```

Numerator 1

```
exists ( "Same High Risk Medications Ordered on Different Days" )
  or ( "Two High Risk Medications with Prolonged Duration" )
  or ( "High Risk Medications with Average Daily Dose Criteria" )
```

Numerator 2

```
( "More than One Antipsychotic Order" )
  or ( "More than One Benzodiazepine Order" )
```

Numerator 3

```
( "Numerator 2"
    and not "Numerator Exclusion"
)
  or ( "Numerator 1"
      and not "Numerator 2"
  )
```

Numerator Exclusion

```
( "More than One Antipsychotic Order"
    and not ( "More than One Benzodiazepine Order" )
    and ( exists ( ( ["Diagnosis": "Schizophrenia"]
          union ["Diagnosis": "Bipolar Disorder"]
          union ["Diagnosis": "Other Bipolar Disorder"] ) AntipsychoticTreatedDiagnoses
          where AntipsychoticTreatedDiagnoses.prevalencePeriod overlaps Interval[start of "Measurement Period" - 1 year, "Antipsychotic Index Prescription Start Date"]
      )
    )
)
  or ( "More than One Benzodiazepine Order"
      and not ( "More than One Antipsychotic Order" )
      and ( exists ( ( ["Diagnosis": "Seizure Disorder"]
            union ["Diagnosis": "REM Sleep Behavior Disorder"]
            union ["Diagnosis": "Benzodiazepine Withdrawal"]
            union ["Diagnosis": "Alcohol Withdrawal"]
            union ["Diagnosis": "Generalized Anxiety Disorder"] ) BenzodiazepineTreatedDiagnoses
            where BenzodiazepineTreatedDiagnoses.prevalencePeriod overlaps Interval[start of "Measurement Period" - 1 year, "Benzodiazepine Index Prescription Start
Date"]
          )
      )
  )
  or ( "More than One Benzodiazepine Order"
      and ( "More than One Antipsychotic Order" )
      and ( exists ( ( ["Diagnosis": "Seizure Disorder"]
            union ["Diagnosis": "REM Sleep Behavior Disorder"]
            union ["Diagnosis": "Benzodiazepine Withdrawal"]
            union ["Diagnosis": "Alcohol Withdrawal"]
            union ["Diagnosis": "Generalized Anxiety Disorder"] ) BenzodiazepineTreatedDiagnoses
            where BenzodiazepineTreatedDiagnoses.prevalencePeriod overlaps Interval[start of "Measurement Period" - 1 year, "Benzodiazepine Index Prescription Start
Date"]
          )
      )
      and ( exists ( ( ["Diagnosis": "Schizophrenia"]
            union ["Diagnosis": "Bipolar Disorder"]
            union ["Diagnosis": "Other Bipolar Disorder"] ) AntipsychoticTreatedDiagnoses
            where AntipsychoticTreatedDiagnoses.prevalencePeriod overlaps Interval[start of "Measurement Period" - 1 year, "Antipsychotic Index Prescription Start Date"]
          )
      )
  )
```

PalliativeCare.Palliative Care in the Measurement Period

```
exists ( ["Assessment, Performed": "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)"] PalliativeAssessment
    where Global."NormalizeInterval"(PalliativeAssessment.relevantDatetime, PalliativeAssessment.relevantPeriod) overlaps "Measurement Period"
)
or exists (["Diagnosis": "Encounter for palliative care"] PalliativeDiagnosis
where PalliativeDiagnosis.prevalencePeriod overlaps "Measurement Period")
  or exists ( ["Encounter, Performed": "Palliative Care Encounter"] PalliativeEncounter
      where PalliativeEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Palliative Care Intervention"] PalliativeIntervention
      where Global."NormalizeInterval"(PalliativeIntervention.relevantDatetime, PalliativeIntervention.relevantPeriod) overlaps "Measurement Period"
  )
```

Qualifying Encounters

```
( ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Ophthalmologic Services"]
  union ["Encounter, Performed": "Preventive Care Services Established Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Discharge Services Nursing Facility"]
  union ["Encounter, Performed": "Nursing Facility Visit"]
  union ["Encounter, Performed": "Care Services in Long Term Residential Facility"]
  union ["Encounter, Performed": "Preventive Care Services Initial Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Annual Wellness Visit"]
  union ["Encounter, Performed": "Home Healthcare Services"]
  union ["Encounter, Performed": "Telephone Visits"]
  union ["Encounter, Performed": "Online Assessments"]
  union ["Encounter, Performed": "Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a
physician or other qualified health care professional. Usually, the presenting problem(s) are minimal."] ) ValidEncounters
  where ValidEncounters.relevantPeriod during "Measurement Period"
```

Same High Risk Medications Ordered on Different Days

```
"More Than One Order"(["Medication, Order": "Anticholinergics, first generation antihistamines"])
  union "More Than One Order"(["Medication, Order": "Anticholinergics, anti Parkinson agents"])
  union "More Than One Order"(["Medication, Order": "Antispasmodics"])
  union "More Than One Order"(["Medication, Order": "Antithrombotic"])
  union "More Than One Order"(["Medication, Order": "Cardiovascular, alpha agonists, central"])
  union "More Than One Order"(["Medication, Order": "Cardiovascular, other"])
  union "More Than One Order"(["Medication, Order": "Central nervous system, antidepressants"])
  union "More Than One Order"(["Medication, Order": "Central nervous system, barbiturates"])
  union "More Than One Order"(["Medication, Order": "Central nervous system, vasodilators"])
  union "More Than One Order"(["Medication, Order": "Central nervous system, other"])
  union "More Than One Order"(["Medication, Order": "Endocrine system, estrogens with or without progestins"])
  union "More Than One Order"(["Medication, Order": "Endocrine system, sulfonylureas, long duration"])
  union "More Than One Order"(["Medication, Order": "Endocrine system, other"])
  union "More Than One Order"(["Medication, Order": "Nonbenzodiazepine hypnotics"])
  union "More Than One Order"(["Medication, Order": "Pain medications, skeletal muscle relaxants"])
  union "More Than One Order"(["Medication, Order": "Pain medications, other"])
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Two High Risk Medications with Prolonged Duration

```
Sum(("More Than One Order"(["Medication, Order": "Anti Infectives, other"]))AntiInfectives
    let DaysSupply: Coalesce(AntiInfectives.daysSupplied, AntiInfectives.supply.value /(AntiInfectives.dosage.value * CMD.ToDaily(AntiInfectives.frequency)))*(1 +
Coalesce(AntiInfectives.refills, 0))
    return all DaysSupply
)> 90
```

Functions

Average Daily Dose(MedicationOrder "Medication, Order")

```
MedicationOrder Order
  let MedicationStrength: "MedicationStrengthPerUnit"(Order.code),
  DaysSupplied: Coalesce(Order.daysSupplied, Order.supply.value /(Order.dosage.value * CMD.ToDaily(Order.frequency)))
  return if DaysSupplied is not null
    and ( MedicationStrength.unit = 'mg'
        or ( MedicationStrength.unit = 'mg/mL'
            and Order.supply.unit = 'mL'
        )
    ) then ( ( Order.supply * MedicationStrength ) / Quantity { value: DaysSupplied, unit: 'd' } )
    else null
```

CMD.CodeToDaily(Frequency Code)

```
case
  when Frequency ~ "Once daily (qualifier value)" then 1.0
  when Frequency ~ "Twice a day (qualifier value)" then 2.0
  when Frequency ~ "Three times daily (qualifier value)" then 3.0
  when Frequency ~ "Four times daily (qualifier value)" then 4.0
  when Frequency ~ "Every twenty four hours (qualifier value)" then 1.0
  when Frequency ~ "Every twelve hours (qualifier value)" then 2.0
  when Frequency ~ "Every thirty six hours (qualifier value)" then 0.67
  when Frequency ~ "Every eight hours (qualifier value)" then 3.0
  when Frequency ~ "Every four hours (qualifier value)" then 6.0
  when Frequency ~ "Every six hours (qualifier value)" then 4.0
  when Frequency ~ "Every seventy two hours (qualifier value)" then 0.34
  when Frequency ~ "Every forty eight hours (qualifier value)" then 0.5
  when Frequency ~ "Every eight to twelve hours (qualifier value)" then 2.0
  when Frequency ~ "Every six to eight hours (qualifier value)" then 3.0
  when Frequency ~ "Every three to four hours (qualifier value)" then 6.0
  when Frequency ~ "Every three to six hours (qualifier value)" then 4.0
  when Frequency ~ "Every two to four hours (qualifier value)" then 6.0
  when Frequency ~ "One to four times a day (qualifier value)" then 4.0
  when Frequency ~ "One to three times a day (qualifier value)" then 3.0
  when Frequency ~ "One to two times a day (qualifier value)" then 2.0
  when Frequency ~ "Two to four times a day (qualifier value)" then 4.0
  else null
end
```

CMD.QuantityToDaily(Frequency Quantity)

```
case Frequency.unit
    when 'h' then (24.0 / Frequency.value)
    when 'min' then (24.0 / Frequency.value) * 60
    when 's' then (24.0 / Frequency.value) * 60 * 60
    when 'd' then (24.0 / Frequency.value) / 24
    when 'wk' then (24.0 / Frequency.value) / (24 * 7)
    when 'mo' then (24.0 / Frequency.value) / (24 * 30) /* assuming 30 days in month */
    when 'a' then (24.0 / Frequency.value) / (24 * 365) /* assuming 365 days in year */
    when 'hour' then (24.0 / Frequency.value)
    when 'minute' then (24.0 / Frequency.value) * 60
    when 'second' then (24.0 / Frequency.value) * 60 * 60
    when 'day' then (24.0 / Frequency.value) / 24
    when 'week' then (24.0 / Frequency.value) / (24 * 7)
    when 'month' then (24.0 / Frequency.value) / (24 * 30) /* assuming 30 days in month */
    when 'year' then (24.0 / Frequency.value) / (24 * 365) /* assuming 365 days in year */
    when 'hours' then (24.0 / Frequency.value)
    when 'minutes' then (24.0 / Frequency.value) * 60
    when 'seconds' then (24.0 / Frequency.value) * 60 * 60
    when 'days' then (24.0 / Frequency.value) / 24
    when 'weeks' then (24.0 / Frequency.value) / (24 * 7)
    when 'months' then (24.0 / Frequency.value) / (24 * 30) /* assuming 30 days in month */
    when 'years' then (24.0 / Frequency.value) / (24 * 365) /* assuming 365 days in year */
    else null
 end
```

CMD.ToDaily(Frequency Choice<Quantity, Code>)

```
case
  when Frequency is Quantity then QuantityToDaily(Frequency as Quantity)
  else CodeToDaily(Frequency as Code)
end
```

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

MedicationStrengthPerUnit(Strength Code)

```
case
  when Strength ~ "reserpine 0.1 MG Oral Tablet" then 0.1 'mg'
  when Strength ~ "reserpine 0.25 MG Oral Tablet" then 0.25 'mg'
  when Strength ~ "digoxin 0.05 MG/ML Oral Solution" then 0.05 'mg/mL'
  when Strength ~ "digoxin 0.0625 MG Oral Tablet" then 0.0625 'mg'
  when Strength ~ "1 ML digoxin 0.1 MG/ML Injection" then 0.1 'mg/mL'
  when Strength ~ "digoxin 0.125 MG Oral Tablet" then 0.125 'mg'
  when Strength ~ "digoxin 0.1875 MG Oral Tablet" then 0.1875 'mg'
  when Strength ~ "digoxin 0.25 MG Oral Tablet" then 0.25 'mg'
  when Strength ~ "2 ML digoxin 0.25 MG/ML Injection" then 0.25 'mg/mL'
  when Strength ~ "doxepin 3 MG Oral Tablet" then 3 'mg'
  when Strength ~ "doxepin 6 MG Oral Tablet" then 6 'mg'
  when Strength ~ "doxepin hydrochloride 10 MG Oral Capsule" then 10 'mg'
  when Strength ~ "doxepin hydrochloride 10 MG/ML Oral Solution" then 10 'mg/mL'
  when Strength ~ "doxepin hydrochloride 25 MG Oral Capsule" then 25 'mg'
  when Strength ~ "doxepin hydrochloride 50 MG Oral Capsule" then 50 'mg'
```

```
    when Strength ~ "doxepin hydrochloride 75 MG Oral Capsule" then 75 'mg'
    when Strength ~ "doxepin hydrochloride 100 MG Oral Capsule" then 100 'mg'
    when Strength ~ "doxepin hydrochloride 150 MG Oral Capsule" then 150 'mg'
    else null
  end
```

More Than One Order(Medication List<"Medication, Order">)

```
"Medication" OrderMedication1
  with "Medication" OrderMedication2
    such that ( OrderMedication1.authorDatetime during "Measurement Period"
       and OrderMedication1.refills >= 1
    )
      or ( date from OrderMedication1.authorDatetime !~ date from OrderMedication2.authorDatetime
         and OrderMedication1.authorDatetime during "Measurement Period"
         and OrderMedication2.authorDatetime during "Measurement Period"
      )
  return OrderMedication1
```

Terminology

- code "1 ML digoxin 0.1 MG/ML Injection" ("RXNORM Code (204504)")
- code "2 ML digoxin 0.25 MG/ML Injection" ("RXNORM Code (104208)")
- code "digoxin 0.05 MG/ML Oral Solution" ("RXNORM Code (393245)")
- code "digoxin 0.0625 MG Oral Tablet" ("RXNORM Code (245273)")
- code "digoxin 0.125 MG Oral Tablet" ("RXNORM Code (197604)")
- code "digoxin 0.1875 MG Oral Tablet" ("RXNORM Code (1441565)")
- code "digoxin 0.25 MG Oral Tablet" ("RXNORM Code (197606)")
- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "doxepin 3 MG Oral Tablet" ("RXNORM Code (966787)")
- code "doxepin 6 MG Oral Tablet" ("RXNORM Code (966793)")
- code "doxepin hydrochloride 10 MG Oral Capsule" ("RXNORM Code (1000048)")
- code "doxepin hydrochloride 10 MG/ML Oral Solution" ("RXNORM Code (1000054)")
- code "doxepin hydrochloride 100 MG Oral Capsule" ("RXNORM Code (1000058)")
- code "doxepin hydrochloride 150 MG Oral Capsule" ("RXNORM Code (1000064)")
- code "doxepin hydrochloride 25 MG Oral Capsule" ("RXNORM Code (1000070)")
- code "doxepin hydrochloride 50 MG Oral Capsule" ("RXNORM Code (1000076)")
- code "doxepin hydrochloride 75 MG Oral Capsule" ("RXNORM Code (1000097)")
- code "Encounter for palliative care" ("ICD10CM Code (Z51.5)")
- code "Every eight hours (qualifier value)" ("SNOMEDCT Code (307469008)")
- code "Every eight to twelve hours (qualifier value)" ("SNOMEDCT Code (396140003)")
- code "Every forty eight hours (qualifier value)" ("SNOMEDCT Code (396131002)")
- code "Every four hours (qualifier value)" ("SNOMEDCT Code (225756002)")
- code "Every seventy two hours (qualifier value)" ("SNOMEDCT Code (396143001)")
- code "Every six hours (qualifier value)" ("SNOMEDCT Code (307468000)")
- code "Every six to eight hours (qualifier value)" ("SNOMEDCT Code (396139000)")
- code "Every thirty six hours (qualifier value)" ("SNOMEDCT Code (396126004)")
- code "Every three to four hours (qualifier value)" ("SNOMEDCT Code (225754004)")
- code "Every three to six hours (qualifier value)" ("SNOMEDCT Code (396127008)")
- code "Every twelve hours (qualifier value)" ("SNOMEDCT Code (307470009)")
- code "Every twenty four hours (qualifier value)" ("SNOMEDCT Code (396125000)")
- code "Every two to four hours (qualifier value)" ("SNOMEDCT Code (225752000)")
- code "Four times daily (qualifier value)" ("SNOMEDCT Code (307439001)")
- code "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")
- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal." ("CPT Code (99211)")
- code "Once daily (qualifier value)" ("SNOMEDCT Code (229797004)")
- code "One to four times a day (qualifier value)" ("SNOMEDCT Code (396109005)")
- code "One to three times a day (qualifier value)" ("SNOMEDCT Code (396108002)")
- code "One to two times a day (qualifier value)" ("SNOMEDCT Code (396107007)")
- code "reserpine 0.1 MG Oral Tablet" ("RXNORM Code (198196)")
- code "reserpine 0.25 MG Oral Tablet" ("RXNORM Code (198197)")
- code "Three times daily (qualifier value)" ("SNOMEDCT Code (229798009)")
- code "Twice a day (qualifier value)" ("SNOMEDCT Code (229799001)")
- code "Two to four times a day (qualifier value)" ("SNOMEDCT Code (396111001)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- valueset "Alcohol Withdrawal" (2.16.840.1.113883.3.464.1003.105.12.1209)
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Anti Infectives, other" (2.16.840.1.113883.3.464.1003.196.12.1481)
- valueset "Anticholinergics, anti Parkinson agents" (2.16.840.1.113883.3.464.1003.1049)
- valueset "Anticholinergics, first generation antihistamines" (2.16.840.1.113883.3.464.1003.1043)
- valueset "Antipsychotics" (2.16.840.1.113883.3.464.1003.196.12.1523)
- valueset "Antispasmodics" (2.16.840.1.113883.3.464.1003.1050)
- valueset "Antithrombotic" (2.16.840.1.113883.3.464.1003.1051)
- valueset "Benzodiazepine Withdrawal" (2.16.840.1.113883.3.464.1003.105.12.1208)
- valueset "Benzodiazepines" (2.16.840.1.113883.3.464.1003.196.12.1522)
- valueset "Bipolar Disorder" (2.16.840.1.113883.3.464.1003.105.12.1157)
- valueset "Cardiovascular, alpha agonists, central" (2.16.840.1.113883.3.464.1003.1052)
- valueset "Cardiovascular, other" (2.16.840.1.113883.3.464.1003.1053)
- valueset "Care Services in Long Term Residential Facility" (2.16.840.1.113883.3.464.1003.101.12.1014)
- valueset "Central nervous system, antidepressants" (2.16.840.1.113883.3.464.1003.1054)
- valueset "Central nervous system, barbiturates" (2.16.840.1.113883.3.464.1003.1055)
- valueset "Central nervous system, other" (2.16.840.1.113883.3.464.1003.1057)
- valueset "Central nervous system, vasodilators" (2.16.840.1.113883.3.464.1003.1056)
- valueset "Digoxin" (2.16.840.1.113883.3.464.1003.1065)
- valueset "Discharge Services Nursing Facility" (2.16.840.1.113883.3.464.1003.101.12.1013)
- valueset "Doxepin" (2.16.840.1.113883.3.464.1003.1067)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Endocrine system, estrogens with or without progestins" (2.16.840.1.113883.3.464.1003.1058)
- valueset "Endocrine system, other" (2.16.840.1.113883.3.464.1003.1060)
- valueset "Endocrine system, sulfonylureas, long duration" (2.16.840.1.113883.3.464.1003.1059)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Generalized Anxiety Disorder" (2.16.840.1.113883.3.464.1003.105.12.1210)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Nonbenzodiazepine hypnotics" (2.16.840.1.113883.3.464.1003.196.12.1480)
- valueset "Nursing Facility Visit" (2.16.840.1.113883.3.464.1003.101.12.1012)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Online Assessments" (2.16.840.1.113883.3.464.1003.101.12.1089)
- valueset "Ophthalmologic Services" (2.16.840.1.113883.3.464.1003.101.11.1206)
- valueset "Other Bipolar Disorder" (2.16.840.1.113883.3.464.1003.105.12.1204)
- valueset "Pain medications, other" (2.16.840.1.113883.3.464.1003.1063)
- valueset "Pain medications, skeletal muscle relaxants" (2.16.840.1.113883.3.464.1003.1062)
- valueset "Palliative Care Encounter" (2.16.840.1.113883.3.464.1003.101.12.1090)
- valueset "Palliative Care Intervention" (2.16.840.1.113883.3.464.1003.198.12.1135)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)

- valueset "Preventive Care Services Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "REM Sleep Behavior Disorder" (2.16.840.1.113883.3.464.1003.105.12.1207)
- valueset "Reserpine" (2.16.840.1.113883.3.464.1003.1044)
- valueset "Schizophrenia" (2.16.840.1.113883.3.464.1003.105.12.1205)
- valueset "Seizure Disorder" (2.16.840.1.113883.3.464.1003.105.12.1206)
- valueset "Telephone Visits" (2.16.840.1.113883.3.464.1003.101.12.1080)

Data Criteria (QDM Data Elements)

- "Assessment, Performed: Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal) (LOINC Code 71007-9)"
- "Assessment, Performed: Hospice care [Minimum Data Set]" using "Hospice care [Minimum Data Set] (LOINC Code 45755-6)"
- "Diagnosis: Alcohol Withdrawal" using "Alcohol Withdrawal (2.16.840.1.113883.3.464.1003.105.12.1209)"
- "Diagnosis: Benzodiazepine Withdrawal" using "Benzodiazepine Withdrawal (2.16.840.1.113883.3.464.1003.105.12.1208)"
- "Diagnosis: Bipolar Disorder" using "Bipolar Disorder (2.16.840.1.113883.3.464.1003.105.12.1157)"
- "Diagnosis: Encounter for palliative care" using "Encounter for palliative care (ICD10CM Code Z51.5)"
- "Diagnosis: Generalized Anxiety Disorder" using "Generalized Anxiety Disorder (2.16.840.1.113883.3.464.1003.105.12.1210)"
- "Diagnosis: Other Bipolar Disorder" using "Other Bipolar Disorder (2.16.840.1.113883.3.464.1003.105.12.1204)"
- "Diagnosis: REM Sleep Behavior Disorder" using "REM Sleep Behavior Disorder (2.16.840.1.113883.3.464.1003.105.12.1207)"
- "Diagnosis: Schizophrenia" using "Schizophrenia (2.16.840.1.113883.3.464.1003.105.12.1205)"
- "Diagnosis: Seizure Disorder" using "Seizure Disorder (2.16.840.1.113883.3.464.1003.105.12.1206)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Care Services in Long Term Residential Facility" using "Care Services in Long Term Residential Facility (2.16.840.1.113883.3.464.1003.101.12.1014)"
- "Encounter, Performed: Discharge Services Nursing Facility" using "Discharge Services Nursing Facility (2.16.840.1.113883.3.464.1003.101.12.1013)"
- "Encounter, Performed: Encounter Inpatient" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Hospice Encounter" using "Hospice Encounter (2.16.840.1.113883.3.464.1003.1003)"
- "Encounter, Performed: Nursing Facility Visit" using "Nursing Facility Visit (2.16.840.1.113883.3.464.1003.101.12.1012)"
- "Encounter, Performed: Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal." using "Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. (CPT Code 99211)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Online Assessments" using "Online Assessments (2.16.840.1.113883.3.464.1003.101.12.1089)"
- "Encounter, Performed: Ophthalmologic Services" using "Ophthalmologic Services (2.16.840.1.113883.3.464.1003.101.11.1206)"
- "Encounter, Performed: Palliative Care Encounter" using "Palliative Care Encounter (2.16.840.1.113883.3.464.1003.101.12.1090)"
- "Encounter, Performed: Preventive Care Services Established Office Visit, 18 and Up" using "Preventive Care Services Established Office Visit, 18 and Up (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 (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Encounter, Performed: Telephone Visits" using "Telephone Visits (2.16.840.1.113883.3.464.1003.101.12.1080)"
- "Intervention, Order: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Palliative Care Intervention" using "Palliative Care Intervention (2.16.840.1.113883.3.464.1003.198.12.1135)"
- "Medication, Order: Anti Infectives, other" using "Anti Infectives, other (2.16.840.1.113883.3.464.1003.196.12.1481)"
- "Medication, Order: Anticholinergics, anti Parkinson agents" using "Anticholinergics, anti Parkinson agents (2.16.840.1.113883.3.464.1003.1049)"
- "Medication, Order: Anticholinergics, first generation antihistamines" using "Anticholinergics, first generation antihistamines (2.16.840.1.113883.3.464.1003.1043)"
- "Medication, Order: Antipsychotics" using "Antipsychotics (2.16.840.1.113883.3.464.1003.196.12.1523)"
- "Medication, Order: Antispasmodics" using "Antispasmodics (2.16.840.1.113883.3.464.1003.1050)"
- "Medication, Order: Antithrombotic" using "Antithrombotic (2.16.840.1.113883.3.464.1003.1051)"
- "Medication, Order: Benzodiazepines" using "Benzodiazepines (2.16.840.1.113883.3.464.1003.196.12.1522)"
- "Medication, Order: Cardiovascular, alpha agonists, central" using "Cardiovascular, alpha agonists, central (2.16.840.1.113883.3.464.1003.1052)"
- "Medication, Order: Cardiovascular, other" using "Cardiovascular, other (2.16.840.1.113883.3.464.1003.1053)"
- "Medication, Order: Central nervous system, antidepressants" using "Central nervous system, antidepressants (2.16.840.1.113883.3.464.1003.1054)"
- "Medication, Order: Central nervous system, barbiturates" using "Central nervous system, barbiturates (2.16.840.1.113883.3.464.1003.1055)"
- "Medication, Order: Central nervous system, other" using "Central nervous system, other (2.16.840.1.113883.3.464.1003.1057)"
- "Medication, Order: Central nervous system, vasodilators" using "Central nervous system, vasodilators (2.16.840.1.113883.3.464.1003.1056)"
- "Medication, Order: Digoxin" using "Digoxin (2.16.840.1.113883.3.464.1003.1065)"
- "Medication, Order: Doxepin" using "Doxepin (2.16.840.1.113883.3.464.1003.1067)"
- "Medication, Order: Endocrine system, estrogens with or without progestins" using "Endocrine system, estrogens with or without progestins (2.16.840.1.113883.3.464.1003.1058)"
- "Medication, Order: Endocrine system, other" using "Endocrine system, other (2.16.840.1.113883.3.464.1003.1060)"
- "Medication, Order: Endocrine system, sulfonylureas, long duration" using "Endocrine system, sulfonylureas, long duration (2.16.840.1.113883.3.464.1003.1059)"
- "Medication, Order: Nonbenzodiazepine hypnotics" using "Nonbenzodiazepine hypnotics (2.16.840.1.113883.3.464.1003.196.12.1480)"
- "Medication, Order: Pain medications, other" using "Pain medications, other (2.16.840.1.113883.3.464.1003.1063)"
- "Medication, Order: Pain medications, skeletal muscle relaxants" using "Pain medications, skeletal muscle relaxants (2.16.840.1.113883.3.464.1003.1062)"
- "Medication, Order: Reserpine" using "Reserpine (2.16.840.1.113883.3.464.1003.1044)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	**Controlling High Blood Pressure**		
eCQM Identifier (Measure Authoring Tool)	165	**eCQM Version Number**	11.0.000
NQF Number	Not Applicable	**GUID**	abdc37cc-bac6-4156-9b91-d1be2c8b7268
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	National Committee for Quality Assurance		
Measure Developer	National Committee for Quality Assurance		
Endorsed By	None		
Description	Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period		
Copyright	This Physician Performance Measure (Measure) and related data specifications are owned and were developed by the National Committee for Quality Assurance (NCQA). NCQA is not responsible for any use of the Measure. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in the Measure. The Measure can be reproduced and distributed, without modification, for noncommercial purposes (e.g., use by healthcare providers in connection with their practices) without obtaining approval from NCQA. Commercial use is defined as the sale, licensing, or distribution of the Measure for commercial gain, or incorporation of the Measure into a product or service that is sold, licensed or distributed for commercial gain. All commercial uses or requests for modification must be approved by NCQA and are subject to a license at the discretion of NCQA. (C) 2012-2021 National Committee for Quality Assurance. All Rights Reserved. Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. NCQA disclaims all liability for use or accuracy of any third party codes contained in the specifications. CPT(R) contained in the Measure specifications is copyright 2004-2021 American Medical Association. LOINC(R) copyright 2004-2021 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2021 International Health Terminology Standards Development Organisation. ICD-10 copyright 2021 World Health Organization. All Rights Reserved.		
Disclaimer	The performance Measure is not a clinical guideline and does not establish a standard of medical care, and has not been tested for all potential applications. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Due to technical limitations, registered trademarks are indicated by (R) or [R] and unregistered trademarks are indicated by (TM) or [TM].		
Measure Scoring	Proportion		
Measure Type	Intermediate Clinical Outcome		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	High blood pressure (HBP), also known as hypertension, is when the pressure in blood vessels is higher than normal (Centers for Disease Control and Prevention [CDC], 2021). The causes of hypertension are multiple and multifaceted and can be based on genetic predisposition, environmental risk factors, being overweight and obese, sodium intake, potassium intake, physical activity, and alcohol use. High blood pressure is common; according to the American Heart Association, between 2013-2016, approximately 121.5 million US adults >= 20 years of age had HBP and the prevalence of hypertension among US adults 65 and older was 77.0 percent (Virani et al., 2021). HBP, known as the "silent killer," increases risks of heart disease and stroke which are two of the leading causes of death in the US; a person who has HBP is four times more likely to die from a stroke and three times more likely to die from heart disease (CDC, 2012). The National Vital Statistics Systems reported that in 2014 there were approximately 73,300 deaths directly due to HBP and 410,624 deaths with any mention of HBP (CDC, 2014). Between 2008 and 2018 the number of deaths due to HBP rose by 57.2 percent (Virani et al., 2021). Managing and treating HBP would reduce cardiovascular disease mortality for males and females by 30.4 percent and 38.0 percent, respectively (Patel et al., 2015). The estimated annual average direct and indirect cost of HBP from 2016 to 2017 was $52.4 billion (Virani et al., 2021). A study on cost-effectiveness on treating hypertension found that controlling HBP in patients with cardiovascular disease and systolic blood pressures of >= 160 mm Hg could be effective and cost-saving (Moran, 2015). Many studies have shown that controlling high blood pressure reduces cardiovascular events and mortality. The Systolic Blood Pressure Intervention Trial (SPRINT) investigated the impact of obtaining a SBP goal of <120 mm Hg compared to a SBP goal of <140 mm Hg among patients 50 and older with established cardiovascular disease and found that the patients with the former goal had reduced cardiovascular events and mortality (SPRINT Research Group et al., 2015). Controlling HBP will significantly reduce the risks of cardiovascular disease mortality and lead to better health outcomes like reduction of heart attacks, stroke, and kidney disease (James et al., 2014). Thus, the relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established.		
Clinical Recommendation Statement	The U.S. Preventive Services Task Force (2015) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation. American College of Cardiology/American Heart Association (2017) -For adults with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher, a blood pressure target of less than 130/80 mmHg is recommended (Level of evidence: B-R (for systolic blood pressures), Level of evidence: C-EO (for diastolic blood pressure)) -For adults with confirmed hypertension, without additional markers of increased CVD risk, a blood pressure target of less than 130/80 mmHg may be reasonable (Note: clinical trial evidence is strongest for a target blood pressure of 140/90 mmHg in this population. However, observational studies suggest that these individuals often have a high lifetime risk and would benefit from blood pressure control earlier in life) (Level of evidence: B-NR (for systolic blood pressure), Level of evidence: C-EO (for diastolic blood pressure)) American College of Physicians and the American Academy of Family Physicians (2017): -Initiate or intensify pharmacologic treatment in some adults aged 60 years or older at high cardiovascular risk, based on individualized assessment, to achieve a target systolic blood pressure of less than 140 mmHg (Grade: weak recommendation, Quality of evidence: low) -Initiate or intensify pharmacologic treatment in adults aged 60 years or older with a history of stroke or transient ischemic attack to achieve a target systolic blood pressure of less than 140 mmHg to reduce the risk of recurrent		

	stroke (Grade: weak recommendation, Quality of evidence: moderate) American Diabetes Association (2021): -For individuals with diabetes and hypertension at higher cardiovascular risk (existing atherosclerotic cardiovascular disease or 10-year atherosclerotic cardiovascular disease risk >=15%), a blood pressure target of <130/80 mmHg may be appropriate, if it can be safely attained (Level of evidence: C) -For individuals with diabetes and hypertension at lower risk for cardiovascular disease (10-year atherosclerotic cardiovascular disease risk <15%), treat to a blood pressure target of <140/90 mmHg (Level of evidence: A)
Improvement Notation	Higher score indicates better quality
	Reference Type: CITATION
Reference	Reference Text: 'American Diabetes Association. (2021). 10. Cardiovascular disease and risk management: Standards of medical care in diabetes—2021. Diabetes Care 2021, 44(Suppl. 1), S125-S150. https://doi.org/10.2337/dc21-S010'
	Reference Type: CITATION
Reference	Reference Text: 'Centers for Disease Control and Prevention. (2012). Vital signs: Getting blood pressure under control. Retrieved from https://www.cdc.gov/vitalsigns/hypertension/index.html'
	Reference Type: CITATION
Reference	Reference Text: 'Centers for Disease Control and Prevention. (2021). Facts About Hypertension. Retrieved from https://www.cdc.gov/bloodpressure/facts.htm'
	Reference Type: CITATION
Reference	Reference Text: 'Centers for Disease Control and Prevention, National Center for Health Statistics. Mortality multiple cause micro-data files, 2014: public-use data file and documentation: NHLBI tabulations. Available from http://www.cdc.gov/nchs/data_access/Vitalstatsonline.htm#Mortality_Multiple'
	Reference Type: CITATION
Reference	Reference Text: 'James, P.A., Oparil, S., Carter, B.L., et al. (2014). 2014 Evidence-based guideline for the management of high blood pressure in adults: report from the panel members appointed to the Eighth Joint National Committee (JNC 8). JAMA. 2014 Feb 5;311(5):507-20. doi: 10.1001/jama.2013.284427. Erratum in: JAMA. 2014 May 7;311(17):1809. PMID: 24352797.'
	Reference Type: CITATION
Reference	Reference Text: 'Moran, A. E., Odden, M. C., Thanataveerat, A., et al. (2015). Cost-effectiveness of hypertension therapy according to 2014 guidelines. [published correction appears in N Engl J. Med. 2015;372:1677]. New England Journal of Medicine. 2015 ;372, 447-455. doi: 10.1056/NEJMsa1406751. [published correction appears on page 1677]'
	Reference Type: CITATION
Reference	Reference Text: 'Patel, S. A., Winkel, M., Ali, M. K., et al. (2015). Cardiovascular mortality associated with 5 leading risk factors: National and state preventable fractions estimated from survey data. Annals of Internal Medicine, 163(4), 245-253. doi: 10.7326/M14-1753'
	Reference Type: CITATION
Reference	Reference Text: 'Qaseem, A., Wilt, T. J., Rich, R., et al. (2017). Pharmacologic treatment of hypertension in adults aged 60 years or older to higher versus lower blood pressure targets: A clinical practice guideline from the American College of Physicians and the American Academy of Family Physicians. Annals of Internal Medicine, 166(6), 430-437. Retrieved from https://annals.org/aim/fullarticle/2598413/pharmacologic-treatment-hypertension-adults-aged-60-years-older-higher-versus'
	Reference Type: CITATION
Reference	Reference Text: 'SPRINT Research Group, Wright, J. T., Jr., Williamson, J. D., et al. (2015). A randomized trial of intensive versus standard blood-pressure control. New England Journal of Medicine, 373(22), 2103–2116.'
	Reference Type: CITATION
Reference	Reference Text: 'U.S. Preventive Services Task Force. (2015). Screening for high blood pressure in adults: U.S. Preventive Services Task Force recommendation statement. Annals of Internal Medicine, 163(10), 778-787. Retrieved from https://annals.org/aim/fullarticle/2456129/screening-high-blood-pressure-adults-u-s-preventive-services-task'
	Reference Type: CITATION
Reference	Reference Text: 'Virani, S.S., Alonso, A., Aparicio, H.J., et al.; on behalf of the American Heart Association Council on Epidemiology and Prevention Statistics Committee and Stroke Statistics Subcommittee. (2021). Heart disease and stroke statistics—2021 update: a report from the American Heart Association. Circulation. 2021;143:e254–e743. doi: 10.1161/CIR.0000000000000950'
	Reference Type: CITATION
Reference	Reference Text: 'Whelton, P. K., Carey, R. M., Aronow, W. S., et al. (2017). Guideline for the prevention, detection, evaluation, and management of high blood pressure in adults: A report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Journal of the American College of Cardiology. https://doi.org/10.1161/HYP.0000000000000065'
Definition	None
	In reference to the numerator element, only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure. This includes blood pressures taken in person by a clinician and blood pressures measured remotely by electronic monitoring devices capable of transmitting the blood pressure data to the clinician. Blood pressure readings taken by a remote monitoring device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record. Do not include BP readings taken during an acute inpatient stay or an ED visit.
Guidance	If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled". If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading. Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.

Transmission Format	TBD
Initial Population	Patients 18-85 years of age by the end of the measurement period who had a visit and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period
Denominator	Equals Initial Population
Denominator Exclusions	Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. Exclude patients who are in hospice care for any part of the measurement period. Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period. Exclude patients 66-80 by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: - Advanced illness with two outpatient encounters during the measurement period or the year prior - OR advanced illness with one inpatient encounter during the measurement period or the year prior - OR taking dementia medications during the measurement period or the year prior Exclude patients 81 and older by the end of the measurement period with an indication of frailty for any part of the measurement period. Exclude patients receiving palliative care for any part of the measurement period.
Numerator	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period
Numerator Exclusions	Not Applicable
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

Population Criteria

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
)in Interval[18, 85]
  and exists "Essential Hypertension Diagnosis"
  and exists AdultOutpatientEncounters."Qualifying Encounters"
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or exists ( "Pregnancy or Renal Diagnosis Exclusions" )
  or exists ( "End Stage Renal Disease Procedures" )
  or exists ( "End Stage Renal Disease Encounter" )
  or AIFrailLTCF."Is Age 66 to 80 with Advanced Illness and Frailty or Is Age 81 or Older with Frailty"
  or AIFrailLTCF."Is Age 66 or Older Living Long Term in a Nursing Home"
  or PalliativeCare."Palliative Care in the Measurement Period"
```

Numerator

```
"Has Systolic Blood Pressure Less Than 140"
  and "Has Diastolic Blood Pressure Less Than 90"
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

AdultOutpatientEncounters.Qualifying Encounters

```
( ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Annual Wellness Visit"]
  union ["Encounter, Performed": "Preventive Care Services Established Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Preventive Care Services Initial Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Home Healthcare Services"]
  union ["Encounter, Performed": "Online Assessments"]
```

```
  union ["Encounter, Performed": "Telephone Visits"] ) ValidEncounter
  where ValidEncounter.relevantPeriod during day of "Measurement Period"
```

AIFrailLTCF.Has Criteria Indicating Frailty

```
exists ( ["Device, Order": "Frailty Device"] FrailtyDeviceOrder
    where FrailtyDeviceOrder.authorDatetime during day of "Measurement Period"
)
  or exists ( ["Assessment, Performed": "Medical equipment used"] EquipmentUsed
      where EquipmentUsed.result in "Frailty Device"
        and Global."NormalizeInterval" ( EquipmentUsed.relevantDatetime, EquipmentUsed.relevantPeriod ) ends during day of "Measurement Period"
  )
  or exists ( ["Diagnosis": "Frailty Diagnosis"] FrailtyDiagnosis
      where FrailtyDiagnosis.prevalencePeriod overlaps "Measurement Period"
  )
  or exists ( ["Encounter, Performed": "Frailty Encounter"] FrailtyEncounter
      where FrailtyEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Symptom": "Frailty Symptom"] FrailtySymptom
      where FrailtySymptom.prevalencePeriod overlaps "Measurement Period"
  )
```

AIFrailLTCF.Has Dementia Medications in Year Before or During Measurement Period

```
exists (["Medication, Active": "Dementia Medications"] DementiaMedication
  where Global."NormalizeInterval" ( DementiaMedication.relevantDatetime, DementiaMedication.relevantPeriod ) overlaps Interval[start of "Measurement Period" - 1 year,
  end of "Measurement Period"])
```

AIFrailLTCF.Has Inpatient Encounter with Advanced Illness

```
exists( ["Encounter, Performed": "Acute Inpatient"] InpatientEncounter
  where exists ( InpatientEncounter.diagnoses Diagnosis
      where Diagnosis.code in "Advanced Illness"
  )
    and InpatientEncounter.relevantPeriod starts during day of Interval[start of "Measurement Period" - 1 year,
    end of "Measurement Period"])
```

AIFrailLTCF.Has Two Outpatient Encounters with Advanced Illness on Different Dates of Service

```
exists (
from
  "Outpatient Encounters with Advanced Illness" OutpatientEncounter1,
  "Outpatient Encounters with Advanced Illness" OutpatientEncounter2
  where OutpatientEncounter2.relevantPeriod ends 1 day or more after day of
  end of OutpatientEncounter1.relevantPeriod
  return OutpatientEncounter1
  )
```

AIFrailLTCF.Is Age 66 or Older Living Long Term in a Nursing Home

```
( AgeInYearsAt(date from
    end of "Measurement Period"
  )>= 66
)
  and ( ( Last(["Assessment, Performed": "Housing status"] HousingStatus
        where Global."NormalizeInterval"(HousingStatus.relevantDatetime, HousingStatus.relevantPeriod)ends on or before
        end of "Measurement Period"
        sort by
        end of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)asc
    )) LastHousingStatus
      where LastHousingStatus.result ~ "Lives in a nursing home (finding)"
  ) is not null
```

AIFrailLTCF.Is Age 66 to 80 with Advanced Illness and Frailty or Is Age 81 or Older with Frailty

```
( AgeInYearsAt(date from
    end of "Measurement Period"
  )in Interval[66, 80]
    and "Has Criteria Indicating Frailty"
    and ( "Has Two Outpatient Encounters with Advanced Illness on Different Dates of Service"
        or "Has Inpatient Encounter with Advanced Illness"
        or "Has Dementia Medications in Year Before or During Measurement Period"
    )
)
  or ( AgeInYearsAt(date from
      end of "Measurement Period"
    )>= 81
      and "Has Criteria Indicating Frailty"
  )
```

AIFrailLTCF.Outpatient Encounters with Advanced Illness

```
( ["Encounter, Performed": "Outpatient"]
  union ["Encounter, Performed": "Observation"]
  union ["Encounter, Performed": "Emergency Department Visit"]
  union ["Encounter, Performed": "Nonacute Inpatient"] ) OutpatientEncounter
  where exists ( OutpatientEncounter.diagnoses Diagnosis
      where Diagnosis.code in "Advanced Illness"
  )
    and OutpatientEncounter.relevantPeriod starts during day of Interval[start of "Measurement Period" - 1 year,
    end of "Measurement Period"]
```

Blood Pressure Days

```
( "Qualifying Diastolic Blood Pressure Reading" DBPExam
    return date from Global."LatestOf" ( DBPExam.relevantDatetime, DBPExam.relevantPeriod )
)
  intersect ( "Qualifying Systolic Blood Pressure Reading" SBPExam
      return date from Global."LatestOf" ( SBPExam.relevantDatetime, SBPExam.relevantPeriod )
  )
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice Services"
  or exists ( "Pregnancy or Renal Diagnosis Exclusions" )
  or exists ( "End Stage Renal Disease Procedures" )
  or exists ( "End Stage Renal Disease Encounter" )
  or AIFrailLTCF."Is Age 66 to 80 with Advanced Illness and Frailty or Is Age 81 or Older with Frailty"
  or AIFrailLTCF."Is Age 66 or Older Living Long Term in a Nursing Home"
  or PalliativeCare."Palliative Care in the Measurement Period"
```

End Stage Renal Disease Encounter

```
["Encounter, Performed": "ESRD Monthly Outpatient Services"] ESRDEncounter
  where ESRDEncounter.relevantPeriod starts on or before
  end of "Measurement Period"
```

End Stage Renal Disease Procedures

```
( ["Procedure, Performed": "Kidney Transplant"]
  union ["Procedure, Performed": "Dialysis Services"] ) ESRDProcedure
  where
  end of Global."NormalizeInterval" ( ESRDProcedure.relevantDatetime, ESRDProcedure.relevantPeriod ) on or before
  end of "Measurement Period"
```

Essential Hypertension Diagnosis

```
["Diagnosis": "Essential Hypertension"] Hypertension
  where Hypertension.prevalencePeriod overlaps Interval[start of "Measurement Period", start of "Measurement Period" + 6 months )
```

Has Diastolic Blood Pressure Less Than 90

```
"Lowest Diastolic Reading on Most Recent Blood Pressure Day".result < 90 'mm[Hg]'
```

Has Systolic Blood Pressure Less Than 140

```
"Lowest Systolic Reading on Most Recent Blood Pressure Day".result < 140 'mm[Hg]'
```

Hospice.Has Hospice Services

```
exists ( ["Encounter, Performed": "Encounter Inpatient"] InpatientEncounter
    where ( InpatientEncounter.dischargeDisposition ~ "Discharge to home for hospice care (procedure)"
        or InpatientEncounter.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)"
    )
      and InpatientEncounter.relevantPeriod ends during day of "Measurement Period"
)
  or exists ( ["Encounter, Performed": "Hospice Encounter"] HospiceEncounter
      where HospiceEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Assessment, Performed": "Hospice care [Minimum Data Set]"] HospiceAssessment
      where HospiceAssessment.result ~ "Yes (qualifier value)"
        and Global."NormalizeInterval" ( HospiceAssessment.relevantDatetime, HospiceAssessment.relevantPeriod ) overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Order": "Hospice Care Ambulatory"] HospiceOrder
      where HospiceOrder.authorDatetime during day of "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Hospice Care Ambulatory"] HospicePerformed
      where Global."NormalizeInterval" ( HospicePerformed.relevantDatetime, HospicePerformed.relevantPeriod ) overlaps "Measurement Period"
  )
```

Initial Population

```
AgeInYearsAt(date from
  end of "Measurement Period"
)in Interval[18, 85]
  and exists "Essential Hypertension Diagnosis"
  and exists AdultOutpatientEncounters."Qualifying Encounters"
```

Lowest Diastolic Reading on Most Recent Blood Pressure Day

```
First("Qualifying Diastolic Blood Pressure Reading" DBPReading
    where Global."LatestOf"(DBPReading.relevantDatetime, DBPReading.relevantPeriod)same day as "Most Recent Blood Pressure Day"
    sort by(result as Quantity)
)
```

Lowest Systolic Reading on Most Recent Blood Pressure Day

```
First("Qualifying Systolic Blood Pressure Reading" SBPReading
    where Global."LatestOf"(SBPReading.relevantDatetime, SBPReading.relevantPeriod)same day as "Most Recent Blood Pressure Day"
    sort by(result as Quantity)
)
```

Most Recent Blood Pressure Day

```
Last("Blood Pressure Days" BPDays
    sort asc
)
```

Numerator

```
"Has Systolic Blood Pressure Less Than 140"
  and "Has Diastolic Blood Pressure Less Than 90"
```

PalliativeCare.Palliative Care in the Measurement Period

```
exists ( ["Assessment, Performed": "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)"] PalliativeAssessment
    where Global."NormalizeInterval"(PalliativeAssessment.relevantDatetime, PalliativeAssessment.relevantPeriod) overlaps "Measurement Period"
)
or exists (["Diagnosis": "Encounter for palliative care"] PalliativeDiagnosis
where PalliativeDiagnosis.prevalencePeriod overlaps "Measurement Period")
  or exists ( ["Encounter, Performed": "Palliative Care Encounter"] PalliativeEncounter
      where PalliativeEncounter.relevantPeriod overlaps "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Palliative Care Intervention"] PalliativeIntervention
      where Global."NormalizeInterval"(PalliativeIntervention.relevantDatetime, PalliativeIntervention.relevantPeriod) overlaps "Measurement Period"
  )
```

Pregnancy or Renal Diagnosis Exclusions

```
( ["Diagnosis": "Pregnancy"]
  union ["Diagnosis": "End Stage Renal Disease"]
  union ["Diagnosis": "Kidney Transplant Recipient"]
  union ["Diagnosis": "Chronic Kidney Disease, Stage 5"] ) PregnancyESRDDiagnosis
  where PregnancyESRDDiagnosis.prevalencePeriod overlaps "Measurement Period"
```

Qualifying Diastolic Blood Pressure Reading

```
["Physical Exam, Performed": "Diastolic blood pressure"] DiastolicBP
  without ( ["Encounter, Performed": "Encounter Inpatient"]
    union ["Encounter, Performed": "Emergency Department Visit"] ) DisqualifyingEncounter
    such that Global."LatestOf" ( DiastolicBP.relevantDatetime, DiastolicBP.relevantPeriod ) during day of DisqualifyingEncounter.relevantPeriod
  where DiastolicBP.result.unit = 'mm[Hg]'
    and Global."LatestOf" ( DiastolicBP.relevantDatetime, DiastolicBP.relevantPeriod ) during day of "Measurement Period"
```

Qualifying Systolic Blood Pressure Reading

```
["Physical Exam, Performed": "Systolic blood pressure"] SystolicBP
  without ( ["Encounter, Performed": "Encounter Inpatient"]
    union ["Encounter, Performed": "Emergency Department Visit"] ) DisqualifyingEncounter
    such that Global."LatestOf" ( SystolicBP.relevantDatetime, SystolicBP.relevantPeriod ) during day of DisqualifyingEncounter.relevantPeriod
  where SystolicBP.result.unit = 'mm[Hg]'
    and Global."LatestOf" ( SystolicBP.relevantDatetime, SystolicBP.relevantPeriod ) during day of "Measurement Period"
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

Global.HasEnd(period Interval<DateTime>)

```
not (
  end of period is null
    or
    end of period = maximum DateTime
)
```

Global.Latest(period Interval<DateTime>)

```
if ( HasEnd(period)) then
end of period
  else start of period
```

Global.LatestOf(pointInTime DateTime, period Interval<DateTime>)

```
Latest(NormalizeInterval(pointInTime, period))
```

Global.NormalizeInterval(pointInTime DateTime, period Interval<DateTime>)

```
if pointInTime is not null then Interval[pointInTime, pointInTime]
  else if period is not null then period
  else null as Interval<DateTime>
```

Terminology

- code "Diastolic blood pressure" ("LOINC Code (8462-4)")
- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Encounter for palliative care" ("ICD10CM Code (Z51.5)")
- code "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")
- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "Housing status" ("LOINC Code (71802-3)")
- code "Lives in a nursing home (finding)" ("SNOMEDCT Code (160734000)")
- code "Medical equipment used" ("LOINC Code (98181-1)")
- code "Systolic blood pressure" ("LOINC Code (8480-6)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- valueset "Acute Inpatient" (2.16.840.1.113883.3.464.1003.101.12.1083)
- valueset "Advanced Illness" (2.16.840.1.113883.3.464.1003.110.12.1082)
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Chronic Kidney Disease, Stage 5" (2.16.840.1.113883.3.526.3.1002)
- valueset "Dementia Medications" (2.16.840.1.113883.3.464.1003.196.12.1510)
- valueset "Dialysis Services" (2.16.840.1.113883.3.464.1003.109.12.1013)
- valueset "Emergency Department Visit" (2.16.840.1.113883.3.464.1003.101.12.1010)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "End Stage Renal Disease" (2.16.840.1.113883.3.526.3.353)
- valueset "ESRD Monthly Outpatient Services" (2.16.840.1.113883.3.464.1003.109.12.1014)
- valueset "Essential Hypertension" (2.16.840.1.113883.3.464.1003.104.12.1011)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Frailty Device" (2.16.840.1.113883.3.464.1003.118.12.1300)
- valueset "Frailty Diagnosis" (2.16.840.1.113883.3.464.1003.113.12.1074)
- valueset "Frailty Encounter" (2.16.840.1.113883.3.464.1003.101.12.1088)
- valueset "Frailty Symptom" (2.16.840.1.113883.3.464.1003.113.12.1075)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Kidney Transplant" (2.16.840.1.113883.3.464.1003.109.12.1012)
- valueset "Kidney Transplant Recipient" (2.16.840.1.113883.3.464.1003.109.12.1029)
- valueset "Nonacute Inpatient" (2.16.840.1.113883.3.464.1003.101.12.1084)

- valueset "Observation" (2.16.840.1.113883.3.464.1003.101.12.1086)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Online Assessments" (2.16.840.1.113883.3.464.1003.101.12.1089)
- valueset "Outpatient" (2.16.840.1.113883.3.464.1003.101.12.1087)
- valueset "Palliative Care Encounter" (2.16.840.1.113883.3.464.1003.101.12.1090)
- valueset "Palliative Care Intervention" (2.16.840.1.113883.3.464.1003.198.12.1135)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Pregnancy" (2.16.840.1.113883.3.526.3.378)
- valueset "Preventive Care Services Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Telephone Visits" (2.16.840.1.113883.3.464.1003.101.12.1080)

Data Criteria (QDM Data Elements)

- "Assessment, Performed: Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" using "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal) (LOINC Code 71007-9)"
- "Assessment, Performed: Hospice care [Minimum Data Set]" using "Hospice care [Minimum Data Set] (LOINC Code 45755-6)"
- "Assessment, Performed: Housing status" using "Housing status (LOINC Code 71802-3)"
- "Assessment, Performed: Medical equipment used" using "Medical equipment used (LOINC Code 98181-1)"
- "Device, Order: Frailty Device" using "Frailty Device (2.16.840.1.113883.3.464.1003.118.12.1300)"
- "Diagnosis: Chronic Kidney Disease, Stage 5" using "Chronic Kidney Disease, Stage 5 (2.16.840.1.113883.3.526.3.1002)"
- "Diagnosis: Encounter for palliative care" using "Encounter for palliative care (ICD10CM Code Z51.5)"
- "Diagnosis: End Stage Renal Disease" using "End Stage Renal Disease (2.16.840.1.113883.3.526.3.353)"
- "Diagnosis: Essential Hypertension" using "Essential Hypertension (2.16.840.1.113883.3.464.1003.104.12.1011)"
- "Diagnosis: Frailty Diagnosis" using "Frailty Diagnosis (2.16.840.1.113883.3.464.1003.113.12.1074)"
- "Diagnosis: Kidney Transplant Recipient" using "Kidney Transplant Recipient (2.16.840.1.113883.3.464.1003.109.12.1029)"
- "Diagnosis: Pregnancy" using "Pregnancy (2.16.840.1.113883.3.526.3.378)"
- "Encounter, Performed: Acute Inpatient" using "Acute Inpatient (2.16.840.1.113883.3.464.1003.101.12.1083)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Emergency Department Visit" using "Emergency Department Visit (2.16.840.1.113883.3.464.1003.101.12.1010)"
- "Encounter, Performed: Encounter Inpatient" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "Encounter, Performed: ESRD Monthly Outpatient Services" using "ESRD Monthly Outpatient Services (2.16.840.1.113883.3.464.1003.109.12.1014)"
- "Encounter, Performed: Frailty Encounter" using "Frailty Encounter (2.16.840.1.113883.3.464.1003.101.12.1088)"
- "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Hospice Encounter" using "Hospice Encounter (2.16.840.1.113883.3.464.1003.1003)"
- "Encounter, Performed: Nonacute Inpatient" using "Nonacute Inpatient (2.16.840.1.113883.3.464.1003.101.12.1084)"
- "Encounter, Performed: Observation" using "Observation (2.16.840.1.113883.3.464.1003.101.12.1086)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Online Assessments" using "Online Assessments (2.16.840.1.113883.3.464.1003.101.12.1089)"
- "Encounter, Performed: Outpatient" using "Outpatient (2.16.840.1.113883.3.464.1003.101.12.1087)"
- "Encounter, Performed: Palliative Care Encounter" using "Palliative Care Encounter (2.16.840.1.113883.3.464.1003.101.12.1090)"
- "Encounter, Performed: Preventive Care Services Established Office Visit, 18 and Up" using "Preventive Care Services Established Office Visit, 18 and Up (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 (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Encounter, Performed: Telephone Visits" using "Telephone Visits (2.16.840.1.113883.3.464.1003.101.12.1080)"
- "Intervention, Order: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Hospice Care Ambulatory" using "Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)"
- "Intervention, Performed: Palliative Care Intervention" using "Palliative Care Intervention (2.16.840.1.113883.3.464.1003.198.12.1135)"
- "Medication, Active: Dementia Medications" using "Dementia Medications (2.16.840.1.113883.3.464.1003.196.12.1510)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"
- "Physical Exam, Performed: Diastolic blood pressure" using "Diastolic blood pressure (LOINC Code 8462-4)"
- "Physical Exam, Performed: Systolic blood pressure" using "Systolic blood pressure (LOINC Code 8480-6)"
- "Procedure, Performed: Dialysis Services" using "Dialysis Services (2.16.840.1.113883.3.464.1003.109.12.1013)"
- "Procedure, Performed: Kidney Transplant" using "Kidney Transplant (2.16.840.1.113883.3.464.1003.109.12.1012)"
- "Symptom: Frailty Symptom" using "Frailty Symptom (2.16.840.1.113883.3.464.1003.113.12.1075)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

Quality ID #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Intermediate Outcome – High Priority

DESCRIPTION:
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients with diabetes seen during the performance period. The most recent quality data code submitted will be used for performance calculation. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

Measure 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:
Patients 18 - 75 years of age, with diabetes with a visit during the measurement period

> ***DENOMINATOR NOTE:*** *To assess the age for exclusions, the patient's age on the date of the encounter should be used.*
>
> **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.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients 18 through 75 years of age on date of encounter
> **AND**
>
> **Diagnosis for diabetes (ICD-10-CM):** E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3219, E10.3291, E10.3292, E10.3293, E10.3299, E10.3311, E10.3312, E10.3313, E10.3319, E10.3391, E10.3392, E10.3393, E10.3399, E10.3411, E10.3412, E10.3413, E10.3419, E10.3491, E10.3492, E10.3493, E10.3499, E10.3511, E10.3512, E10.3513, E10.3519, E10.3521, E10.3522, E10.3523, E10.3529, E10.3531, E10.3532, E10.3533, E10.3539, E10.3541, E10.3542, E10.3543, E10.3549, E10.3551, E10.3552, E10.3553, E10.3559, E10.3591,

E10.3592, E10.3593, E10.3599, E10.36, E10.37X1, E10.37X2, E10.37X3, E10.37X9, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3219, E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, E11.3312, E11.3313, E11.3319, E11.3391, E11.3392, E11.3393, E11.3399, E11.3411, E11.3412, E11.3413, E11.3419, E11.3491, E11.3492, E11.3493, E11.3499, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533, E11.3539, E11.3541, E11.3542, E11.3543, E11.3549, E11.3551, E11.3552, E11.3553, E11.3559, E11.3591, E11.3592, E11.3593, E11.3599, E11.36, E11.37X1, E11.37X2, E11.37X3, E11.37X9, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3219, E13.3291, E13.3292, E13.3293, E13.3299, E13.3311, E13.3312, E13.3313, E13.3319, E13.3391, E13.3392, E13.3393, E13.3399, E13.3411, E13.3412, E13.3413, E13.3419, E13.3491, E13.3492, E13.3493, E13.3499, E13.3511, E13.3512, E13.3513, E13.3519, E13.3521, E13.3522, E13.3523, E13.3529, E13.3531, E13.3532, E13.3533, E13.3539, E13.3541, E13.3542, E13.3543, E13.3549, E13.3551, E13.3552, E13.3553, E13.3559, E13.3591, E13.3592, E13.3593, E13.3599, E13.36, E13.37X1, E13.37X2, E13.37X3, E13.37X9, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13, O24.311, O24.312, O24.313, O24.319, O24.32, O24.33, O24.811, O24.812, O24.813, O24.819, O24.82, O24.83

AND

Patient encounter during performance period (CPT or HCPCS): 97802, 97803, 97804,99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, G0270, G0271, G0438, G0439

AND NOT

DENOMINATOR EXCLUSIONS:

Hospice services provided to patient any time during the measurement period: G9687

OR

Palliative care services provided to patient any time during the measurement period: G9988

OR

Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period: G2081

OR

Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period: G2090

OR

Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period: G2091

Table: Dementia Exclusion Medications

Description	Prescription
Cholinesterase inhibitors	Donepezil Rivastigimine Galantamine

Description	Prescription
Miscellaneous central nervous system agents	Memantine

- **Codes to identify Frailty:** 99504, 99509, E0100, E0105, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0163, E0165, E0167, E0168, E0170, E0171, E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290, E0291, E0292, E0293, E0294, E0295, E0296, E0297, E0301, E0302, E0303, E0304, E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0462, E0465, E0466, E0470, E0471, E0472, E0561, E0562, E1130, E1140, E1150, E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, E1296, E1297, E1298, G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000, T1001, T1002, T1003, T1004, T1005, T1019, T1020, T1021, T1022, T1030, T1031, L89.000, L89.001, L89.002, L89.003, L89.004, L89.006, L89.009, L89.010, L89.011, L89.012, L89.013, L89.014, L89.016, L89.019, L89.020, L89.021, L89.022, L89.023, L89.024, L89.026, L89.029, L89.100, L89.101, L89.102, L89.103, L89.104, L89.106, L89.109, L89.110, L89.111, L89.112, L89.113, L89.114, L89.116, L89.119, L89.120, L89.121, L89.122, L89.123, L89.124, L89.126, L89.129, L89.130, L89.131, L89.132, L89.133, L89.134, L89.136, L89.139, L89.140, L89.141, L89.142, L89.143, L89.144, L89.146, L89.149, L89.150, L89.151, L89.152, L89.153, L89.154, L89.156, L89.159, L89.200, L89.201, L89.202, L89.203, L89.204, L89.206, L89.209, L89.210, L89.211, L89.212, L89.213, L89.214, L89.216, L89.219, L89.220, L89.221, L89.222, L89.223, L89.224, L89.226, L89.229, L89.300, L89.301, L89.302, L89.303, L89.304, L89.306, L89.309, L89.310, L89.311, L89.312, L89.313, L89.314, L89.316, L89.319, L89.320, L89.321, L89.322, L89.323, L89.324, L89.326, L89.329, L89.40, L89.41, L89.42, L89.43, L89.44, L89.45, L89.46, L89.500, L89.501, L89.502, L89.503, L89.504, L89.506, L89.509, L89.510, L89.511, L89.512, L89.513, L89.514, L89.516, L89.519, L89.520, L89.521, L89.522, L89.523, L89.524, L89.526, L89.529, L89.600, L89.601, L89.602, L89.603, L89.604, L89.606, L89.609, L89.610, L89.611, L89.612, L89.613, L89.614, L89.616, L89.619, L89.620, L89.621, L89.622, L89.623, L89.624, L89.626, L89.629, L89.810, L89.811, L89.812, L89.813, L89.814, L89.816, L89.819, L89.890, L89.891, L89.892, L89.893, L89.894, L89.896, L89.899, L89.90, L89.91, L89.92, L89.93, L89.94, L89.95, L89.96, M62.50, M62.81, M62.84, R26.0, R26.1, R26.2, R26.89, R26.9, R41.81, R53.1, R53.81, R53.83, R54, R62.7, R63.4, R63.6, R64, W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS, Y92.199, Z59.3, Z73.6, Z74.01, Z74.09, Z74.1, Z74.2, Z74.3, Z74.8, Z74.9, Z91.81, Z99.11, Z99.3, Z99.81, Z99.89

- **Codes to identify Advanced Illness:** A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C91.00, C91.02, C92.00, C92.02, C93.00, C93.02, C93.90, C93.92, C93.Z0, C93.Z2, C94.30, C94.32, F01.50, F01.51, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01.C18, F01.C2, F01.C3, F01.C4, F02.80, F02.81, F02.811, F02.818, F02.82, F02.83, F02.84, F02.A0, F02.A11, F02.A18, F02.A2, F02.A3, F02.A4, F02.B0, F02.B11, F02.B18, F02.B2,

F02.B3, F02.B4, F02.C0, F02.C11, F02.C18, F02.C2, F02.C3, F02.C4, F03.90, F03.91, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A0, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, F04, F10.27, F10.96, F10.97, G10, G12.21, G20, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.170, J84.178, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6

NUMERATOR:
Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%

Numerator Instruction:
INVERSE MEASURE - A lower calculated performance rate for this measure indicates better clinical care or control. The "Performance Not Met" numerator option for this measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures, a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.

Patient is numerator compliant if most recent HbA1c level >9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. Do not include HbA1c levels reported by the patient.

Numerator Options:

Performance Met:	Most recent hemoglobin A1c level > 9.0% **(3046F)**
OR	
Performance Met:	Hemoglobin A1c level was not performed during the measurement period (12 months) **(3046F *with* 8P)**
OR	
Performance Not Met:	Most recent hemoglobin A1c (HbA1c) level < 7.0% **(3044F)**
OR	
Performance Not Met:	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% **(3051F)**
OR	
Performance Not Met:	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% **(3052F)**

RATIONALE:
Diabetes is the seventh leading cause of death in the United States. In 2017, diabetes affected approximately 34 million Americans (10.5 percent of the U.S. population) and killed approximately 84,000 people (Centers for Disease Control and Prevention [CDC], 2020a). Diabetes is a long-lasting disease marked by high blood glucose levels, resulting from the body's inability to produce or use insulin properly (CDC, 2020b). People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney damage, amputation of feet or legs, and premature death (CDC, 2021).

In 2017, diabetes cost the U.S. an estimated $327 billion: $237 billion in direct medical costs and $90 billion in reduced productivity. This is a 34 percent increase from the estimated $245 billion spent on diabetes in 2012 (American Diabetes Association [ADA], 2018).

Controlling A1c blood levels helps reduce the risk of microvascular complications (eye, kidney and nerve diseases) (ADA, 2021).

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (2021):

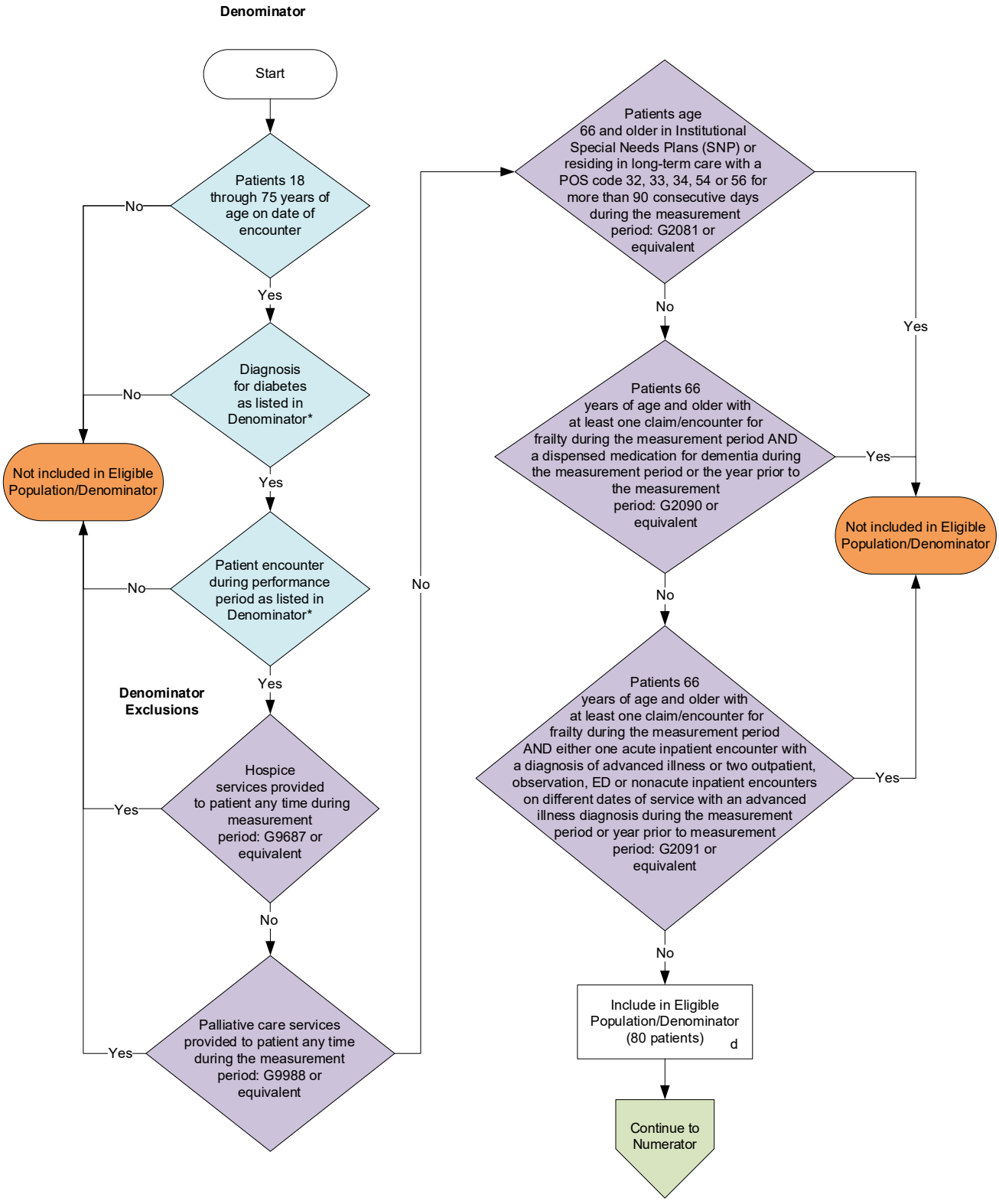
- An A1C goal for many nonpregnant adults of <7% (53 mmol/mol) without significant hypocalcemia is appropriate. (Level of evidence: A)

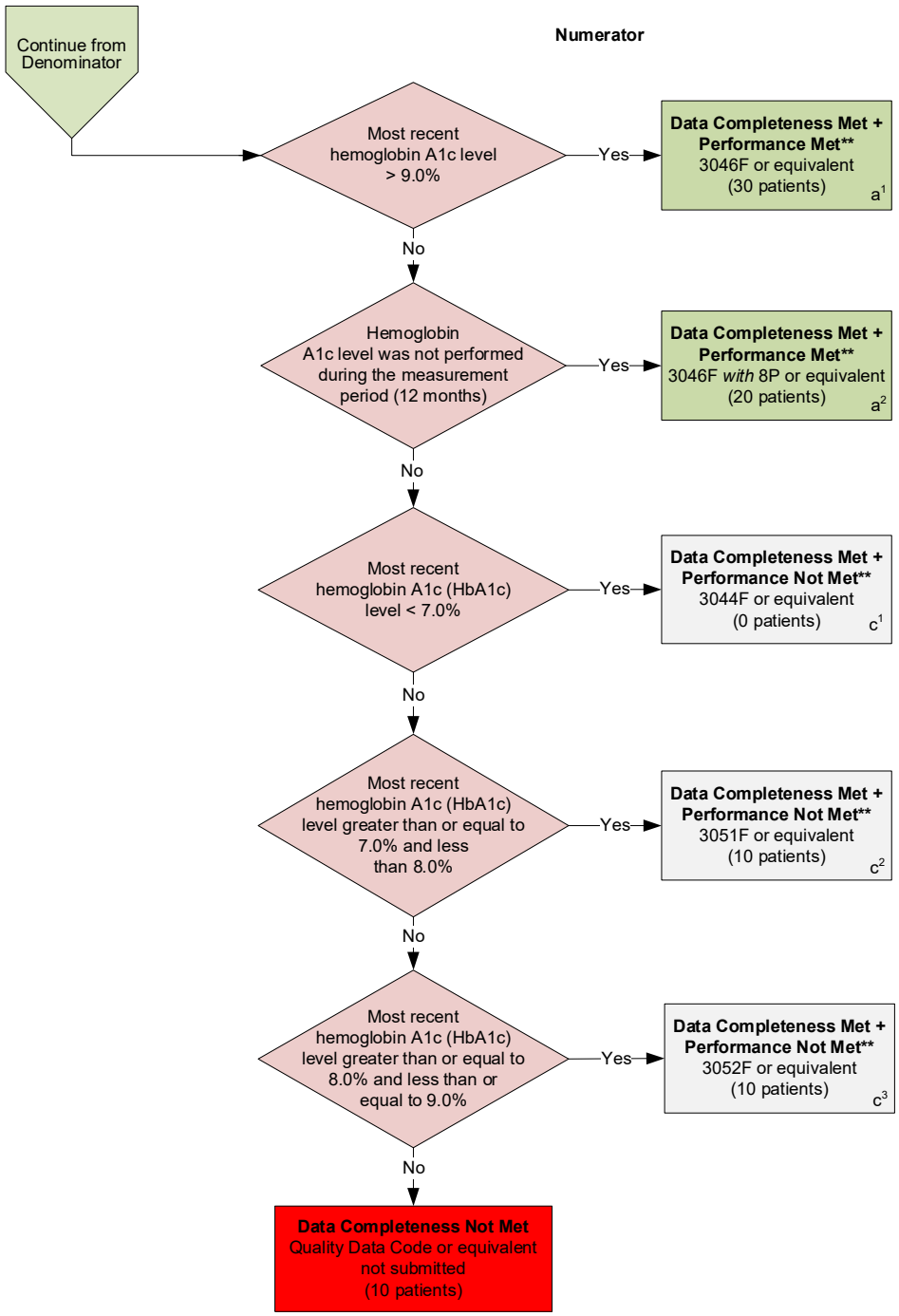
- On the basis of provider judgement and patient preference, achievement of lower A1C levels than the goal of 7% may be acceptable, and even beneficial, if it can be achieved safely without significant hypoglycemia or other adverse effects of treatment. (Level of evidence: C)

- Less stringent A1C goals (such as <8% [64 mmol/mol]) may be appropriate for patients limited life expectancy, where the harms of treatment are greater than the benefits. (Level of evidence: B)

2023 Clinical Quality Measure Flow for Quality ID #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

***Disclaimer**: Refer to the measure specification for specific coding and instructions to submit this measure.*





SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a^1+a^2=50 patients) + Performance Not Met ($c^1+c^2+c^3$=20 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=**
Performance Met (a^1+a^2=50 patients) = 50 patients = **71.43%**
Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
**A lower calculated performance rate for this measure indicates better clinical care or control.
NOTE: Submission Frequency: Patient-Intermediate

2023 Clinical Quality Measure Flow Narrative for Quality ID #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

***Disclaimer**: Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients 18 through 75 years of age on date of encounter*:
    a. If *Patients 18 through 75 years of age on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients 18 through 75 years of age on date of encounter* equals Yes, proceed to check *Diagnosis for diabetes as listed in Denominator**.
3. Check *Diagnosis for diabetes as listed in Denominator**:
    a. If *Diagnosis for diabetes as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis for diabetes as listed in Denominator** equals Yes, proceed to check *Patient encounter during performance period as listed in Denominator**.
4. Check *Patient encounter during performance period as listed in Denominator**:
    a. If *Patient encounter during performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during performance period as listed in Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during measurement period*.
5. Check *Hospice services provided to patient any time during measurement period*:
    a. If *Hospice services provided to patient any time during measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Hospice services provided to patient any time during the measurement period* equals No, proceed to check *Palliative care services provided to patient any time during the measurement period*.
6. Check *Palliative care services provided to patient any time during the measurement period*:
    a. If *Palliative care services provided to patient any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Palliative care services provided to patient any time during the measurement period* equals No, proceed to check *Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period*.
7. Check *Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period*:
    a. If *Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

b. If *Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period* equals No, proceed to check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period*.

8. Check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period*:

    a. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period* equals No, proceed to check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or year prior to measurement period*.

9. Check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or year prior to measurement period*:

    a. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or year prior to measurement period* equals Yes, do not include in the *Eligible Population/Denominator*. Stop processing.

    b. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or year prior to measurement period* equals No, include in the *Eligible Population/Denominator*.

10. Denominator Population:

    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.

11. Start Numerator

12. Check *Most recent hemoglobin A1c level is greater than 9.0 percent*:

    a. If *Most recent hemoglobin A1c level is greater than 9.0 percent* equals Yes, include in *Data Completeness Met and Performance Met***.

        - *Data Completeness Met and Performance Met*** letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of

this document. Letter a^1 equals 30 patients in the Sample Calculation.

b. If *Most recent hemoglobin A1c level is greater than 9.0 percent* equals No, proceed to check *Hemoglobin A1c level was not performed during the measurement period (12 months)*.

13. Check *Hemoglobin A1c level was not performed during the measurement period (12 months)*:

    a. If *Hemoglobin A1c level was not performed during the measurement period (12 months)* equals Yes, include in *Data Completeness Met and Performance Met***.

        - *Data Completeness Met and Performance Met*** letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 20 patients in the Sample Calculation.

    b. If *Hemoglobin A1c level was not performed during the measurement period (12 months)* equals No, proceed to check *Most recent hemoglobin A1c (HbA1c) level is less than 7.0 percent*.

14. Check *Most recent hemoglobin A1c (HbA1c) level is less than 7.0 percent*:

    a. If *Most recent hemoglobin A1c (HbA1c) level is less than 7.0 percent* equals Yes, include in the *Data Completeness Met and Performance Not Met***.

        - *Data Completeness Met and Performance Not Met*** letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 0 patients in the Sample Calculation.

    b. If *Most recent hemoglobin A1c (HbA1c) level is less than 7.0 percent* equals No, proceed to check *Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0 percent and less than 8.0 percent*.

15. Check *Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0 percent and less than 8.0 percent*:

    a. If *Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0 percent and less than 8.0 percent* equals Yes, include in *Data Completeness Met and Performance Not Met***.

        - *Data Completeness Met and Performance Not Met*** letter is as the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    b. If *Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0 percent and less than 8.0 percent* equals No, proceed to check *Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0 percent and less than or equal to 9.0 percent*.

16. Check *Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0 percent and less than or equal to 9.0 percent.*

    a. If *Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0 percent and less than or equal to 9.0 percent* equals Yes include in *Data Completeness Met and Performance Not Met***.

        - *Data Completeness Met and Performance Not Met*** letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^3 equals 10 patients in the Sample Calculation.

    b. If *Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0 percent and less than or equal to*

9.0 percent equals No, check *Data Completeness Not Met*.

17. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a^1 plus a^2 equals 50 patients) plus Performance Not Met (c^1 plus c^2 plus c^3 equals 20 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate** equals Performance Met (a^1 plus a^2 equals 50 patients) divided by Data Completeness Numerator (70 patients). All equals 50 patients divided by 70 patients. All equals 71.43 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

**A lower calculated performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Intermediate

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #14 (NQF 0087): Age-Related Macular Degeneration (AMD): Dilated Macular Examination

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage AND the level of macular degeneration severity during one or more office visits within the 12 month performance period.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians who provide the primary management of patients with age-related macular degeneration (in either one or both eyes) will submit this measure.

Measure 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:
All patients aged 50 years and older with a diagnosis of AMD

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for age-related macular degeneration (ICD-10-CM): H35.3110, H35.3111, H35.3112, H35.3113, H35.3114, H35.3120, H35.3121, H35.3122, H35.3123, H35.3124, H35.3130, H35.3131, H35.3132, H35.3133, H35.3134, H35.3210, H35.3211, H35.3212, H35.3213, H35.3220, H35.3221, H35.3222, H35.3223, H35.3230, H35.3231, H35.3232, H35.3233
AND
Patient encounter during the performance period (CPT): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02
WITHOUT
Place of Service (POS): 12

NUMERATOR:
Patients who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage AND the level of macular degeneration severity

during one or more office visits within 12 months

Definitions:
Macular Thickening – Acceptable synonyms for "macular thickening" include: intraretinal thickening, serous detachment of the retina, pigment epithelial detachment or macular edema.
Severity of Macular Degeneration – Early, intermediate and advanced; or active choroidal neovascularization, inactive choroidal neovascularization, or with inactive scar.
Geographic Atrophy – The advanced form of non-neovascular AMD, will have one or more zones of well- demarcated retinal pigment epithelial and/or choriocapillaris atrophy.

NUMERATOR NOTE: *Denominator Exception(s) are determined on or any date during the performance period prior to the date of the denominator eligible encounter.*

Numerator Options:

Performance Met:	Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage AND the level of macular degeneration severity **(G9974)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not performing a dilated macular examination **(G9975)**
OR	
Denominator Exception:	Documentation of patient reason(s) for not performing a dilated macular examination **(G9892)**
OR	
Performance Not Met:	Dilated macular exam was not performed, reason not otherwise specified **(G9893)**

RATIONALE:
A documented complete macular examination is a necessary prerequisite to determine the presence and severity of AMD, so that a decision can be made as to the benefits of prescribing antioxidant vitamins. Furthermore, periodic assessment is necessary to determine whether there is progression of the disease and to plan the on-going treatment of the disease, since several therapies exist that reduce vision loss once the advanced neovascular form of AMD occurs. In patients with neovascular AMD, early detection and prompt treatment improves the visual outcome. Intravitreal injection therapy using anti-vascular endothelial growth factor (VEGF) agents (e.g., aflibercept, bevacizumab, and ranibizumab) is the most effective way to manage neovascular AMD and represents the first line of treatment. While no data exist on the frequency or absence of regular examinations of the macula for patients with AMD, parallel data for key structural assessments for glaucoma, cataract and diabetic retinopathy suggest that significant gaps are likely.

CLINICAL RECOMMENDATION STATEMENTS:
According to the American Academy of Ophthalmology, a physical examination should include a stereoscopic biomicroscopic examination of the macula. Binocular slit-lamp biomicroscopy of the ocular fundus is often necessary to detect subtle clinical signs of CNV. These include small areas of hemorrhage, hard exudates, subretinal fluid, macular edema, subretinal fibrosis, or pigment epithelial elevation.

American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Age-Related Macular Degeneration. San Francisco, CA: American Academy of Ophthalmology; 2019. Available at: www.aao.org/ppp

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2023 Clinical Quality Measure Flow for Quality ID #14 (NQF 0087): Age-Related Macular Degeneration (AMD): Dilated Macular Examination

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=50 patients) + Denominator Exception (b^1+b^2=10 patients) + Performance Not Met (c=10 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a=50 patients) = 50 patients = **83.33%**

Data Completeness Numerator (70 patients) – Denominator Exception (b^1+b^2=10 patients) = 60 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

2023 Clinical Quality Measure Flow Narrative for Quality ID #14 (NQF 0087): Age-Related Macular Degeneration (AMD): Dilated Macular Examination

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients aged greater than or equal to 50 years on date of encounter*:
    a. If *Patients aged greater than or equal to 50 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 50 years on date of encounter* equals Yes, proceed to check *Diagnosis for AMD as listed in Denominator**.
3. Check *Diagnosis for AMD as listed in Denominator**:
    a. If *Diagnosis for AMD as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis for AMD as listed in Denominator** equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
4. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Telehealth Modifier*.
5. Check *Telehealth Modifier*:
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, proceed to check *Place of Service (POS).*
6. Check *Place of Service (POS):*
    a. If *Place of Service (POS)* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.
    b. If *Place of Service (POS)* equals No, include in *Eligible Population/Denominator*.
7. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
8. Start Numerator
9. Check *Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage AND the level of macular degeneration severity*:
    a. If *Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage AND the level of macular degeneration severity*

equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 50 patients in the Sample Calculation.

b. If *Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage AND the level of macular degeneration severity* equals No, proceed to check *Documentation of medical reason(s) for not performing a dilated macular examination*.

10. Check *Documentation of medical reason(s) for not performing a dilated macular examination*:

    a. If *Documentation of medical reason(s) for not performing a dilated macular examination* equals Yes, include in *Data Completeness Met and Denominator Exception*.

    - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not performing a dilated macular examination* equals No, proceed to check *Documentation of patient reason(s) for not performing a dilated macular examination*.

11. Check *Documentation of patient reason(s) for not performing a dilated macular examination*:

    a. If *Documentation of patient reason(s) for not performing a dilated macular examination* equals Yes, include in *Data Completeness Met and Denominator Exception*.

    - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 0 patients in the Sample Calculation.

    b. If *Documentation of patient reason(s) for not performing a dilated macular examination* equals No, proceed to check *Dilated macular exam was not performed, reason not otherwise specified*.

12. Check *Dilated macular exam was not performed, reason not otherwise specified*:

    a. If *Dilated macular exam was not performed, reason not otherwise specified* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

    - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 10 patients in the Sample Calculation.

    b. If *Dilated macular exam was not performed, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

13. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a equals 50 patients) plus Denominator Exception (b^1 plus b^2 equals 10 patients) plus Performance Not Met (c equals 10 patients) divided by Eligible Population / Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 50 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b^1 plus b^2 equals 10 patients). All equals 50 patients divided by 60 patients. All equals 83.33 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for all patients with diabetic retinopathy seen during the performance period. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

Measure 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:
All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

> ***DENOMINATOR NOTE:*** **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.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis of diabetic retinopathy (ICD-10-CM): E08.311, E08.319, E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E09.311, E09.319, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492,

E10.3493, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3291, E13.3292, E13.3293, E13.3311, E13.3312, E13.3313, E13.3391, E13.3392, E13.3393, E13.3411, E13.3412, E13.3413, E13.3491, E13.3492, E13.3493, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593

AND

Patient encounter during the performance period (CPT): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350

WITHOUT

Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02

WITHOUT

Place of Service (POS): 12

AND

Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy: G8397

NUMERATOR:

Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

Definitions:

Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

Findings – Includes level of severity of retinopathy (e.g., mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema.

NUMERATOR NOTE: *Denominator Exception(s) are determined on the date of the denominator eligible encounter.*

Numerator Options:

Performance Met:	Findings of dilated macular or fundus exam communicated to the physician or other qualified health care professional managing the diabetes care **(5010F)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes **(5010F *with* 1P)**
OR	
Denominator Exception:	Documentation of patient reason(s) for not communicating the findings of the dilated macular or

	fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes **(5010F *with* 2P)**
OR	
Performance Not Met:	Findings of dilated macular or fundus exam were not communicated to the physician or other qualified health care professional managing thediabetes care, reason not otherwise specified **(5010F *with* 8P)**

RATIONALE:

Diabetic retinopathy is a prevalent complication of diabetes, estimated to affect 28.5% of diabetic patients in the US (Zhang et al., 2010). Diabetic Retinopathy is a key indicator of systemic complications of diabetes (Zhang, 2010). Coordination of care between the eye care specialist and the physician managing a patient's ongoing diabetes care is essential in stemming the progression of vision loss. Communication from the eye care specialist to a primary care physician facilitates the exchange of information about the severity and progression of a patient's diabetic retinopathy, adherence to recommended ocular care, need for follow-up visits, and treatment plans (Storey et al. , 2016). Data from the Diabetes Control and Complications Trial showed that diabetic treatment and maintenance of glucose control delays the onset and slows the progression of diabetic retinopathy (Aiello & DCCT/EDIC Research Group, 2014).

CLINICAL RECOMMENDATION STATEMENTS:

The ophthalmologist should refer patients with diabetes to a primary care physician for appropriate management of their systemic condition and should communicate examination results to the physician managing the patient's ongoing diabetes care. An Eye MD Examination Report Form is available from the American Academy of Ophthalmology (Academy).

Because patients with diabetes may be under the care of multiple practitioners, effective communication and care coordination is necessary to optimize care.

One of the patient outcome criteria is optimal control of blood glucose, blood pressure, and other risk factors through close communication with the patient's primary care physician on the status of the diabetic retinopathy and the need for optimal metabolic control.

American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Diabetic Retinopathy. San Francisco, CA: American Academy of Ophthalmology; 2019. Available at: www.aao.org/ppp

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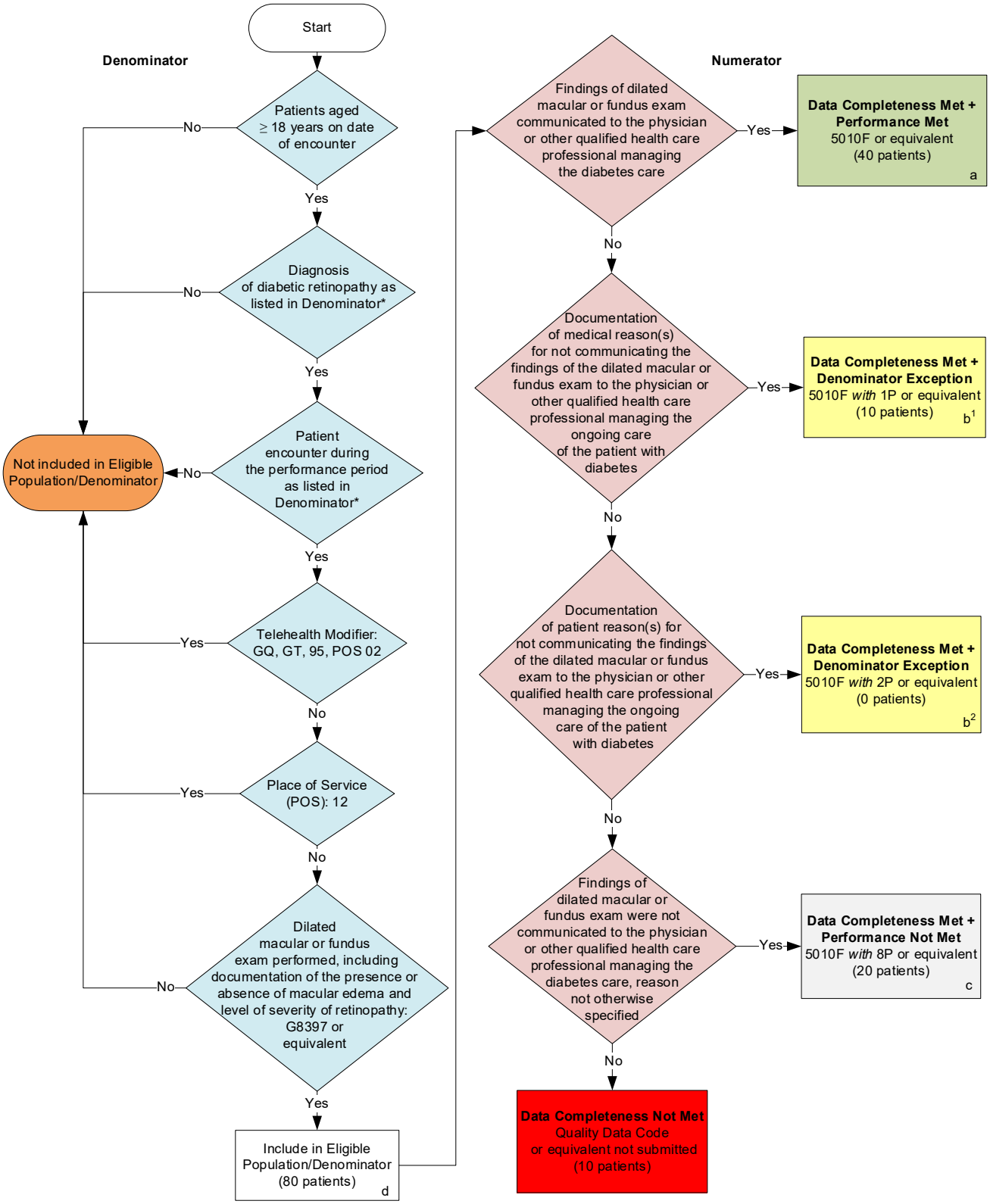
2023 Clinical Quality Measure Flow for Quality ID #19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 patients) + Denominator Exception (b^1+b^2=10 patients) + Performance Not Met (c=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (70 patients) – Denominator Exception (b^1+b^2=10 patients) = 60 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

v7

2023 Clinical Quality Measure Flow Narrative for Quality ID #19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years on date of encounter*:
    a. If *Patients aged greater than or equal to 18 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years on date of encounter* equals Yes, proceed to check *Diagnosis of diabetic retinopathy as listed in Denominator**.
3. Check *Diagnosis of diabetic retinopathy as listed in Denominator**:
    a. If *Diagnosis of diabetic retinopathy as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis of diabetic retinopathy as listed in Denominator** equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
4. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in the Denominator** equals Yes, proceed to check *Telehealth Modifier*.
5. Check *Telehealth Modifier*:
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, proceed to check *Place of Service (POS)*.
6. Check *Place of Service (POS)*:
    a. If *Place of Service (POS)* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Place of Service (POS)* equals No, proceed to check *Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy*.
7. Check *Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy*:
    a. If *Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy* equals Yes, include in *Eligible Population/Denominator*.

8. Denominator Population:

    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.

9. Start Numerator

10. Check *Findings of dilated macular or fundus exam communicated to the physician or other qualified health care professional managing the diabetes care*:

    a. If *Findings of dilated macular or fundus exam communicated to the physician or other qualified health care professional managing the diabetes care* equals Yes, include in *Data Completeness Met and Performance Met*.

        • *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in the Sample Calculation.

    b. If *Findings of dilated macular or fundus exam communicated to the physician or other qualified health care professional managing the diabetes care* equals No, proceed to check *Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes*.

11. Check *Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes*:

    a. If *Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        • *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes* equals No, proceed to check *Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes*.

12. Check *Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes*:

    a. If *Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        • *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 0 patients in the Sample Calculation.

    b. If *Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus*

exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes equals No, proceed to check *Findings of dilated macular or fundus exam were not communicated to the physician or other qualified health care professional managing the diabetes care, reason not otherwise specified*.

13. Check *Findings of dilated macular or fundus exam were not communicated to the physician or other qualified health care professional managing the diabetes care, reason not otherwise specified*:

    a. If *Findings of dilated macular or fundus exam were not communicated to the physician or other qualified health care professional managing the diabetes care, reason not otherwise specified* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 20 patients in the Sample Calculation.

    b. If *Findings of dilated macular or fundus exam were not communicated to the physician or other qualified health care professional managing the diabetes care, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

14. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a equals 40 patients) plus Denominator Exception (b^1 plus b^2 equals 10 patients) plus Performance Not Met (c equals 20 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b^1 plus b^2 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #117 (NQF 0055): Diabetes: Eye Exam

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients with diabetes mellitus seen 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 based on services provided and the measure-specific denominator coding.

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

Measure 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:
Patients 18 - 75 years of age with diabetes with a visit during the measurement period

> ***DENOMINATOR NOTE:*** *To assess the age for exclusions, the patient's age on the date of the encounter should be used.*
>
> **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.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients 18 to 75 years of age on date of encounter
> **AND**
> **Diagnosis for diabetes (ICD-10-CM):** E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3219, E10.3291, E10.3292, E10.3293, E10.3299, E10.3311, E10.3312, E10.3313, E10.3319, E10.3391, E10.3392, E10.3393, E10.3399, E10.3411, E10.3412, E10.3413, E10.3419, E10.3491, E10.3492, E10.3493, E10.3499, E10.3511, E10.3512, E10.3513, E10.3519, E10.3521, E10.3522, E10.3523, E10.3529, E10.3531, E10.3532, E10.3533, E10.3539, E10.3541, E10.3542, E10.3543, E10.3549, E10.3551, E10.3552, E10.3553, E10.3559, E10.3591, E10.3592, E10.3593, E10.3599, E10.36, E10.37X1, E10.37X2,

E10.37X3, E10.37X9, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3219,E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, E11.3312, E11.3313, E11.3319, E11.3391, E11.3392, E11.3393, E11.3399, E11.3411, E11.3412, E11.3413, E11.3419, E11.3491, E11.3492, E11.3493, E11.3499, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533, E11.3539, E11.3541, E11.3542, E11.3543, E11.3549, E11.3551, E11.3552, E11.3553, E11.3559, E11.3591, E11.3592, E11.3593, E11.3599, E11.36, E11.37X1, E11.37X2, E11.37X3, E11.37X9, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3219, E13.3291, E13.3292, E13.3293, E13.3299, E13.3311, E13.3312, E13.3313, E13.3319, E13.3391, E13.3392, E13.3393, E13.3399, E13.3411, E13.3412, E13.3413, E13.3419, E13.3491, E13.3492, E13.3493, E13.3499, E13.3511, E13.3512, E13.3513, E13.3519, E13.3521, E13.3522, E13.3523, E13.3529, E13.3531, E13.3532, E13.3533, E13.3539, E13.3541, E13.3542, E13.3543, E13.3549, E13.3551, E13.3552, E13.3553, E13.3559, E13.3591, E13.3592, E13.3593, E13.3599, E13.36, E13.37X1, E13.37X2, E13.37X3, E13.37X9, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13, O24.311, O24.312, O24.313, O24.319, O24.32, O24.33, O24.811, O24.812, O24.813, O24.819, O24.82, O24.83

AND

Patient encounter during the performance period (CPT or HCPCS): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, G0438, G0439

AND NOT

DENOMINATOR EXCLUSIONS:

Patient is using hospice services any time during the measurement period: G9714

OR

Patient is using palliative care services any time during the measurement period: G9994

OR

Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period: G2105

OR

Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period: G2106

OR

Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period: G2107

Table: Dementia Exclusion Medications

Description	Prescription
Cholinesterase inhibitors	Donepezil Rivastigimine Galantamine

Description	Prescription
Miscellaneous central nervous system agents	Memantine

- **Codes to identify Frailty:** 99504, 99509, E0100, E0105, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0163, E0165, E0167, E0168, E0170, E0171, E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290, E0291, E0292, E0293, E0294, E0295, E0296, E0297, E0301, E0302, E0303, E0304, E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0462, E0465, E0466, E0470, E0471, E0472, E0561, E0562, E1130, E1140, E1150, E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, E1296, E1297, E1298, G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000, T1001, T1002, T1003, T1004, T1005, T1019, T1020, T1021, T1022, T1030, T1031, L89.000, L89.001, L89.002, L89.003, L89.004, L89.006, L89.009, L89.010, L89.011, L89.012, L89.013, L89.014, L89.016, L89.019, L89.020, L89.021, L89.022, L89.023, L89.024, L89.026, L89.029, L89.100, L89.101, L89.102, L89.103, L89.104, L89.106, L89.109, L89.110, L89.111, L89.112, L89.113, L89.114, L89.116, L89.119, L89.120, L89.121, L89.122, L89.123, L89.124, L89.126, L89.129, L89.130, L89.131, L89.132, L89.133, L89.134, L89.136, L89.139, L89.140, L89.141, L89.142, L89.143, L89.144, L89.146, L89.149, L89.150, L89.151, L89.152, L89.153, L89.154, L89.156, L89.159, L89.200, L89.201, L89.202, L89.203, L89.204, L89.206, L89.209, L89.210, L89.211, L89.212, L89.213, L89.214, L89.216, L89.219, L89.220, L89.221, L89.222, L89.223, L89.224, L89.226, L89.229, L89.300, L89.301, L89.302, L89.303, L89.304, L89.306, L89.309, L89.310, L89.311, L89.312, L89.313, L89.314, L89.316, L89.319, L89.320, L89.321, L89.322, L89.323, L89.324, L89.326, L89.329, L89.40, L89.41, L89.42, L89.43, L89.44, L89.45, L89.46, L89.500, L89.501, L89.502, L89.503, L89.504, L89.506, L89.509, L89.510, L89.511, L89.512, L89.513, L89.514, L89.516, L89.519, L89.520, L89.521, L89.522, L89.523, L89.524, L89.526, L89.529, L89.600, L89.601, L89.602, L89.603, L89.604, L89.606, L89.609, L89.610, L89.611, L89.612, L89.613, L89.614, L89.616, L89.619, L89.620, L89.621, L89.622, L89.623, L89.624, L89.626, L89.629, L89.810, L89.811, L89.812, L89.813, L89.814, L89.816, L89.819, L89.890, L89.891, L89.892, L89.893, L89.894, L89.896, L89.899, L89.90, L89.91, L89.92, L89.93, L89.94, L89.95, L89.96, M62.50, M62.81, M62.84, R26.0, R26.1, R26.2, R26.89, R26.9, R41.81, R53.1, R53.81, R53.83, R54, R62.7, R63.4, R63.6, R64, W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS, Y92.199, Z59.3, Z73.6, Z74.01, Z74.09, Z74.1, Z74.2, Z74.3, Z74.8, Z74.9, Z91.81, Z99.11, Z99.3, Z99.81, Z99.89

- **Codes to identify Advanced Illness:** A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C91.00, C91.02, C92.00, C92.02, C93.00, C93.02, C93.90, C93.92, C93.Z0, C93.Z2, C94.30, C94.32, F01.50, F01.51, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01.C18, F01.C2, F01.C3, F01.C4, F02.80, F02.81, F02.811, F02.818, F02.82, F02.83, F02.84, F02.A0, F02.A11, F02.A18, F02.A2, F02.A3, F02.A4, F02.B0, F02.B11, F02.B18, F02.B2, F02.B3, F02.B4, F02.C0, F02.C11, F02.C18, F02.C2, F02.C3, F02.C4, F03.90, F03.91, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A0, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, F04, F10.27, F10.96, F10.97, G10, G12.21, G20, G30.0,

G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.170, J84.178, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6

NUMERATOR:

Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following:

• Diabetic with a diagnosis of retinopathy during the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period

• Diabetic with no diagnosis of retinopathy during the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period or the year prior to the measurement period

NUMERATOR NOTE: *The eye exam must be performed or reviewed by an ophthalmologist or optometrist, or there must be evidence that fundus photography results were read by a system that provides an artificial intelligence (AI) interpretation. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.*

Numerator Options:

Performance Met:	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy **(2022F)**
OR	
Performance Met:	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy **(2023F)**
OR	
Performance Met:	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy **(2024F)**
OR	
Performance Met:	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy **(2025F)**
OR	
Performance Met:	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy **(2026F)**
OR	
Performance Met:	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy **(2033F)**
OR	
Performance Met:	Low risk for retinopathy (no evidence of retinopathy in the prior year) **(3072F)**

NOTE: *This code can only be used if the claim/encounter was during the measurement period because it indicates that the patient had "no evidence of retinopathy in the prior year". This code definition indicates*

results were negative; therefore, a result is not required.

OR

Performance Not Met:	Dilated eye exam was not performed, reason not otherwise specified **(2022F or 2024F or 2026F with 8P)**

RATIONALE:

Diabetes is the seventh leading cause of death in the United States. In 2017, diabetes affected approximately 34 million Americans (10.5 percent of the U.S. population) and killed approximately 84,000 people (Centers for Disease Control and Prevention [CDC], 2020a). Diabetes is a long-lasting disease marked by high blood glucose levels, resulting from the body's inability to produce or use insulin properly (CDC, 2020b). People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney damage, amputation of feet or legs, and premature death (CDC, 2021).

In 2017, diabetes cost the U.S. an estimated $327 billion: $237 billion in direct medical costs and $90 billion in reduced productivity. This is a 34 percent increase from the estimated $245 billion spent on diabetes in 2012 (American Diabetes Association, 2018).

Diabetic retinopathy is progressive damage to the small blood vessels in the retina that may result in loss of vision. It is the leading cause of blindness in adults between 20-74 years of age. Approximately 4.1 million adults are affected by diabetic retinopathy (CDC, 2020c).

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (2021):
- Adults with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (Level of evidence: B)
- Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist at the time of the diabetes diagnosis. (Level of evidence: B)
-If there is no evidence of retinopathy for one or more annual eye exam and glycemia is well controlled, then screening every 1–2 years may be considered. If any level of diabetic retinopathy is present, subsequent dilated retinal examinations should be repeated at least annually by an ophthalmologist or optometrist. If retinopathy is progressing or sight threatening, then examinations will be required more frequently. (Level of evidence: B)

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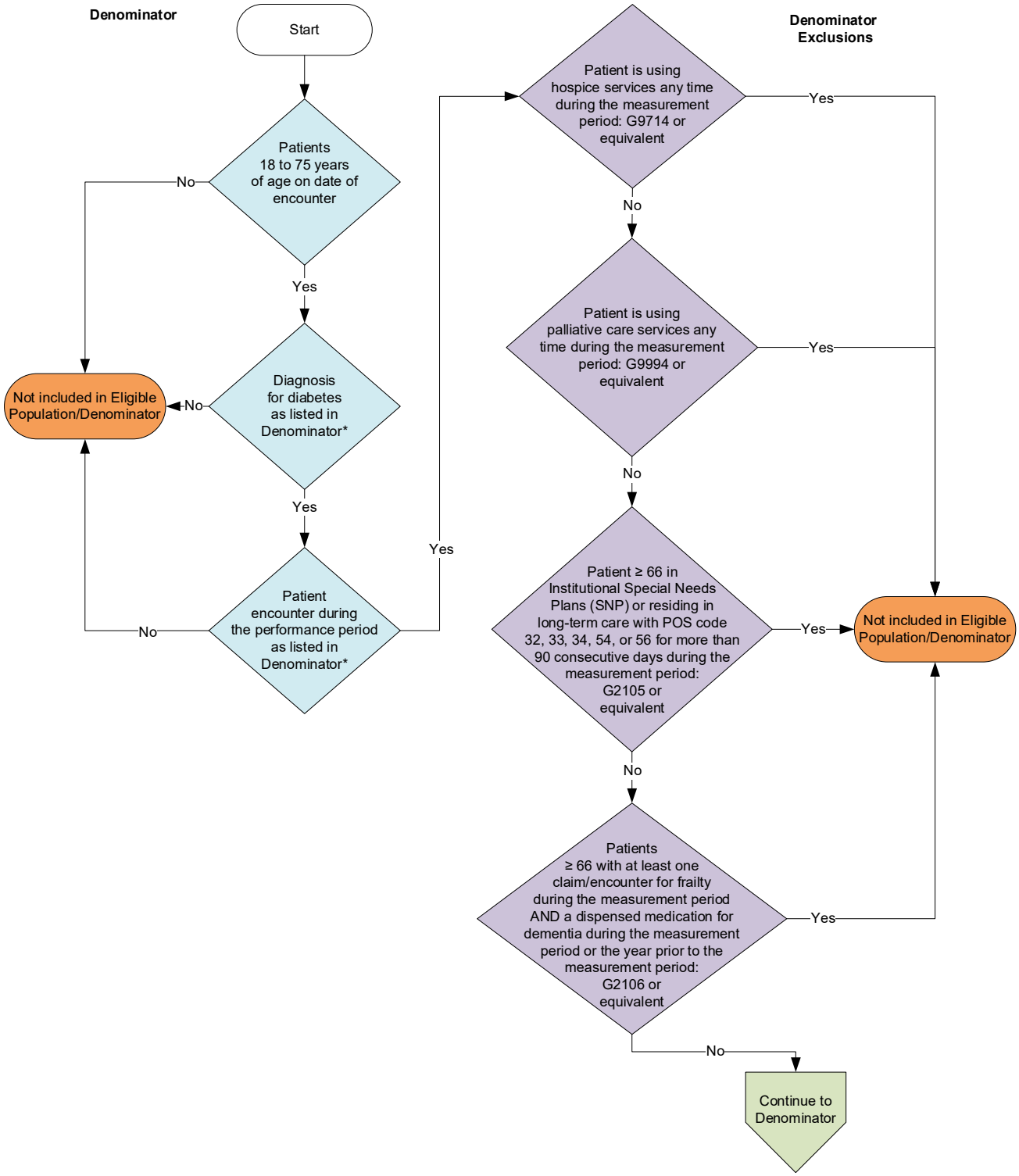
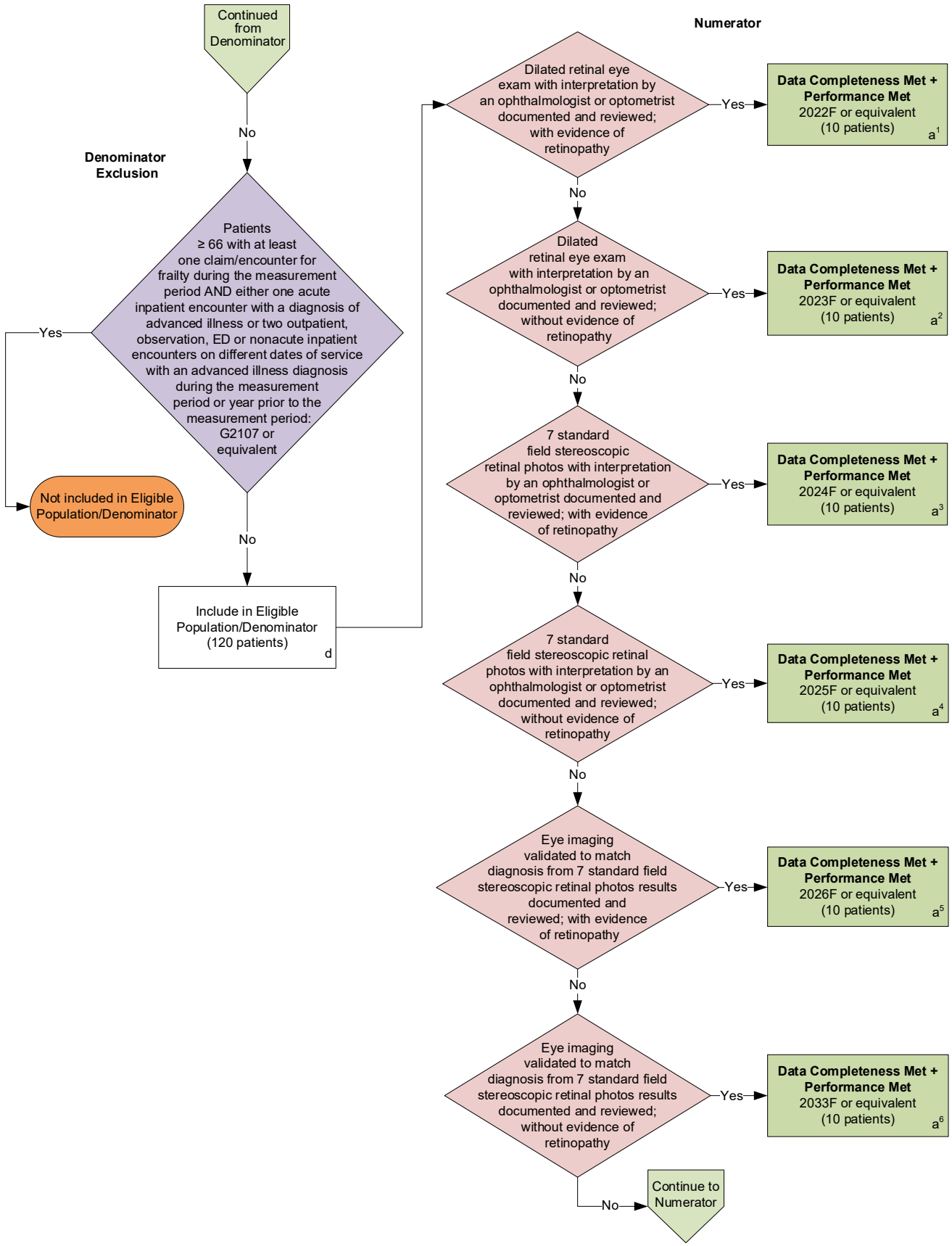
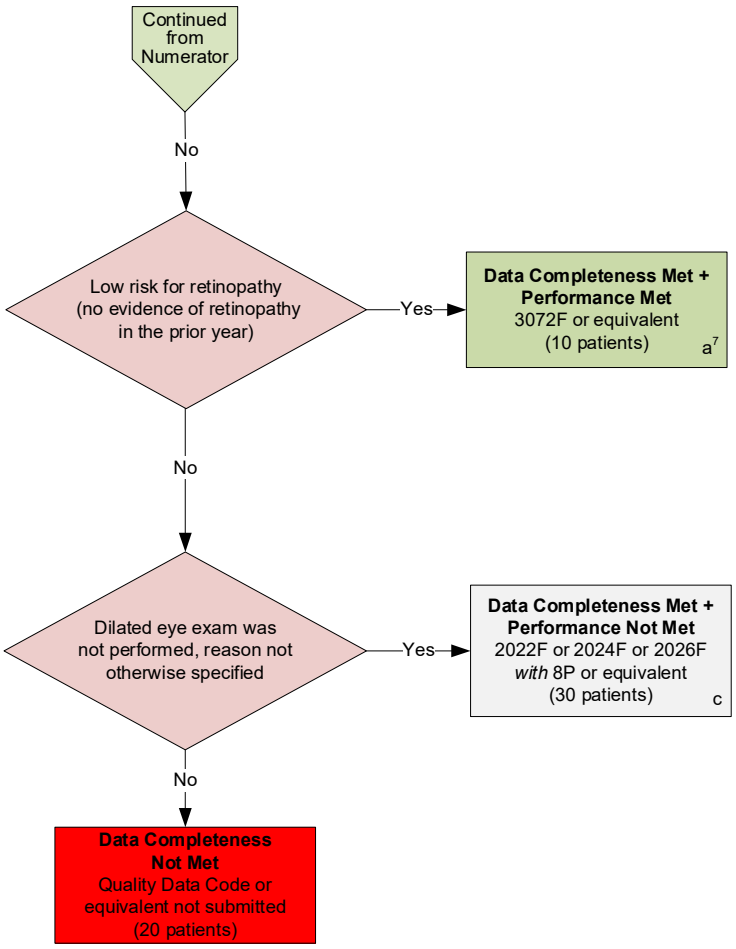
accuracy of any CPT or other codes contained in the specifications.

2023 Clinical Quality Measure Flow for Quality ID #117 (NQF 0055): Diabetes: Eye Exam

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*







SAMPLE CALCULATIONS

Data Completeness=

Performance Met ($a^1+a^2+a^3+a^4+a^5+a^6+a^7$=70 patients) + Performance Not Met (c=30 patients) = 100 patients = **83.33%**

Eligible Population / Denominator (d=120 patients) = 120 patients

Performance Rate=

Performance Met ($a^1+a^2+a^3+a^4+a^5+a^6+a^7$=70 patients) = 70 patients = **70.00%**

Data Completeness Numerator (100 patients) = 100 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

2023 Clinical Quality Measure Flow Narrative for Quality ID #117 (NQF 0055): Diabetes: Eye Exam

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients 18 to 75 years of age on date of encounter*:
    a. If *Patients 18 to 75 years of age on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients 18 to 75 years of age on date of encounter* equals Yes, proceed to check *Diagnosis for diabetes as listed in Denominator**.
3. Check *Diagnosis for diabetes as listed in Denominator**:
    a. If *Diagnosis for diabetes as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis for diabetes as listed in Denominator** equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
4. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Patient is using hospice services any time during the measurement period*.
5. Check *Patient is using hospice services any time during the measurement period*:
    a. If *Patient is using hospice services any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing
    b. If *Patient is using hospice services any time during the measurement period* equals No, proceed to check *Patient is using palliative care services any time during the measurement period*.
6. Check *Patient is using palliative care services any time during the measurement period:*
    a. If *Patient is using palliative care services any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing
    b. If *Patient is using palliative care services any time during the measurement period* equals No, proceed to check *Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period*.
7. Check *Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period*:
    a. If *Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

b. If *Patient age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period* equals No, proceed to check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period*.

8. Check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period*:

   a. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period* equals No, proceed to check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period*.

9. Check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period*:

   a. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period* equals No, include in *Eligible Population/Denominator*.

10. Denominator Population:

    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 120 patients in the Sample Calculation.

11. Start Numerator

12. Check *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy*:

    a. If *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy* equals Yes, include in *Data Completeness Met and*

Performance Met.

- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[1] equals 10 patients in the Sample Calculation.

b. If *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy* equals No, proceed to check *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy*.

13. Check *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy*.

a. If *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy* equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[2] equals 10 patients in the Sample Calculation.

b. If *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy* equals No, proceed to check *7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy*.

14. Check *7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy*:

a. If *7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy* equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[3] equals 10 patients in the Sample Calculation.

b. If *7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy* equals No, proceed to check *7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy*.

15. Check *7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy*.

a. If *7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy* equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[4] equals 10 patients in the Sample Calculation.

b. If *7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist*

documented and reviewed; without evidence of retinopathy equals No, proceed to check *Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy*.

16. Check *Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy*.

    a. If *Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[5] equals 10 patients in the Sample Calculation.

    b. If *Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy* equals No, proceed to check *Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy*.

17. Check *Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy*:

    a. If *Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy* equals Yes, include in the *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[6] equals 10 patients in the Sample Calculation.

    b. If *Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy* equals No, proceed to check *Low risk for retinopathy (no evidence of retinopathy in the prior year)*.

18. Check *Low risk for retinopathy (no evidence of retinopathy in the prior year)*:

    a. If *Low risk for retinopathy (no evidence of retinopathy in the prior year)* equals Yes, include in the *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[7] equals 10 patients in the Sample Calculation.

    b. If *Low risk for retinopathy (no evidence of retinopathy in the prior year)* equals No, proceed to check *Dilated eye exam was not performed, reason not otherwise specified*.

19. Check *Dilated eye exam was not performed, reason not otherwise specified*:

    a. If *Dilated eye exam was not performed, reason not otherwise specified* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.

b. If *Dilated eye exam was not performed, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

20. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 20 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a^1 plus a^2 plus a^3 plus a^4 plus a^5 plus a^6 plus a^7 equals 70 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population/Denominator (d equals 120 patients). All equals 100 patients divided by 120 patients. All equals 83.33 percent.

Performance Rate equals Performance Met (a^1 plus a^2 plus a^3 plus a^4 plus a^5 plus a^6 plus a^7 equals 70 patients) divided by Data Completeness Numerator (100 patients). All equals 70 patients divided by 100 patients. All equals 70.00 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if the most recent BMI was outside of normal parameters.

INSTRUCTIONS:
There is no diagnosis associated with this measure. This measure is to be submitted a minimum of **once per performance period** for patients seen 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 based on the services provided at the time of the qualifying encounter and the measure-specific denominator coding. The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above or below normal parameters" (See Definitions for examples of follow-up plan treatments). If more than one BMI is submitted during the measurement period, the most recent BMI will be used to determine if the performance has been met. Review the exclusions and exceptions criteria to determine those patients that BMI measurement may not be appropriate or necessary.

Measure 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:
All patients aged 18 and older on the date of the encounter with at least one eligible encounter during the measurement period

Definition:
Not Eligible for BMI Screening or Follow-Up Plan (Denominator Exclusions) – A patient is not eligible if one or more of the following reasons are documented:

- Patients receiving palliative or hospice care on the date of the current encounter or any time prior to the current encounter
- Patients who are pregnant on the date of the current encounter or any time during the measurement period prior to the current encounter

***DENOMINATOR NOTE*:** **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.

Denominator Criteria (Eligible Cases):
Patients aged ≥18 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97802, 97803, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99236, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99424, 99491, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447, G0473
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02, FQ, 93
WITHOUT
Place of Service (POS): 12
AND NOT
DENOMINATOR EXCLUSIONS:
Documentation stating the patient has received or is currently receiving palliative or hospice care: G9996
OR
Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter: G9997

NUMERATOR:
Patients with a documented BMI during the encounter or during the previous twelve months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the encounter

Definitions:
Normal BMI Parameters – Age 18 years and older BMI >= 18.5 and < 25 kg/m2
BMI – Body mass index (BMI) is a number calculated using the Quetelet index: weight divided by height squared (W/H2) and is commonly used to classify weight categories. "BMI" can be calculated using:

Metric Units: BMI = Weight (kg) / (Height (m) x Height (m))

OR

English Units: BMI = Weight (lbs) / (Height (in) x Height (in)) x 703

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI outside of normal parameters. A "follow-up" plan may include, but is not limited to:

- Documentation of education
- Referral (for example a Registered Dietitian Nutritionist (RDN), occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon) for lifestyle/behavioral therapy
- Pharmacological interventions
- Dietary supplements
- Exercise counseling
- Nutrition counseling

Patients with a Documented Reason for Not Screening BMI (Denominator Exception) -
Patient Reason:

- Patients who refuse measurement of height and/or weight on the date of the current encounter or any time during the measurement period prior to the current encounter

OR

Medical Reason:

- Patients with a documented medical reason for not documenting BMI such as patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Patients with a Documented Reason for Not Documenting a Follow-up Plan for BMI Outside Normal Parameters (Denominator Exception) -

Medical Reason(s):

- Patients (e.g., elderly patients 65 years of age or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as illness or physical disability, mental illness, dementia, confusion, or nutritional deficiency such as vitamin/mineral deficiency; patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Numerator Instructions:

- **Height and Weight** - An eligible clinician or their staff is required to measure both height and weight. Both height and weight must be measured within twelve months of the current encounter. Self-reported values cannot be used.
    - The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider.
    - If more than one BMI is reported during the measurement period, the most recent BMI will be used to determine if the performance has been met-.
- **Follow-Up Plan** – If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI, outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above or below normal parameters". (See Definitions for examples of follow-up plan treatments).
- **Performance Met** for **G8417** & **G8418** –
    - If the provider documents a BMI and a follow-up plan for a BMI outside normal parameters at the current encounter **OR**
    - If the patient has a documented BMI within the previous twelve months of the current encounter, the provider documents a follow-up plan for a BMI outside normal parameters at the current encounter **OR**
    - If the patient has a documented BMI within the previous twelve months of the current encounter **AND** the patient has a documented follow-up plan for a BMI outside normal parameters within the previous twelve months of the current encounter

Numerator Options:

Performance Met:	BMI is documented within normal parameters and no follow-up plan is required **(G8420)**
OR	
Performance Met:	BMI is documented as above normal parameters and a follow-up plan is documented **(G8417)**
OR	
Performance Met:	BMI is documented as below normal parameters and a follow-up plan is documented **(G8418)**

OR

Denominator Exception: BMI not documented due to medical reason OR patient refusal of height or weight measurement **(G2181)**

OR

Denominator Exception: BMI is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason **(G9716)**

OR

Performance Not Met: BMI not documented and no reason is given **(G8421)**

OR

Performance Not Met: BMI documented outside normal parameters, no follow-up plan documented, no reason given **(G8419)**

RATIONALE:

BMI Above Normal Parameters

"Obesity is a chronic, multifactorial disease with complex psychological, environmental (social and cultural), genetic, physiologic, metabolic and behavioral causes and consequences. The prevalence of overweight and obese people is increasing worldwide at an alarming rate in both developing and developed countries. Environmental and behavioral changes brought about by economic development, modernization and urbanization have been linked to the rise in global obesity. The health consequences are becoming apparent (1)."

More than a third of U.S. adults have a body mass index [BMI] >= 30 kg/m2 and are at increased risk for diabetes, cardiovascular disease (CVD), and obstructive sleep apnea (2,3, 4). Hales reported that the prevalence of obesity among adults and youth in the United States was 39.8 percent and 18.5 percent respectively, from 2015–2016. Furthermore, the prevalence of obesity in adults increased to 42.4 percent in 2018, with the highest percentage among adults in the 40–59 age bracket compared with other age groups (5). Hales also disaggregated the data according to race/ethnicity and noted that obesity prevalence was higher among non-Hispanic Black adults and Hispanic adults when compared with other races and ethnicities. Obesity prevalence was lowest among non-Hispanic Asian men and women. Among men, obesity prevalence was higher among Hispanic men compared with non-Hispanic Black men and non-Hispanic White men. Obesity prevalence was higher among Hispanic men compared with non-Hispanic Black men. Among women, the prevalence among non-Hispanic Black women was 56.9 percent, which was higher than all other race/ethnicities. In general, the prevalence of obesity in the U.S. remains higher than the Healthy People 2020 goal of 30.5 percent among adults (6).

BMI continues to be a common and reasonably reliable measurement to identify overweight and obese adults who may be at an increased risk for future morbidity. Although good quality evidence supports obtaining a BMI, it is important to recognize it is not a perfect measurement. For example, BMI and its associated disease and mortality risk appear to vary among ethnic subgroups. Black/African Americans appear to have the lowest mortality risk at a BMI of 26.2-28.5 kg/m2 in Black women and 27.1-30.2 kg/m2 in Black men. In contrast, Asian populations may experience lowest mortality rates starting at a BMI of 23 to 24 kg/m2. The correlation between BMI and diabetes risk also varies by ethnicity (7). Moreover, BMI is not a direct measure of adiposity and as a consequence, it can over or underestimate adiposity. However, overall, BMI is a derived value that correlates well with total body fat and markers of secondary complications, e.g., hypertension and dyslipidemia (8).

Furthermore, it is important to enhance beneficiary access to appropriate treatments for obesity, which could result in decreased healthcare costs and lower obesity rates. Behavioral weight management treatment has been identified as an effective first-line treatment for obesity with an average initial weight loss of 8-10 percent. This percentage weight loss is associated with a significant risk reduction for diabetes and CVD (9). Evidence also shows that when provided 14 or more high-intensity behavioral intervention sessions of face-to-face individual or group treatment across 6 months, participants lose up to 8 percent of their weight during that time and experience improvements in heart disease risk factors and quality of life (10). There is also evidence that high-intensity behavioral counseling is effective, whether delivered in-person, by phone, or electronically (11). Moreover,

Intensive Behavioral Therapy (IBT) for obesity provided by Registered Dietitian Nutritionists for 6-12 months shows significant mean weight loss of up to 10 percent of body weight, maintained over one year's time (12). Despite the evidence that supports weight management counseling, the rate of use in primary care for patients with obesity decreased by 10 percent from 39.9 percent in 1995-1996 to 29.9 percent in 2007-2008 (13). Weight management counseling during primary care visits further declined from 33 percent to 21 percent between 2008-2009 and 2012-2013. This suggests that obesity management in primary care remains suboptimal (14).

Therefore, screening for BMI and follow-up is critical and will help in reaching the quality goals of population health and cost reduction. However, due to concerns for other underlying conditions (such as bone health) or nutrition related deficiencies providers are cautioned to use their best clinical judgment and when considering weight management programs for overweight patients, especially the elderly (15).

BMI Below Normal Parameters

On the other end of the body weight spectrum is underweight (BMI <18.5 kg/m2), which is equally detrimental to population health. When compared to normal weight individuals (BMI 18.5-25 kg/m2), underweight individuals have significantly higher death rates with a Hazard Ratio of 2.27 and 95 percent confidence intervals (CI) = 1.78, 2.90 (16).

Poor nutrition or underlying health conditions can result in underweight (17). The National Health and Nutrition Examination Survey (NHANES) results from 2007-2010 indicate that women are more likely to be underweight than men (18). However, all patients should be equally screened for underweight and followed up with nutritional counseling to reduce mortality and morbidity associated with underweight.

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CLINICAL RECOMMENDATION STATEMENTS:

All adults should be screened annually using a BMI measurement. BMI measurements ≥25kg/m2 should be used to initiate further evaluation of overweight or obesity after taking into account age, gender, ethnicity, fluid status, and muscularity; therefore, clinical evaluation and judgment must be used when BMI is employed as the anthropometric indicator of excess adiposity, particularly in athletes and those with sarcopenia (1) (Grade A).

Overweight and Underweight Categories:
Underweight <18.5; Normal weight 18.5-24.9; Overweight 25-29.9; Obese class I 30-34.9; Obese class II 35-39.9; Obese class III ≥40 (1).

BMI cutoff point value of ≥23 kg/m2 should be used in the screening and confirmation of excess adiposity in Asian adults (1) (Grade B).

Lifestyle/Behavioral Therapy for Overweight and Obesity should include behavioral interventions that enhance adherence to prescriptions for a reduced-calorie meal plan and increased physical activity (behavioral interventions can include: self-monitoring of weight, food intake, and physical activity; clear and reasonable goal-setting; education pertaining to obesity, nutrition, and physical activity; face-to-face and group meetings; stimulus control; systematic approaches for problem solving; stress reduction; cognitive restructuring [i.e., cognitive behavioral therapy], motivational interviewing; behavioral contracting; psychological counseling; and mobilization of social support structures) (1) (Grade A).

Behavioral lifestyle intervention should be tailored to a patient's ethnic, cultural, socioeconomic, and educational background (1) (Grade B).

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians offer or refer adults with a BMI of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.
Interventions:

- Effective intensive behavioral interventions were designed to help participants achieve or maintain a weight loss of at least five percent through a combination of dietary changes and increased physical activity

- Most interventions lasted for one to two years, and the majority had at least 12 sessions in the first year
- Most behavioral interventions focused on problem solving to identify barriers, self-monitoring of weight, peer support, and relapse prevention
- Interventions also provided tools to support weight loss or weight loss maintenance (e.g., pedometers, food scales, or exercise videos) (Grade B) (2).

Nutritional safety for the elderly should be considered when recommending weight reduction. "A clinical decision to forego obesity treatment in older adults should be guided by an evaluation of the potential benefits of weight reduction for day-to-day functioning and reduction of the risk of future cardiovascular events, as well as the patient's motivation for weight reduction. Care must be taken to ensure that any weight reduction program minimizes the likelihood of adverse effects on bone health or other aspects of nutritional status" (3) (Evidence Category D). In addition, weight reduction prescriptions in older persons should be accompanied by proper nutritional counseling and regular body weight monitoring (3).

The possibility that a standard approach to weight loss will work differently in diverse patient populations must be considered when setting expectations about treatment outcomes (3) (Evidence Category B).

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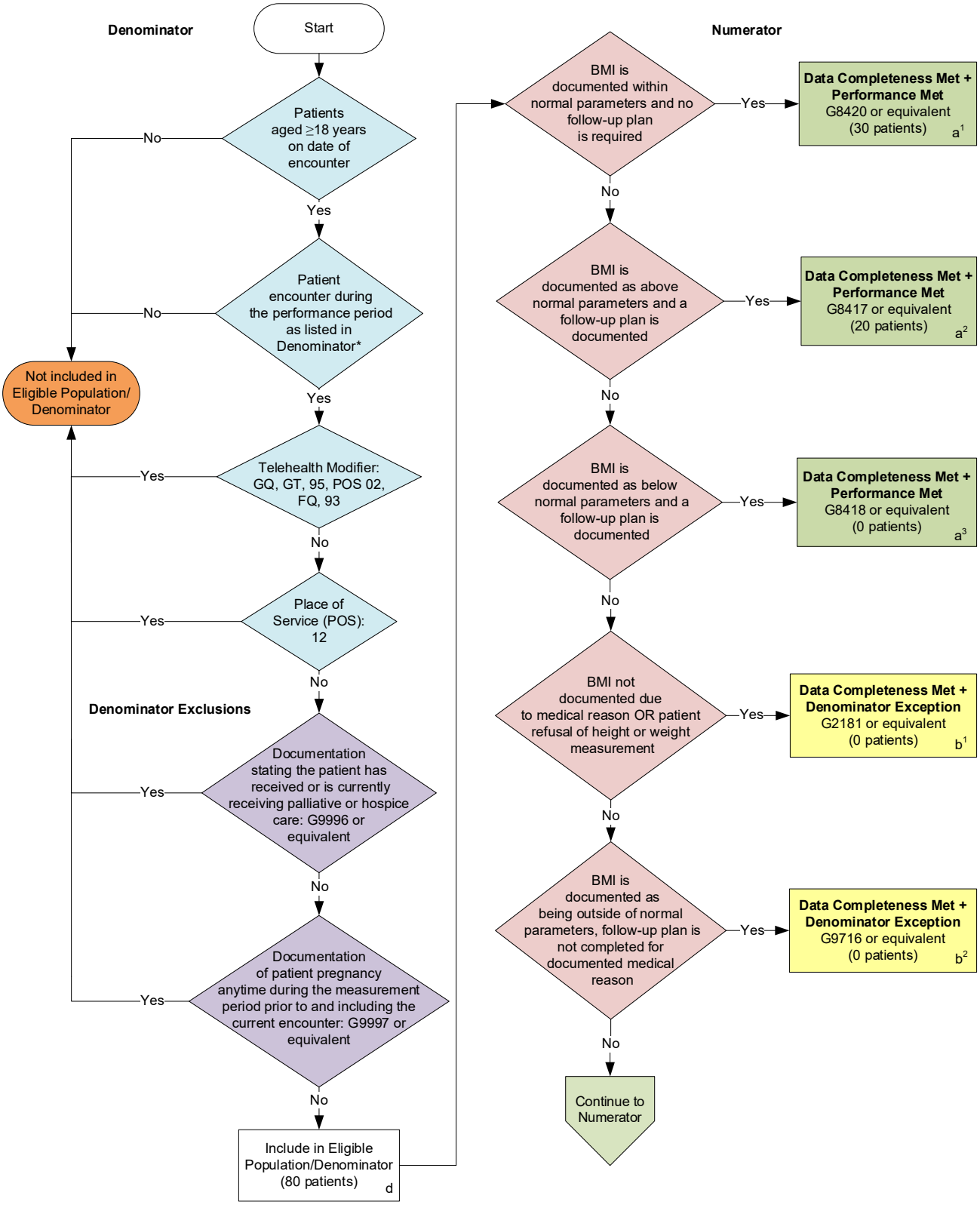
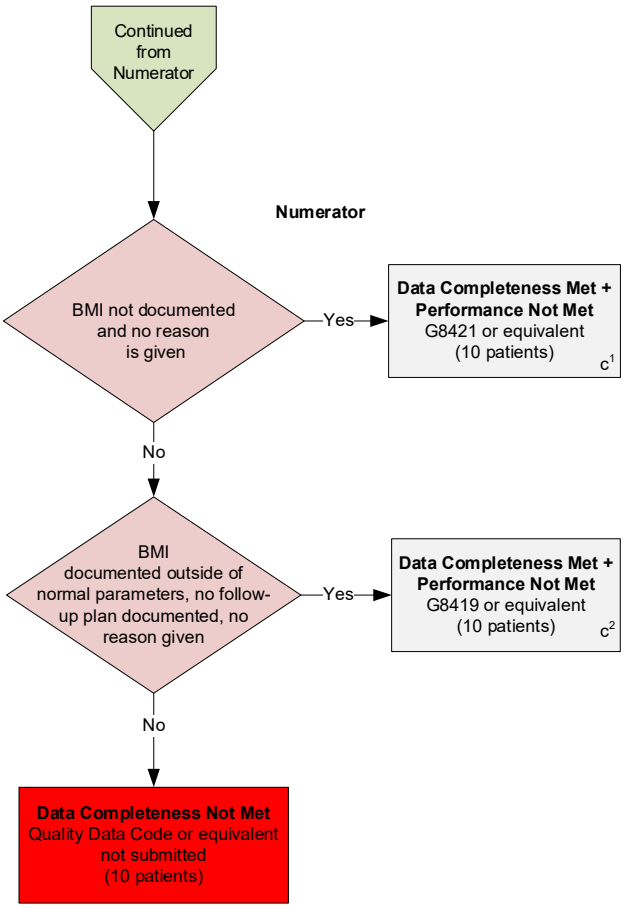
2023 Clinical Quality Measure Flow for Quality ID #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*





SAMPLE CALCULATIONS

Data Completeness=

Performance Met ($a^1+a^2+a^3$=50 patients) + Denominator Exception (b^1+b^2=0 patients) + Performance Not Met (c^1+c^2=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met ($a^1+a^2+a^3$=50 patients) = 50 patients = **71.43%**

Data Completeness Numerator (70 patients) – Denominator Exception (b^1+b^2=0 patients) = 70 patients

* See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Intermediate
NOTE: Telehealth modifiers **include but are not limited to**: GQ, GT, 95, POS 02, FQ, 93

2023 Clinical Quality Measure Flow Narrative for Quality ID #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years on date of encounter*:
    a. If *Patients aged greater than or equal to 18 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years on date of encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Telehealth Modifier*.
4. Check *Telehealth Modifier*:
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, proceed to check *Place of Service (POS).*
5. Check *Place of Service (POS):*
    a. If *Place of Service (POS)* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Place of Service (POS)* equals No, proceed to check *Documentation stating the patient has received or is currently receiving palliative or hospice care.*
6. Check *Documentation stating the patient has received or is currently receiving palliative or hospice care:*
    a. If *Documentation stating the patient has received or is currently receiving palliative or hospice care* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Documentation stating the patient has received or is currently receiving palliative or hospice care* equals No, proceed to check *Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter.*
7. Check *Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter*:
    a. If *Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.
    b. If *Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter* equals No, include in *Eligible Population/Denominator*.
8. Denominator Population

- Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.

9. Start Numerator

10. Check *BMI is documented within normal parameters and no follow-up plan is required:*

    a. If *BMI is documented within normal parameters and no follow-up plan is required* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 30 patients in Sample Calculation.

    b. If *BMI is documented within normal parameters and no follow-up plan is required* equals No, proceed to check *BMI is documented as above normal parameters and a follow-up plan is documented.*

11. Check *BMI is documented as above normal parameters and a follow-up plan is documented:*

    a. If *BMI is documented as above normal parameters and a follow-up plan is documented* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 20 patients in the Sample Calculation.

    b. If *BMI is documented as above normal parameters and a follow-up plan is documented* equals No, proceed to check *BMI is documented as below normal parameters and a follow-up plan is documented.*

12. Check *BMI is documented as below normal parameters and a follow-up plan is documented:*

    a. If *BMI is documented as below normal parameters and a follow-up plan is documented* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^3 equals 0 patients in the Sample Calculation.

    b. If *BMI is documented as below normal parameters and a follow-up plan is documented* equals No, proceed to check *BMI not documented due to medical reason OR patient refusal of height or weight measurement.*

13. Check *BMI not documented due to medical reason OR patient refusal of height or weight measurement:*

    a. If *BMI not documented due to medical reason OR patient refusal of height or weight measurement* equals Yes, include in *Data Completeness Met and Denominator Exception.*

        - *Data Completeness Met and Denominator Exception* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 0 patients in the Sample Calculation.

    b. If *BMI not documented due to medical reason OR patient refusal of height or weight measurement* equals No, proceed to check *BMI is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason.*

14. Check *BMI is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason:*

    a. If *BMI is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 0 patients in the Sample Calculation.

    b. If *BMI is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason* equals No, proceed to check *BMI not documented and no reason is given*.

15. Check *BMI not documented and no reason is given:*

    a. If *BMI not documented and no reason is given* equals Yes, include in *Data Completeness Met and Performance Not Met*

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

    b. If *BMI not documented and no reason is given* equals No, proceed to check *BMI documented outside of normal parameters, no follow-up plan documented, no reason given.*

16. Check *BMI documented outside of normal parameters, no follow-up plan documented, no reason given*:

    a. If *BMI documented outside of normal parameters, no follow-up plan documented, no reason given* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    b. If *BMI documented outside of normal parameters, no follow-up plan documented, no reason given* equals No, proceed to check *Data Completeness Not Met.*

17. Check *Data Completeness Not Met:*

        - If *Data Completeness Not Met,* Quality Data Code or equivalent not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a^1 plus a^2 plus a^3 equals 50 patients) plus Denominator Exception (b^1 plus b^2 equals 0 patients) plus Performance Not Met (c^1 plus c^2 equals 20 patients) divided by Eligible Population / Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 plus a^2 plus a^3 equals 50 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b^1 plus b^2 equals 0 patients). All equals 50 patients divided by 70 patients. All equals 71.43 percent.

* See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Intermediate

NOTE: Telehealth modifiers **include but are not limited to**: GQ, GT, 95, POS 02, FQ, 93

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #130: Documentation of Current Medications in the Medical Record

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter.

INSTRUCTIONS:
This measure is to be submitted at **each denominator eligible visit** during the 12-month performance period. Merit-based Incentive Payment System (MIPS) eligible clinicians meet the intent of this measure by making their best effort to document a current, complete and accurate medication list during each encounter. There is no diagnosis associated with this measure. This measure may be submitted by MIPS eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

Measure 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:
All visits occurring during the 12-month measurement period for patients aged 18 years and older

> ***DENOMINATOR NOTE*****:** **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.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Patient encounter during the performance period (CPT or HCPCS):** 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 90839, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92548, 92550, 92557, 92567, 92568, 92570, 92588, 92626, 96116, 96156, 96158, 97129, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 98960, 98961, 98962, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99236, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99424, 99491, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

NUMERATOR:

Eligible clinician attests to documenting, updating, or reviewing the patient's current medications using all immediate resources available on the date of the encounter

Definitions:

Current Medications – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals, vitamins, minerals, dietary (nutritional) supplements, and cannabis/cannabidiol products with each medication's name, dosage, frequency and administered route.

Route – Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical).

Not Eligible (Denominator Exception) – A patient is "not eligible" if there is documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status).

NUMERATOR NOTE: *The MIPS eligible clinician must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. MIPS eligible clinicians submitting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.*

*This list **must** include ALL known prescriptions, over-the-counter (OTC) products, herbals, vitamins, minerals, dietary (nutritional) supplements, cannabis/cannabidiol products AND **must** contain the medications' name, dosage, frequency and route of administration.*

*By submitting the action described in this measure, the provider attests to having documented a list of current medications utilizing all immediate resources available at the time of the encounter. **G8427** should be submitted if the MIPS eligible clinician documented that the patient is not currently taking any medications.*

Numerator Options:

Performance Met:	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications **(G8427)**
OR	
Denominator Exception:	Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation) **(G8430)**
OR	
Performance Not Met:	Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given **(G8428)**

RATIONALE:

According to the National Center for Health Statistics, during the years of 2013-2016, 48.4% of patients (both male and female) were prescribed at least one prescription medication with 12.6% taking 5 or more medications. Additionally, 89.8% of patients (both male and female) aged 65 years and older were prescribed at least one medication with 40.9% taking 5 or more medications [1]. In this context, maintaining an accurate and complete medication list has proven to be a challenging documentation endeavor for various health care provider settings. While most of outpatient encounters (two-thirds) result in providers prescribing at least one medication, hospitals have been the focus of medication safety efforts [2]. Nassaralla, Naessens, Chaudhry, Hansen, and Scheitel (2007) caution that this is at odds with the current trend, where patients with chronic illnesses are increasingly being treated in the outpatient setting and require careful monitoring of multiple medications. Additionally, Nassaralla et al. (2007) reveal that it is in fact in outpatient settings where more fatal adverse drug events (ADE) occur when these are compared to those occurring in hospitals (1 of 131 outpatient deaths compared to 1 in 854 inpatient deaths) [3]. In the outpatient setting, ADEs occur 25% of the time and over one-third of these are considered preventable [4].

Particularly vulnerable are patients over 65 years, with evidence suggesting that the rate of ADEs per 10,000 person per year increases with age; 25-44 years old at 1.3; 45-64 at 2.2, and 65 + at 3.8 [5]. Other vulnerable groups include individuals who are chronically ill or disabled [6]. These population groups are more likely to experience ADEs and subsequent hospitalization.

A multiplicity of providers and inadequate care coordination among them has been identified as barriers to collecting complete and reliable medication records. A study conducted by Poornima et al. (2015) indicates that reconciliation and documentation continue to be poorly executed with discrepancies occurring in 92% of medication lists among admittance to the emergency room (74 of 80 patients). Of 80 patients included in the study, the home medications were re ordered for 65% of patients on their admission and of the 65% the majority (29%) had a change in their dosing interval, while 23% had a change in their route of administration, and 13% had a change in dose. A total of 361 medication discrepancies, or the difference between the medications patients were taking before admission and those listed in their admission orders, were identified in at least 74 patients. The study found that "Through an appropriate reconciliation programme, around 80% of errors relating to medication and the potential harm caused by these errors could be reduced" [7]. Presley et al. (2020) also recognized specific barriers to sufficient medication documentation and reconciliation in rural and resource-limited care settings [8].

Documentation of current medications in the medical record facilitates the process of medication review and reconciliation by the provider, which is necessary for reducing ADEs and promoting medication safety. The need for provider to provider coordination regarding medication records, and the existing gap in implementation, is highlighted in the American Medical Association's Physician's Role in Medication Reconciliation, which states that "critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes"]9]. This is because clinical decisions based on information that is incomplete and/or inaccurate are likely to lead to medication error and ADEs. Weeks, Corbette, & Stream (2010) noted similar barriers and identified the utilization of health information technology as an opportunity for facilitating the creation of universal medication lists [10].

One 2015 meta-analysis showed an association between EHR documentation with an overall RR of 0.46 (95% CI = 0.38 to 0.55; P < 0.001) and ADEs with an overall RR of 0.66 (95% CI = 0.44 to 0.99; P = 0.045). This meta-analysis provides evidence that the use of the EHR can improve the quality of healthcare delivered to patients by reducing medication errors and ADEs [11].

References:

1. National Center for Health Statistics. (2018). Health, United States, 2018: Supplementary Table 38. Prescription drug use in the past 30 days, by sex, race and Hispanic origin, and age: United States, selected years 1988–1994 through 2013–2016 Retrieved from https://www.cdc.gov/nchs/data/hus/2018/038.pdf
2. Stock, R., Scott, J., & Gurtel, S. (2009). Using an electronic prescribing system to ensure accurate medication lists in a large multidisciplinary medical group. *The Joint Commission Journal on Quality and Patient Safety*, 35(5), 271-277
3. Nassaralla, C. L., Naessens, J. M., Chaudhry, R., Hansen, M. A., & Scheitel, S. M. (2007). Implementation of a medication reconciliation process in an ambulatory internal medicine clinic. *Quality and Safety in Health Care*, 16(2), 90-94. http://doi.org/10.1136/qshc.2006.021113
4. Tache, S. V., Sonnichsen, A., & Ashcroft, D. M. (2011). Prevalence of adverse drug events in ambulatory care: A systematic review. *The Annals of Pharmacotherapy*, 45(7-8), 977-989. http://doi.org/10.1345/aph.1P627'
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6. Nabhanizadeh, A., Oppewal, A., Boot, F. H., & Maes-Festen, D. (2019). Effectiveness of medication reviews in identifying and reducing medication-related problems among people with intellectual disabilities: A systematic review. *Journal of Applied Research in Intellectual Disabilities*, 32(4), 750–761. https://doi.org/10.1111/jar.12580
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VA-MARQUIS). *American Journal of Health-System Pharmacy*, 77, 128-137. https://doi.org/10.1093/ajhp/zxz275
9. American Medical Association. (2007). The physician's role in medication reconciliation: Issues, strategies, and safety principles. Retrieved from https://pogoe.org/sites/default/files/Medication%20Reconciliation.pdf
10. Weeks, D. L., Corbette, C. F., & Stream, G. (2010). Beliefs of ambulatory care physicians about accuracy of patient medication records and technology-enhanced solutions to improve accuracy. *Journal for Healthcare Quality*, 32(5), 12-21. http://doi.org/10.1111/j.1945-1474.2010.00097.x
11. Campanella, P., Lovato, E., Marone, C., Fallacara, L., Mancuso, A., Ricciardi, W., & Specchia, M. L. (2016). The impact of electronic health records on health care quality: A systematic review and meta-analysis. *European Journal of Public Health,* 26(1), 60-64. https://doi.org/10.1093/eurpub/ckv122

CLINICAL RECOMMENDATION STATEMENTS:

The Joint Commission's 2020 Ambulatory Health Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section "Use Medicines Safely NPSG.03.06.01" states the following: "Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take.. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor." [1]

The National Quality Forum's Safe Practices for Better Healthcare - 2010 Update, states the following: "the healthcare organization must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care" [2].

References:

1. The Joint Commission. (2020). Ambulatory Health Care National Patient Safety Goals. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2020/simplified_2020-ahc-npsg-eff-july-final.pdf
2. National Quality Forum. (2010). Safe practices for better healthcare - 2010 update. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2020/simplified_2020-ahc-npsg-eff-july-final.pdf

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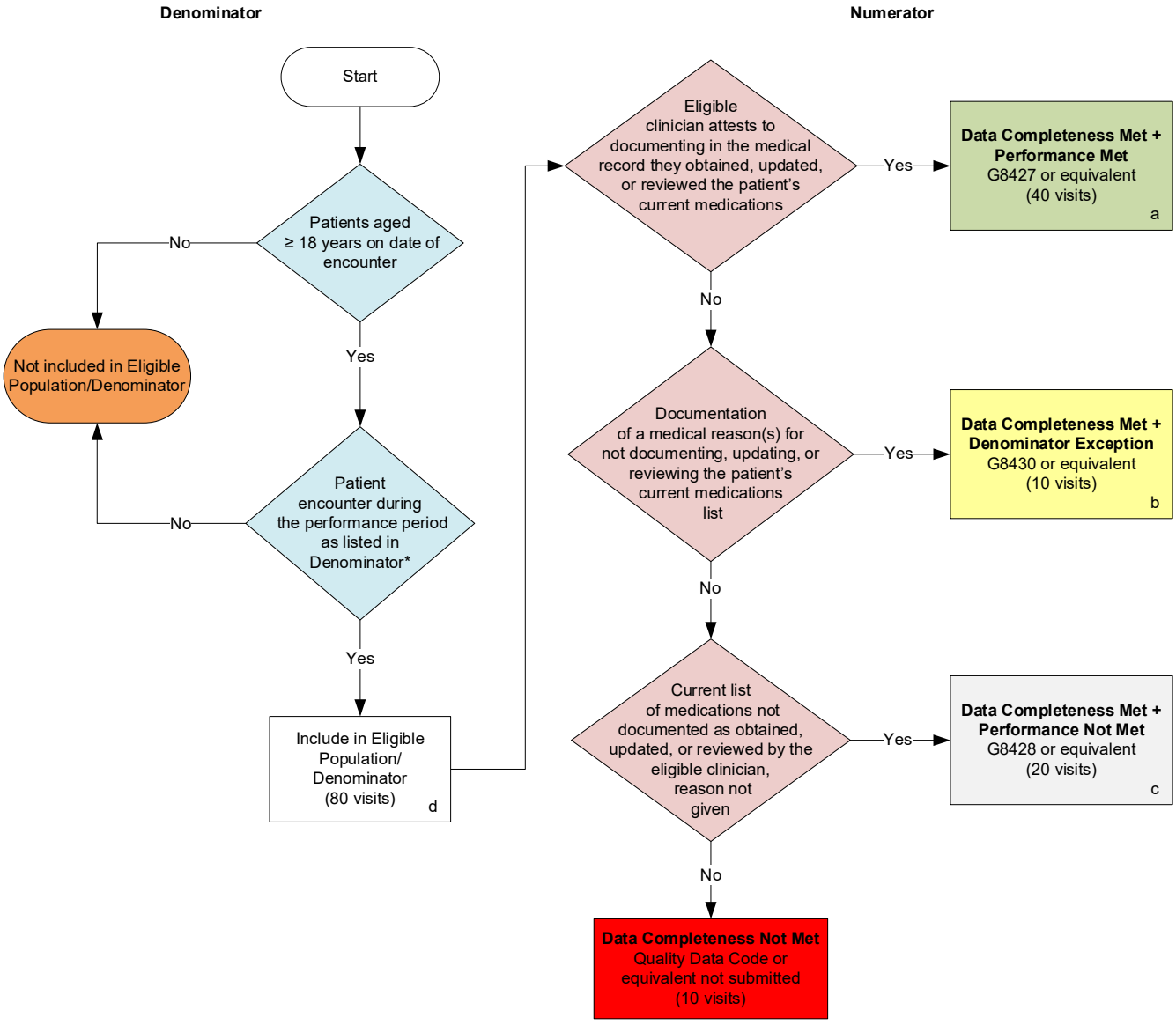
Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.

2023 Clinical Quality Measure Flow for Quality ID #130: Documentation of Current Medications in the Medical Record

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 visits) + Denominator Exception (b=10 visits) + Performance Not Met (c=20 visits) = 70 visits = **87.50%**

Eligible Population / Denominator (d=80 visits) = 80 visits

Performance Rate=

Performance Met (a=40 visits) = 40 visits = **66.67%**

Data Completeness Numerator (70 visits) – Denominator Exception (b=10 visits) = 60 visits

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Visit

2023 Clinical Quality Measure Flow Narrative For Quality ID #130: Documentation of Current Medications in the Medical Record

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years on date of encounter*:
    a. If *Patients aged greater than or equal to 18 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years on date of encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator*.*
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Denominator Population:
    - Denominator Population is all Eligible Visits in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 visits in the Sample Calculation.
5. Start Numerator
6. Check *Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications*:
    a. If *Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications* equals Yes, include in *Data Completeness Met and Performance Met.*
        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 visits in the Sample Calculation.
    b. If *Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications* equals No, proceed to check *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list*.
7. Check *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list*:
    a. If *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list* equals Yes, include in *Data Completeness Met and Denominator Exception*.
        - *Data Completeness Met and Denominator Exception* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 10 visits in the Sample Calculation.
    b. If *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list* equals No, proceed to check *Current list of medications not documented as obtained, updated,*

or reviewed by the eligible clinician, reason not given.

8. Check *Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given*:

    a. If *Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met.*

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 20 visits in the Sample Calculation

    b. If *Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given* equals No, proceed to check *Data Completeness Not Met*.

9. Check *Data Completeness Not Met*:

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 visits have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 40 visits) plus Denominator Exception (b equals 10 visits) plus Performance Not Met (c equals 20 visits) divided by Eligible Population / Denominator (d equals 80 visits). All equals 70 visits divided by 80 visits. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 visits) divided by Data Completeness Numerator (70 visits) minus Denominator Exception (b equals 10 visits). All equals 40 visits divided by 60 visits. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Visit

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #137: Melanoma: Continuity of Care – Recall System

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Structure – High Priority

DESCRIPTION:
Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical skin exam, AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients with a current diagnosis of melanoma or a history of melanoma seen during the performance period. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians providing care for patients with melanoma or a history of melanoma will submit this measure.

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

Measure 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:
All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma

> ***DENOMINATOR NOTE:*** **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.*
>
> **Denominator Criteria (Eligible Cases):**
> **Diagnosis for melanoma or history of melanoma (ICD-10-CM):** C43.0, C43.10, C43.111, C43.112, C43.121, C43.122, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.111, D03.112, D03.121, D03.122, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, Z85.820, Z86.006
> **AND**
> **Patient encounter during the performance period (CPT):** 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99424, 99426

NUMERATOR:
Patients whose information is entered, at least once within a 12 month period, into a recall system that includes:

A target date for the next complete physical exam AND
A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

Numerator Instructions:
To satisfy this measure, the recall system must be linked to a process to notify patients when their next physical exam is due, and to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment and must include the following elements at a minimum: patient identifier, patient contact information, cancer diagnosis(es), date(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam.

NUMERATOR NOTE: *For Denominator Exception(s), patients are ineligible for this measure if at the time of encounter there are system reason(s) for not entering the patient's information into a recall system (e.g. melanoma is being monitored by another physician provider).*

Numerator Options:

Performance Met:	Patient information entered into a recall system that includes: target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments **(7010F)**
OR	
Denominator Exception:	Documentation of system reason(s) for not entering patient's information into a recall system (e.g., melanoma being monitored by another physician provider) **(7010F *with* 3P)**
OR	
Performance Not Met:	Recall system not utilized, reason not otherwise specified **(7010F *with* 8P)**

RATIONALE:
Lack of follow-up with providers is noted in the Institute of Medicine (IOM) report on patient errors. Follow-up for skin examination and surveillance is an important aspect in the management of patients with a current diagnosis or a history of melanoma. The presence of a recall system, whether it is electronic or paper based, enables providers to ensure that patients receive follow-up appointments in accordance with their individual needs.

CLINICAL RECOMMENDATION STATEMENTS:
Skin examination and surveillance at least once a year for life is recommended for all melanoma patients, including those with stage 0, in situ melanoma. Clinicians should educate all patients about post-treatment monthly self-exam of their skin and of their lymph nodes if they had stage 1A to IV melanoma. Specific signs or symptoms are indications for additional radiologic imaging. (NCCN, 2011)

No clear data regarding follow-up interval exists, but at least annual history and physical examination with attention to the skin and lymph nodes is recommended. (AAD, 2011)

Regular clinical follow-up and interval patient self-exam of skin and regional lymph nodes are the most important means of detecting recurrent disease or new primary melanoma; findings from history and physical exam should direct the need for further studies to detect local, regional, and distant metastasis. (AAD, 2011)

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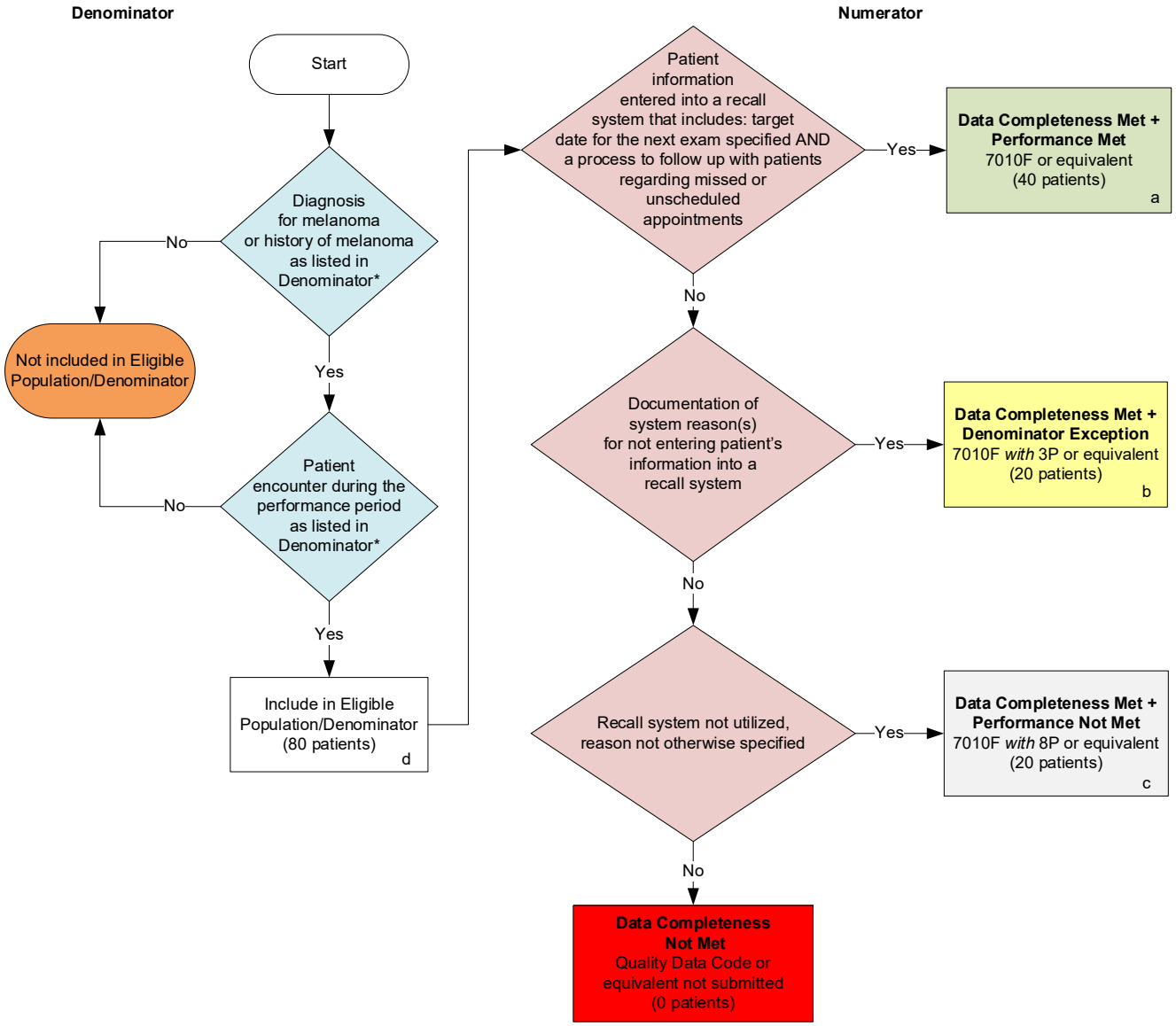
2023 Clinical Quality Measure Flow for Quality ID #137: Melanoma: Continuity of Care – Recall System

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 patients) + Denominator Exception (b=20 patients) + Performance Not Met (c=20 patients) = 80 patients = **100.00%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (80 patients) – Denominator Exception (b=20 patients) = 60 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

2023 Clinical Quality Measure Flow Narrative for Quality ID #137: Melanoma: Continuity of Care – Recall System

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Diagnosis for melanoma or history of melanoma as listed in Denominator**:
    a. If *Diagnosis for melanoma or history of melanoma as listed in Denominator** equals No, do not include in *Eligible Population/Denominator.* Stop processing.
    b. If *Diagnosis for melanoma or history of melanoma as listed in Denominator** equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
5. Start Numerator
6. Check *Patient information entered into a recall system that includes: target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments*:
    a. If *Patient information entered into a recall system that includes: target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in the Sample Calculation.
    b. If *Patient information entered into a recall system that includes: target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments* equals No, proceed to check *Documentation of system reason(s) for not entering patient's information into a recall system*.
7. Check *Documentation of system reason(s) for not entering patient's information into a recall system*:
    a. If *Documentation of system reason(s) for not entering patient's information into a recall system* equals Yes, include in *Data Completeness Met and Denominator Exception*.
        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 20 patients in the Sample Calculation.

b. If *Documentation of system reason(s) for not entering patient's information into a recall system* equals No, proceed to check *Recall system not utilized, reason not otherwise specified*.

8. Check *Recall System not utilized, reason not otherwise specified*:

    a. If *Recall system not utilized, reason not otherwise specified* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 20 patients in the Sample Calculation.

    b. If *Recall system not utilized, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

9. Check *Data Completeness Not Met*:

        - *If Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 0 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a equals 40 patients) plus Denominator Exception (b equals 20 patients) plus Performance Not Met (c equals 20 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 80 patients divided by 80 patients. All equals 100.00 percent.

Performance Rate equals Performance Met (a equals 40 patients) divided by Data Completeness Numerator (80 patients) minus Denominator Exception (b equals 20 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #138: Melanoma: Coordination of Care

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patient visits, regardless of age, with a new occurrence of melanoma that have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.

INSTRUCTIONS:
This measure is to be submitted at **each denominator eligible visit** occurring during the performance period ending November 30th for melanoma patients seen during the performance period. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians providing care for patients with melanoma will submit this measure.

Measure 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.

THERE ARE TWO SUBMISSION CRITERIA FOR THIS MEASURE:

1) All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma during excision of malignant lesion

OR

2) All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma evaluated in an outpatient setting

SUBMISSION CRITERIA 1: ALL VISITS FOR PATIENTS, REGARDLESS OF AGE, DIAGNOSED WITH A NEW OCCURRENCE OF MELANOMA DURING EXCISION OF MALIGNANT LESION

DENOMINATOR (SUBMISSION CRITERIA 1):
All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

DENOMINATOR NOTE: *The diagnosis of melanoma does not need to be present on the date of excision. This diagnosis would need to be attributed to the procedure in order to be considered denominator eligible.*

Denominator Criteria (Eligible Cases) 1:
Diagnosis for melanoma (ICD-10-CM): C43.0, C43.10, C43.111, C43.112, C43.121, C43.122, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.111, D03.112, D03.121, D03.122, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
AND

Patient encounter for excision of malignant melanoma (CPT): 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646, 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14301, 17311, 17313
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02

NUMERATOR (SUBMISSION CRITERIA 1):
Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Definition:
Communication – "Communication" may include: documentation in the medical record that the physician(s) treating the melanoma communicated (e.g., verbally, by letter, copy of treatment plan sent) with the physician(s) providing the continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma.

Numerator Instructions:
A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

NUMERATOR NOTE: *For Denominator Exception(s), patients are ineligible for this measure if at the time of encounter there are patient or system reason(s) for not communicating the treatment plan (e.g. patient asks for treatment plan not to be communicated or patient does not have a Primary Care or referring Physician).*

Numerator Options:

Performance Met:	Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis **(5050F)**
OR	
Denominator Exception:	Documentation of patient reason(s) for not communicating treatment plan (e.g., patient asks that treatment plan not be communicated to the physician(s) providing continuing care) **(5050F *with* 2P)**
OR	
Denominator Exception:	Documentation of system reason(s) for not communicating treatment plan (e.g., patient does not have a primary care physician or referring physician) **(5050F *with* 3P)**
OR	
Performance Not Met:	Treatment plan not communicated, reason not otherwise specified **(5050F *with* 8P)**

OR

SUBMISSION CRITERIA 2: ALL VISITS FOR PATIENTS, REGARDLESS OF AGE, DIAGNOSED WITH A NEW OCCURRENCE OF MELANOMA EVALUATED IN AN OUTPATIENT SETTING

DENOMINATOR (SUBMISSION CRITERIA 2):
All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

DENOMINATOR NOTE: *For providers who do surveillance, pathology would have to be completed for melanoma to be diagnosed after the initial visit. The diagnosis of the melanoma can be attributed to the initial encounter in which the biopsy occurred to be eligible for this measure. If outpatient visit and excision occur in the same visit, then it would be expected that the clinician would submit measure data via submission criteria one.*

**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.

Denominator Criteria (Eligible Cases) 2:
Diagnosis for melanoma (ICD-10-CM): C43.0, C43.10, C43.111, C43.112, C43.121, C43.122, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.111, D03.112, D03.121, D03.122, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
AND
Patient encounter during the performance period (CPT): 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99424, 99426
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02

NUMERATOR (SUBMISSION CRITERIA 2):
Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Definition:
Communication – "Communication" may include: documentation in the medical record that the physician(s) treating the melanoma communicated (e.g., verbally, by letter, copy of treatment plan sent) with the physician(s) providing the continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma.

Numerator Instructions:
A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

NUMERATOR NOTE: *Denominator Exception(s), patients are ineligible for this measure if at the time of encounter there are patient or system reason(s) for not communicating the treatment plan (e.g. patient asks for treatment plan not to be communicated or patient does not have a Primary Care or referring Physician.*

Numerator Options:

Performance Met:	Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis **(5050F)**
OR	
Denominator Exception:	Documentation of patient reason(s) for not communicating treatment plan (e.g., patient asks that treatment plan not be communicated to the physician(s) providing continuing care) **(5050F *with* 2P)**
OR	
Denominator Exception:	Documentation of system reason(s) for not communicating treatment plan (e.g., patient does not have a primary care physician or referring physician) **(5050F *with* 3P)**
OR	
Performance Not Met:	Treatment plan not communicated, reason not otherwise specified **(5050F *with* 8P)**

RATIONALE:
Perceived lack of follow-up with primary care providers which is reinforced in the Institute of Medicine (IOM) report on patient errors. The intention of this measure is to enable the primary care provider and clinicians providing continuing care to support, facilitate, and coordinate the care of the patient.

Deficits in communication have clearly been shown to adversely affect post-discharge care transitions. A recent summary of the literature found that direct communication between hospital physicians and primary care physicians occurs infrequently (in 3%-20% of cases studied), the availability of a discharge summary at the first post-discharge visit is low (12%-34%) and did not improve greatly even after 4 weeks (51%-77%), affecting the quality of care in approximately 25% of follow-up visits. This systematic review of the literature also found that discharge summaries often lack important information such as diagnostic test results, treatment or hospital course, discharge medications, test results pending at discharge, patient or family counseling, and follow-up plans (Kripalani, 2007).

CLINICAL RECOMMENDATION STATEMENTS:

Each local skin cancer multi-disciplinary team (LSMDT) and specialist skin cancer multi-disciplinary team (SSMDT) should have at least one skin cancer clinical nurse specialist (CNS) who will play a leading role in supporting patients and caregivers. There should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and caregivers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may also include a copy of the letter confirming the diagnosis and treatment plan sent by the consultant to the general practitioner (GP).

- Provide a rapid referral service for patients who require specialist management through the LSMDT/SSMDT.
- Be responsible for the provision of information, advice, and support for patients managed in primary care and their care givers.
- Maintain a register of all patients treated, whose care should be part of a regular audit presented to the LSMDT/SSMDT.
- Liaise and communicate with all members of the skin cancer site-specific network group.
- Ensure that referring GPs are given prompt and full information about their patients' diagnosis or treatment in line with national standards on communication to GPs of cancer diagnoses.
- Collect data for network-wide audit. (NICE, 2006)

Communication and information exchange between the medical home and the receiving provider should occur in an amount of time that will allow the receiving provider to effectively treat the patient. This communication and information exchange should ideally occur whenever patients are at a transition of care; e.g., at discharge from the inpatient setting. The timeliness of this communication should be consistent with the patient´s clinical presentation and, in the case of a patient being discharged, the urgency of the follow-up required. Communication and information exchange between the MD and other physicians may be in the form of a call, voicemail, fax or other secure, private, and accessible means including mutual access to an EHR.

The Transitions of Care Consensus Conference (TOCCC) proposed a minimal set of data elements that should always be part of the transition record and be part of any initial implementation of this standard. That list includes the following:

- Principle diagnosis and problem list
- Medication list (reconciliation) including over the counter/ herbals, allergies and drug interactions
- Clearly identifies the medical home/transferring coordinating physician/institution and their contact information
- Patient's cognitive status
- Test results/pending results

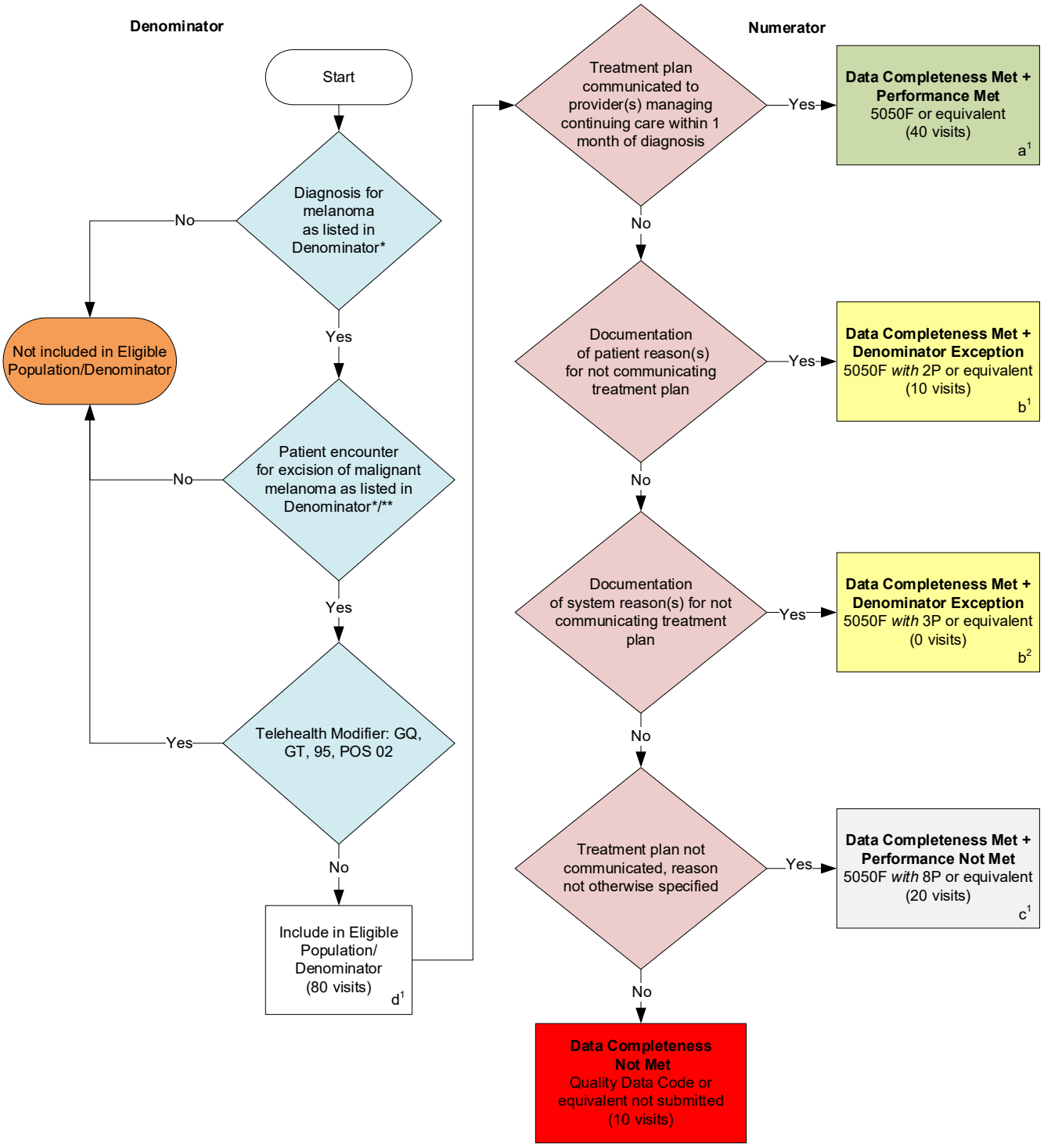
The TOCCC recommended the following additional elements that should be included in an "ideal transition record" in addition to the above:

- Emergency plan and contact number and person
- Treatment and diagnostic plan
- Prognosis and goals of care
- Advance directives, power of attorney, consent
- Planned interventions, durable medical equipment, wound care, etc.

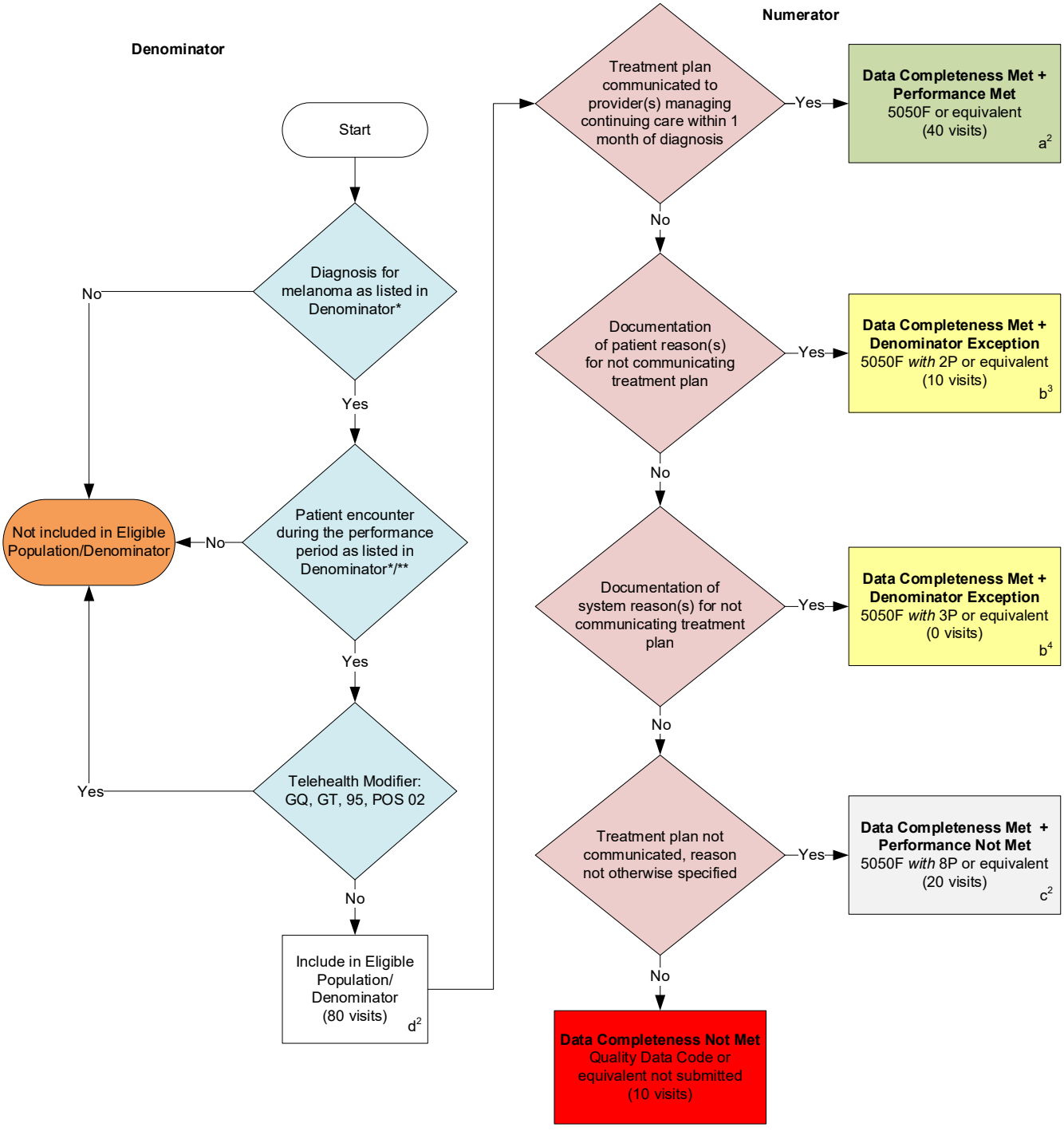
- Assessment of caregiver status
- Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transition record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive. (ACP, SGIMSHM, AGS, ACEP, SAEM, 2009) (Consensus Policy Statement)

2023 Clinical Quality Measure Flow for Quality ID #138:
Melanoma: Coordination of Care
Submission Criteria One

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



Submission Criteria Two



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a^1+a^2=80 visits) + Denominator Exception ($b^1+b^2+b^3+b^4$=20 visits) + Performance Not Met (c^1+c^2=40 visits) = 140 visits = **87.50%**

Eligible Population / Denominator (d^1+d^2=160 visits) = 160 visits

Performance Rate=

Performance Met (a^1+a^2=80 visits) = 80 visits = **66.67%**

Data Completeness Numerator (140 visits) – Denominator Exception ($b^1+b^2+b^3+b^4$=20 visits) = 120 visits

*See the posted measure specification for specific coding and instructions to submit this measure.

**Eligible cases are determined, and must be submitted, if the visit includes either the CPT codes for excision of malignant melanoma or CPT codes for outpatient setting encounter (as listed in measure specifications).

NOTE: Submission Frequency: Visit

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

2023 Clinical Quality Measure Flow Narrative for Quality ID #138: Melanoma: Coordination of Care

Disclaimer: *Refer to the measure specification for specific coding and instruction to submit this measure.*

Submission Criteria One:

1. Start with Denominator
2. Check *Diagnosis for melanoma as listed in Denominator*:*
    a. If *Diagnosis for melanoma as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis for melanoma as listed in Denominator** equals Yes, proceed to check *Patient encounter for excision of malignant melanoma as listed in Denominator*/***.
3. Check *Patient encounter for excision of malignant melanoma as listed in Denominator*/***:
    a. If *Patient encounter for excision of malignant melanoma as listed in Denominator*/*** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter for excision of malignant melanoma as listed in Denominator*/*** equals Yes, proceed to check *Telehealth Modifier*.
4. Check *Telehealth Modifier:*
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, include in *Eligible Population/Denominator.*
5. Denominator Population:
    a. Denominator Population is all Eligible Visits in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^1 equals 80 visits in the Sample Calculation.
6. Start Numerator
7. Check *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis*:
    a. If *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 40 visits in the Sample Calculation.
    b. If *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis* equals No, proceed to check *Documentation of patient reason(s) for not communicating treatment plan*.
8. Check *Documentation of patient reason(s) for not communicating treatment plan*:
    a. If *Documentation of patient reason(s) for not communicating treatment plan* equals Yes, include in *Data Completeness Met and Denominator Exception*.
        - *Data Completeness Met and Denominator Exception* letter is represented in the Data

Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 visits in the Sample Calculation.

b. If *Documentation of patient reason(s) for not communicating treatment plan* equals No, proceed to check *Documentation of system reason(s) for not communicating treatment plan*.

9. Check *Documentation of system reason(s) for not communicating treatment plan*:

   a. If *Documentation of system reason(s) for not communicating treatment plan* equals Yes, include in *Data Completeness Met and Denominator Exception*.

      - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 0 visits in the Sample Calculation.

   b. If *Documentation of system reason(s) for not communicating treatment plan* equals No, proceed to check *Treatment plan not communicated, reason not otherwise specified*.

10. Check *Treatment plan not communicated, reason not otherwise specified*:

    a. If *Treatment plan not communicated, reason not otherwise specified* equals Yes, include in *Data Completeness Met and Performance Not Met*.

       - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 20 visits in the Sample Calculation.

    b. If *Treatment plan not communicated, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

       - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 visits have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Submission Criteria Two:

1. Start with Denominator

2. Check *Diagnosis for melanoma as listed in Denominator**:

   a. If *Diagnosis for melanoma as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Diagnosis for melanoma as listed in Denominator** equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator*/**.*

3. Check *Patient encounter during the performance period as listed in Denominator*/**:

   a. If *Patient encounter during the performance period as listed in Denominator*/** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Patient encounter during the performance period as listed in Denominator*/** equals Yes, proceed to check *Telehealth Modifier*.

4. Check *Telehealth Modifier*.

    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.

    b. If *Telehealth Modifier* equals No, include in *Eligible Population/Denominator*.

5. Denominator Population:

    a. Denominator Population is all Eligible Visits in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 80 visits in the Sample Calculation.

6. Start Numerator

7. Check *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis*:

    a. If *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 40 visits in the Sample Calculation.

    b. If *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis* equals No, proceed to check *Documentation of patient reason(s) for not communicating treatment plan*.

8. Check *Documentation of patient reason(s) for not communicating treatment plan*:

    a. If *Documentation of patient reason(s) for not communicating treatment plan* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^3 equals 10 visits in the Sample Calculation.

    b. If *Documentation of patient reason(s) for not communicating treatment plan* equals No, proceed to check *Documentation of system reason(s) for not communicating treatment plan*.

9. Check *Documentation of system reason(s) for not communicating treatment plan*:

    a. If *Documentation of system reason(s) for not communicating treatment plan* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^4 equals 0 visits in the Sample Calculation.

    b. If *Documentation of system reason(s) for not communicating treatment plan* equals No, proceed to check *Treatment plan not communicated, reason not otherwise specified*.

10. Check *Treatment plan not communicated, reason not otherwise specified*:

    a. If *Treatment plan not communicated, reason not otherwise specified* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data

Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 20 visits in the Sample Calculation.

b. If *Treatment plan not communicated, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

- If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 visits have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a^1 plus a^2 equals 80 visits) plus Denominator Exception (b^1 plus b^2 plus b^3 plus b^4 equals 20 visits) plus Performance Not Met (c^1 plus c^2 equals 40 visits) divided by Eligible Population/Denominator (d^1 plus d^2 equals 160 visits). All equals 140 visits divided by 160 visits. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 80 visits) divided by Data Completeness Numerator (140 visits) minus Denominator Exception (b^1 plus b^2 plus b^3 plus b^4 equals 20 visits). All equals 80 visits divided by 120 visits. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

**Eligible cases are determined, and must be submitted, if the visit includes either the CPT codes for excision of malignant melanoma or CPT codes for outpatient setting encounter (as listed in measure specifications).

NOTE: Submission Frequency: Visit

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #141 (NQF 0563): Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Outcome – High Priority

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within the 12 month performance period.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for glaucoma patients seen during the performance period. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians who provide the primary management of patients with POAG will submit this measure.

Measure 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:
All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for primary open-angle glaucoma (ICD-10-CM): H40.1111, H40.1112, H40.1113, H40.1114, H40.1121, H40.1122, H40.1123, H40.1124, H40.1131, H40.1132, H40.1133, H40.1134, H40.1211, H40.1212, H40.1213, H40.1214, H40.1221, H40.1222, H40.1223, H40.1224, H40.1231, H40.1232, H40.1233, H40.1234, H40.151, H40.152, H40.153
AND
Patient encounter during the performance period (CPT): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02
WITHOUT
Place of Service (POS): 12

NUMERATOR:
Patients whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the

pre- intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within the 12 month performance period

Definitions:

Plan of Care – May include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist.

Plan to Recheck – In the event certain factors do not allow for the IOP to be measured (e.g., patient has an eye infection) but the physician has a plan to measure the IOP at the next visit; the plan of care code should be submitted.

Glaucoma Treatment Not Failed – The most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.

Numerator Instructions:

Pre-Intervention Level – The patient's IOP in the affected eye prior to the initiation of therapy. For patients who have just begun management of their POAG, i.e. a newly diagnosed patient or a patient recently transferred to the care of the physician, a provider can meet the measure's performance requirements by documenting a plan of care and submitting CPT II **0517F**. Patients whose POAG is well managed are assumed to have met the requirement to reduce their IOP by greater than or equal to 15% and should submit CPT II **3284F**.

Numerator Options:

Performance Met: Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level **(3284F)**

OR

Performance Met: Glaucoma plan of care documented **(0517F)**

AND

Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level **(3285F)**

OR

Performance Not Met: Glaucoma plan of care not documented, reason not otherwise specified **(0517F with 8P)**

AND

Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level **(3285F)**

OR

Performance Not Met: IOP measurement not documented, reason not otherwise specified **(3284F with 8P)**

RATIONALE:

1. Scientific basis for intraocular pressure (IOP) control as outcomes measure (intermediate)
   Analyses of results of several randomized clinical trials all demonstrate that reduction of IOP of at least 18% (EMGT, CIGTS, AGIS, CNTGS) reduces the rate of worsening of visual fields by at least 40%. The various studies, however, achieved different levels of mean IOP lowering in realizing their benefit in patient outcomes, ranging from 18% in the "normal pressure" subpopulation of EMGT to 42% in the CIGTS study.

   (Level I studies) As such, an appropriate "failure" indicator is to NOT achieve at least a 15% IOP reduction. The rationales for a failure indicator are that 1) the results of different studies can lead experienced clinicians to believe that different levels of IOP reduction are appropriate; 2) to minimize the impact of adverse selection for those patients whose IOPs are more difficult to control; and 3) because each patient's clinical course may require IOP reduction that may vary from 18 to 40+%.

In addition, "…several population-based studies have demonstrated that the prevalence of POAG as well as the incidence of POAG, increases as the level of IOP increases. These studies provide strong evidence that IOP plays an important role in the neuropathy of POAG. Furthermore, studies have demonstrated that reduction in the level of IOP lessens the risk of visual field progression in open-angle glaucoma. In addition, treated eyes that have a greater IOP fluctuation are at increased risk of progression.

Intraocular pressure is the intermediate outcome of therapy used by the FDA for approval of new drugs and devices and, as noted above, has been shown to be directly related to ultimate patient outcomes of vision loss. As such, failure to achieve minimal pressure lowering, absent an appropriate plan of care to address the situation, would constitute performance whose improvement would directly benefit patients with POAG.

2. Evidence for gap in care

   Based on studies in the literature reviewing documentation of IOP achieved under care, the gap could be as great as 50% or more in the community of ophthalmologists and optometrists treating patients with primary open-angle glaucoma. Based on loose criteria for control, IOP was controlled in 66% of follow-up visits for patients with mild glaucoma and 52% of visits for patients with moderate to severe glaucoma.

   Another study of a single comprehensive insurance plan suggested that a large proportion of individuals felt to require treatment for glaucoma or suspect glaucoma are falling out of care and are being monitored at rates lower than expected from recommendations of published guidelines.

CLINICAL RECOMMENDATION STATEMENTS:
The goal of treatment is to maintain the IOP within a range at which visual field loss is unlikely to significantly reduce a patient's health-related quality of life over his or her lifetime.

The estimated upper limit of this range is considered the "target pressure." The initial target pressure is an estimate and a means toward the ultimate goal of protecting the patient's vision. The target pressure should be individualized and may need adjustment further down or even up during the course of the disease.

When initiating therapy, the ophthalmologist assumes that the measured pretreatment pressure range contributed to optic nerve damage and is likely to cause additional damage in the future. Factors to consider when choosing a target pressure include the stage of overall glaucomatous damage as determined by the degree of structural optic nerve injury and/or functional visual field loss, baseline IOP at which damage occurred, age of patient, and additional risk factors (e.g., central corneal thickness (CCT), life expectancy, prior rate of progression). Lowering the pretreatment IOP by 25% or more has been shown to slow progression of POAG.Choosing a lower target IOP can be justified if there is more severe optic nerve damage, if the damage is progressing rapidly, or if other risk factors such as family history, age, or disc hemorrhages are present. Choosing a less aggressive target IOP may be reasonable if the risks of treatment outweigh the benefits (e.g., if a patient does not tolerate medical or laser therapy well and surgical intervention would be difficult or if the patient's anticipated life expectancy is limited).

American Academy of Ophthalmology Glaucoma Panel. Preferred Practice Pattern® Guidelines. Primary Open-Angle Glaucoma. San Francisco, CA: American Academy of Ophthalmology; 2020. Available at: www.aao.org/ppp.

The intent of this measure is to have this indicator apply to both optometrists and ophthalmologists (and any other physician who provides glaucoma care); the use of "ophthalmologists" only in the preceding verbatim section reflects the wording in the American Academy of Ophthalmology Preferred Practice pattern.

COPYRIGHT:
The measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications.

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Commercial uses of the measure require a license agreement between the user and the American Academy of Ophthalmology (Academy). Neither the Academy, AMA, nor the former AMA-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI), nor PCPI, nor their members, shall be responsible for any use of the measure.

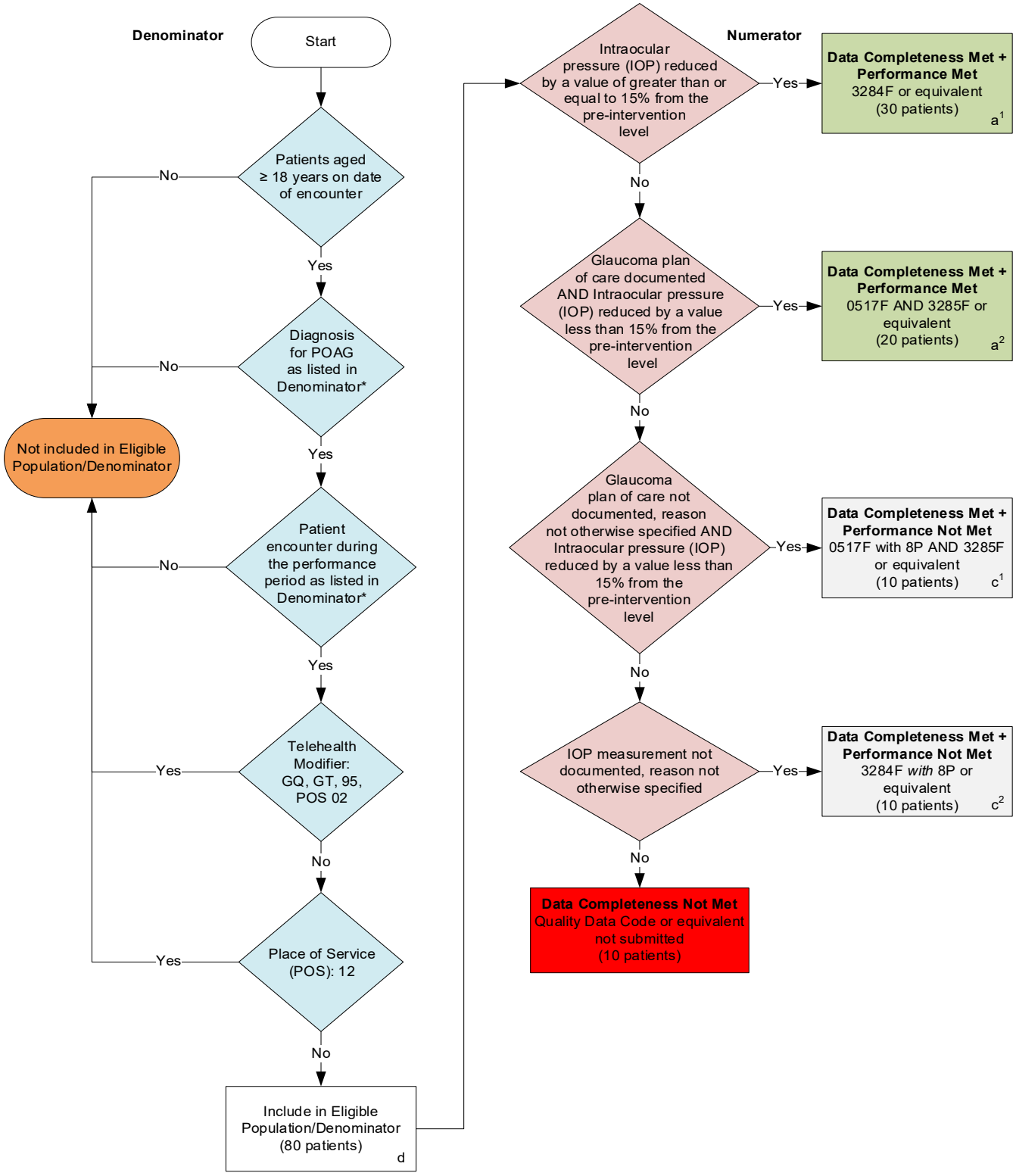
The American Medical Association's and PCPI® Foundation's significant past efforts and contributions to the development and updating of the measure is acknowledged. The Academy is solely responsible for the review and enhancement ("Maintenance") of the measure as of May 15, 2014.

THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the measure specifications for convenience A license agreement must be entered prior to a third party's use of Current Procedural Terminology (CPT®) or other proprietary code set contained in the Measures. Any other use of CPT or other coding by the third party is strictly prohibited. The Academy, its members, AMA and former members of the PCPI disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

2023 Clinical Quality Measure Flow for Quality ID #141 (NQF 0563): Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a^1+a^2=50 patients) + Performance Not Met (c^1+c^2=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a^1+a^2=50 patients) = 50 patients = **71.43%**

Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

2023 Clinical Quality Measure Flow Narrative for Quality ID #141 (NQF 0563): Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years on date of encounter*:
    a. If *Patients aged greater than or equal to 18 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years on date of encounter* equals Yes, proceed to check *Diagnosis for POAG as listed in Denominator**.
3. Check *Diagnosis for POAG as listed in Denominator**:
    a. If *Diagnosis for POAG as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis for POAG as listed in Denominator** equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
4. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Telehealth Modifier*.
5. Check *Telehealth Modifier*:
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, proceed to check *Place of Service (POS)*.
6. Check *Place of Service (POS):*
    a. If *Place of Service (POS)* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Place of Service (POS)* equals No, include in *Eligible Population/Denominator*.
7. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
8. Start Numerator
9. Check *Intraocular pressure (IOP) reduced by a value of greater than or equal to 15 percent from the pre-intervention level*:
    a. If *Intraocular pressure (IOP) reduced by a value of greater than or equal to 15 percent from the pre-*

intervention level equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 30 patients in the Sample Calculation.

b. If *Intraocular pressure (IOP) reduced by a value of greater than or equal to 15 percent from the pre-intervention level* equals No, proceed to check *Glaucoma plan of care documented AND Intraocular pressure (IOP) reduced by a value less than 15 percent from the pre-intervention level*.

10. Check *Glaucoma plan of care documented AND Intraocular pressure (IOP) reduced by a value less than 15 percent from the pre-intervention level*:

    a. If *Glaucoma plan of care documented AND Intraocular pressure (IOP) reduced by a value less than 15 percent from the pre-intervention level* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 20 patients in the Sample Calculation.

    b. If *Glaucoma plan of care documented AND Intraocular pressure (IOP) reduced by a value less than 15 percent from the pre-intervention level* equals No, proceed to check *Glaucoma plan of care not documented, reason not otherwise specified AND Intraocular pressure (IOP) reduced by a value less than 15 percent from the pre-intervention level*.

11. Check *Glaucoma plan of care not documented, reason not otherwise specified AND Intraocular pressure (IOP) reduced by a value less than 15 percent from the pre-intervention level*:

    a. If *Glaucoma plan of care not documented, reason not otherwise specified AND Intraocular pressure (IOP) reduced by a value less than 15 percent from the pre-intervention level* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

    b. If *Glaucoma plan of care not documented, reason not otherwise specified AND Intraocular pressure (IOP) reduced by a value less than 15 percent from the pre-intervention level* equals No, proceed to check *IOP measurement not documented, reason not otherwise specified*.

12. Check *IOP measurement not documented, reason not otherwise specified*:

    a. If *IOP measurement not documented, reason not otherwise specified* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    b. If *IOP measurement not documented, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

13. Check *Data Completeness Not Met*:

a. If *Data Completeness Not Met*, the Quality Data Code was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a^1 plus a^2 equals 50 patients) plus Performance Not Met (c^1 plus c^2 equals 20 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 50 patients) divided by Data Completeness Numerator (70 patients). All equals 50 patients divided by 70 patients. All equals 71.43 percent.

*See the posted measure specification for the specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #191 (NQF 0565): Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Outcome – High Priority

DESCRIPTION:
Percentage of cataract surgeries for patients aged 18 years and older with a diagnosis of uncomplicated cataract and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following the cataract surgery.

INSTRUCTIONS:
This measure is to be submitted **each time** a procedure for uncomplicated cataract is performed during the performance period. This measure is intended to reflect the quality of services provided for the patients receiving uncomplicated cataract surgery. This measure is to be submitted by the Merit-based Incentive Payment System (MIPS) eligible clinician performing the cataract surgery procedure. Clinicians who provide only preoperative or postoperative management of cataract surgery patients are not eligible for this measure.

NOTE: *This is an outcome measure and can be calculated solely using third party intermediary data.*

- *For patients who receive the cataract surgical procedures specified in the denominator coding, it should be reported whether or not the patient had best-corrected visual acuity of 20/40 or better achieved in the operative eye within 90 days following cataract surgery.*
- *Cataract surgeries performed on patients who have any of the listed significant ocular conditions [comorbid] in the exclusion criteria should be removed from the denominator; these patients have existing ocular conditions that could impact the outcome of surgery and are not included in the measure calculation for those patients who have best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following the cataract surgery.*
- *Include only cataract surgery procedures performed through **September 30th** of the performance period. This will allow the post-operative period to occur within the performance period.*

Measure 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:
All cataract surgeries for patients aged 18 years and older who did not meet any exclusion criteria

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of procedure
AND

Procedure during the performance period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984
WITHOUT
Modifier: 56 or 55
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02
AND NOT
DENOMINATOR EXCLUSION:
Any of the following significant ocular conditions that impact the visual outcome of surgery
(Patients with documentation of the presence of one or more of the following significant ocular conditions that impact the visual outcome of surgery prior to date of cataract surgery which is still active at the time of the cataract surgery are excluded from the measure calculation)

Table 1 - Significant Ocular Conditions

Significant Ocular Condition	Corresponding ICD-10-CM Codes
Acute and Subacute Iridocyclitis	H20.00, H20.011, H20.012, H20.013, H20.021, H20.022, H20.023, H20.031, H20.032, H20.033, H20.041, H20.042, H20.043, H20.051, H20.052, H20.053
Amblyopia	H53.001, H53.002, H53.003, H53.011, H53.012, H53.013, H53.021, H53.022, H53.023, H53.031, H53.032, H53.033, H53.041, H53.042, H53.043
Burn Confined to Eye and Adnexa	T26.01XA, T26.02XA, T26.11XA, T26.12XA, T26.21XA, T26.22XA, T26.31XA, T26.32XA, T26.41XA, T26.42XA, T26.51XA, T26.52XA, T26.61XA, T26.62XA, T26.71XA, T26.72XA, T26.81XA, T26.82XA, T26.91XA, T26.92XA
Cataract Secondary to Ocular Disorders	H26.211, H26.212, H26.213, H26.221, H26.222, H26.223
Cataract, Congenital	Q12.0
Cataract, Mature or Hypermature	H26.9
Cataract, Posterior Polar	H25.041, H25.042, H25.043
Central Corneal Ulcer	H16.011, H16.012, H16.013
Certain Types of Iridocyclitis	H20.21, H20.22, H20.23, H20.811, H20.812, H20.813, H20.821, H20.822, H20.823, H20.9
Choroidal Degenerations	H35.33
Choroidal Detachment	H31.401, H31.402, H31.403, H31.411, H31.412, H31.413, H31.421, H31.422, H31.423
Choroidal Hemorrhage and Rupture	H31.301, H31.302, H31.303, H31.311, H31.312, H31.313, H31.321, H31.322, H31.323
Chronic Iridocyclitis	A18.54, H20.11, H20.12, H20.13, H20.9
Cloudy Cornea	H17.01, H17.02, H17.03, H17.11, H17.12, H17.13, H17.811, H17.812, H17.813, H17.821, H17.822, H17.823
Corneal Edema	H18.11, H18.12, H18.13, H18.20, H18.221, H18.222, H18.223, H18.231, H18.232, H18.233, H18.421, H18.422, H18.423, H18.43
Corneal Opacity and Other Disorders of Cornea	H17.01, H17.02, H17.03, H17.11, H17.12, H17.13, H17.89, H17.9

Significant Ocular Condition	Corresponding ICD-10-CM Codes
Degeneration of Macula and Posterior Pole	H35.30, H35.3110, H35.3111, H35.3112, H35.3113, H35.3114, H35.3120, H35.3121, H35.3122, H35.3123, H35.3124, H35.3130, H35.3131, H35.3132, H35.3133, H35.3134, H35.3210, H35.3211, H35.3212, H35.3213, H35.3220, H35.3221, H35.3222, H35.3223, H35.3230, H35.3231, H35.3232, H35.3233, H35.341, H35.342, H35.343, H35.351, H35.352, H35.353, H35.361, H35.362, H35.363, H35.371, H35.372, H35.373, H35.381, H35.382, H35.383
Degenerative Disorders of Globe	H44.2A1, H44.2A2, H44.2A3, H44.2B1, H44.2B2, H44.2B3, H44.2C1, H44.2C2, H44.2C3, H44.2D1, H44.2D2, H44.2D3, H44.2E1, H44.2E2, H44.2E3, H44.21, H44.22, H44.23, H44.311, H44.312, H44.313, H44.321, H44.322, H44.323, H44.391, H44.392, H44.393
Diabetic Macular Edema	E08.311, E08.3211, E08.3212, E08.3213, E08.3311, E08.3312, E08.3313, E08.3411, E08.3412, E08.3413, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.37X1, E08.37X2, E08.37X3, E09.311, E09.3211, E09.3212, E09.3213, E09.3311, E09.3312, E09.3313, E09.3411, E09.3412, E09.3413, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.37X1, E09.37X2, E09.37X3, E10.311, E10.3211, E10.3212, E10.3213, E10.3311, E10.3312, E10.3313, E10.3411, E10.3412, E10.3413, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.37X1, E10.37X2, E10.37X3, E11.311, E11.3211, E11.3212, E11.3213, E11.3311, E11.3312, E11.3313, E11.3411, E11.3412, E11.3413, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.37X1, E11.37X2, E11.37X3, E13.311, E13.3211, E13.3212, E13.3213, E13.3311, E13.3312, E13.3313, E13.3411, E13.3412, E13.3413, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.37X1, E13.37X2, E13.37X3

Significant Ocular Condition	Corresponding ICD-10-CM Codes
Diabetic Retinopathy	E08.311, E08.319, E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E09.311, E09.319, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492, E10.3493, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3291, E13.3292, E13.3293, E13.3311, E13.3312, E13.3313, E13.3391, E13.3392, E13.3393, E13.3411, E13.3412, E13.3413, E13.3491, E13.3492, E13.3493, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593
Disorders of Optic Chiasm	H47.41, H47.42, H47.43, H47.49
Disorders of Visual Cortex	H47.611, H47.612, H47.621, H47.622, H47.631, H47.632, H47.641, H47.642
Disseminated Chorioretinitis and Disseminated Retinochoroiditis	A18.53, H30.101, H30.102, H30.103, H30.111, H30.112, H30.113, H30.121, H30.122, H30.123, H30.131, H30.132, H30.133, H30.141, H30.142, H30.143
Focal Chorioretinitis and Focal Retinochoroiditis	H30.001, H30.002, H30.003, H30.011, H30.012, H30.013, H30.021, H30.022, H30.023, H30.031, H30.032, H30.033, H30.041, H30.042, H30.043

Significant Ocular Condition	Corresponding ICD-10-CM Codes
Glaucoma	H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.1110, H40.1111, H40.1112, H40.1113, H40.1114, H40.1120, H40.1121, H40.1122, H40.1123, H40.1124, H40.1130, H40.1131, H40.1132, H40.1133, H40.1134, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1310, H40.1311, H40.1312, H40.1313, H40.1314, H40.1320, H40.1321, H40.1322, H40.1323, H40.1324, H40.1330, H40.1331, H40.1332, H40.1333, H40.1334, H40.1410, H40.1411, H40.1412, H40.1413, H40.1414, H40.1420, H40.1421, H40.1422, H40.1423, H40.1424, H40.1430, H40.1431, H40.1432, H40.1433, H40.1434, H40.151, H40.152, H40.153, H40.20X0, H40.20X1, H40.20X2, H40.20X3, H40.20X4, H40.211, H40.212, H40.213, H40.2210, H40.2211, H40.2212, H40.2213, H40.2214, H40.2220, H40.2221, H40.2222, H40.2223, H40.2224, H40.2230, H40.2231, H40.2232, H40.2233, H40.2234, H40.231, H40.232, H40.233, H40.241, H40.242, H40.243, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.61X0, H40.61X1, H40.61X2, H40.61X3, H40.61X4, H40.62X0, H40.62X1, H40.62X2, H40.62X3, H40.62X4, H40.63X0, H40.63X1, H40.63X2, H40.63X3, H40.63X4, H40.811, H40.812, H40.813, H40.821, H40.822, H40.823, H40.831, H40.832, H40.833, H40.89, Q15.0
Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes	H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.811, H40.812, H40.813, H40.821, H40.822, H40.823, H40.831, H40.832, H40.833, H40.89, H40.9, H42
Hereditary Choroidal Dystrophies	H31.20, H31.21, H31.22, H31.23, H31.29
Hereditary Corneal Dystrophies	H18.501, H18.502, H18.503, H18.511, H18.512, H18.513, H18.521, H18.522, H18.523, H18.531, H18.532, H18.533, H18.541, H18.542, H18.543, H18.551, H18.552, H18.553, H18.591, H18.592, H18.593
Hereditary Retinal Dystrophies	H35.50, H35.51, H35.52, H35.53, H35.54, H36
Hypotony of Eye	H44.40, H44.411, H44.412, H44.413, H44.421, H44.422, H44.423, H44.431, H44.432, H44.433, H44.441, H44.442, H44.443
Injury to Optic Nerve and Pathways	S04.011A, S04.012A, S04.02XA, S04.031A, S04.032A, S04.041A, S04.042A
Macular Scar of Posterior Polar	H31.011, H31.012, H31.013
Morgagnian Cataract	H25.21, H25.22, H25.23
Nystagmus and Other Irregular Eye Movements	H55.00, H55.01, H55.02, H55.03, H55.04, H55.09, H55.81, H55.89
Open Wound of Eyeball	S05.11XA, S05.12XA, S05.21XA, S05.22XA, S05.31XA, S05.32XA, S05.51XA, S05.52XA, S05.61XA, S05.62XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A
Optic Atrophy	H47.20, H47.211, H47.212, H47.213, H47.22, H47.231, H47.232, H47.233, H47.291, H47.292, H47.293

Significant Ocular Condition	Corresponding ICD-10-CM Codes
Optic Neuritis	H46.01, H46.02, H46.03, H46.11, H46.12, H46.13, H46.2, H46.3, H46.8, H46.9
Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis	H30.21, H30.22, H30.23, H30.811, H30.812, H30.813, H30.891, H30.892, H30.893, H30.91, H30.92, H30.93
Other Background Retinopathy and Retinal Vascular Changes	H35.021, H35.022, H35.023, H35.051, H35.052, H35.053, H35.061, H35.062, H35.063
Other Disorders of Optic Nerve	H47.011, H47.012, H47.013
Other Endophthalmitis	H16.241, H16.242, H16.243, H21.331, H21.332, H21.333, H33.121, H33.122, H33.123, H44.111, H44.112, H44.113, H44.121, H44.122, H44.123, H44.131, H44.132, H44.133, H44.19
Other Proliferative Retinopathy	H35.101, H35.102, H35.103, H35.111, H35.112, H35.113, H35.121, H35.122, H35.123, H35.131, H35.132, H35.133, H35.141, H35.142, H35.143, H35.151, H35.152, H35.153, H35.161, H35.162, H35.163, H35.171, H35.172, H35.173
Pathologic Myopia	H44.2A1, H44.2A2, H44.2A3, H44.2B1, H44.2B2, H44.2B3, H44.2C1, H44.2C2, H44.2C3, H44.2D1, H44.2D2, H44.2D3, H44.2E1, H44.2E2, H44.2E3, H44.21, H44.22, H44.23, H44.30
Posterior Lenticonus	Q12.2, Q12.4, Q12.8
Prior Penetrating Keratoplasty	H18.601, H18.602, H18.603, H18.611, H18.612, H18.613, H18.621, H18.622, H18.623
Purulent Endophthalmitis	H44.001, H44.002, H44.003, H44.011, H44.012, H44.013, H44.021, H44.022, H44.023
Retinal Detachment with Retinal Defect	H33.001, H33.002, H33.003, H33.011, H33.012, H33.013, H33.021, H33.022, H33.023, H33.031, H33.032, H33.033, H33.041, H33.042, H33.043, H33.051, H33.052, H33.053, H33.41, H33.42, H33.43, H33.8
Retinal Vascular Occlusion	H34.11, H34.12, H34.13, H34.231, H34.232, H34.233, H34.8110, H34.8111, H34.8112, H34.8120, H34.8121, H34.8122, H34.8130, H34.8131, H34.8132, H34.8310, H34.8311, H34.8312, H34.8320, H34.8321, H34.8322, H34.8330, H34.8331, H34.8332
Retrolental Fibroplasias	H35.171, H35.172, H35.173
Scleritis	H15.021, H15.022, H15.023, H15.031, H15.032, H15.033, H15.041, H15.042, H15.043, H15.051, H15.052, H15.053, H15.091, H15.092, H15.093
Separation of Retinal Layers	H35.711, H35.712, H35.713, H35.721, H35.722, H35.723, H35.731, H35.732, H35.733
Traumatic Cataract	H26.101, H26.102, H26.103, H26.111, H26.112, H26.113, H26.121, H26.122, H26.123, H26.131, H26.132, H26.133
Uveitis	H44.111, H44.112, H44.113, H44.131, H44.132, H44.133
Vascular Disorders of Iris and Ciliary Body	H21.1X1, H21.1X2, H21.1X3
Visual Field Defects	H53.411, H53.412, H53.413, H53.421, H53.422, H53.423, H53.431, H53.432, H53.433, H53.451, H53.452, H53.453, H53.461, H53.462, H53.47, H53.481, H53.482, H53.483

NUMERATOR:

Cataract surgeries with best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following cataract surgery

Numerator Options:

Performance Met: Best-corrected visual acuity of 20/40 or better

	(distance or near) achieved within the 90 days following cataract surgery **(4175F)**
OR	
Performance Not Met:	Best-corrected visual acuity of 20/40 or better (distance or near) not achieved within the 90 days following cataract surgery, reason not otherwise specified **(4175F *with* 8P)**

RATIONALE:

In the United States, cataracts affect more than 24 million adults over 40 years (National Eye Institute, 2019). According to the American Academy of Ophthalmology (Academy) (2021), cataract surgery has a substantial beneficial impact on visual function and on quality of life.

1. Scientific basis for measuring visual acuity outcomes after cataract surgery

   The only reason to perform cataract surgery (other than for a limited set of medical indications) is to improve a patient's vision and associated functioning. The use of a 20/40 visual acuity threshold is based on several considerations. First, it is the level for unrestricted operation of a motor vehicle in the US. Second, it has been consistently used by the FDA in its assessment for approval of intraocular lens (IOL) and other vision devices. Third, it is the literature standard to denote success in cataract surgery. Fourth, work by West et al. in the Salisbury Eye Study suggests that 20/40 is a useful threshold for 50th percentile functioning for several vision-related tasks.

   Most patients achieve excellent visual acuity after cataract surgery (20/40 or better). This outcome is achieved consistently through careful attention through the accurate measurement of axial length and corneal power and the appropriate selection of an IOL power calculation formula. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this after surgery in eyes without comorbid ocular conditions that would impact the success of the surgery would reflect care that should be assessed for opportunities for improvement.

   The exclusion of patients with other ocular and systemic conditions known to increase the risk of an adverse outcome reflects the findings of the two published prediction rule papers for cataract surgery outcomes, by Mangione et al. (1995) and Steinberg et al. (1994). In both papers, the presence of comorbid glaucoma and macular degeneration negatively impacted the likelihood of successful outcomes of surgery. Further, as noted in the prior indicator, exclusion of eyes with ocular conditions that could impact the success of the surgery would NOT eliminate the large majority of eyes undergoing surgery while also minimizing the potential adverse selection that might otherwise occur relative to those patients with the most complex situations who might benefit the most from having surgery to maximize their remaining vision.

2. Evidence of a gap in care

   Cataract surgery successfully restores vision in the majority of people who have the procedure.

   Data from a study of 368,256 cataract surgeries show that corrected visual acuity (CDVA) of 0.5 (20/40) or better was achieved in 94.3% and CDVA of 1.0 (20/20) or better was achieved in 61.3% of cases (Lundstrom et al., 2013).

   Additionally, data from a UK multi-center Cataract National Dataset found a postoperative visual acuity of 6/12 (20/40) or better was achieved for 94.7% of eyes with no co-pathologies and in 79.9% of eyes with one or more co-pathologies (Jaycock et al., 2009).

   A rate of 85.5-94.7% of patients achieving a 20/40 or better visual acuity in the context of approximately 3 million cataract surgeries in the US annually would mean that between 160,000 to 435,000 individuals would

not achieve a 20/40 or better visual acuity which suggests an opportunity for improvement.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcome measure. As such, there is no statement in the guideline specific to this measurement topic.

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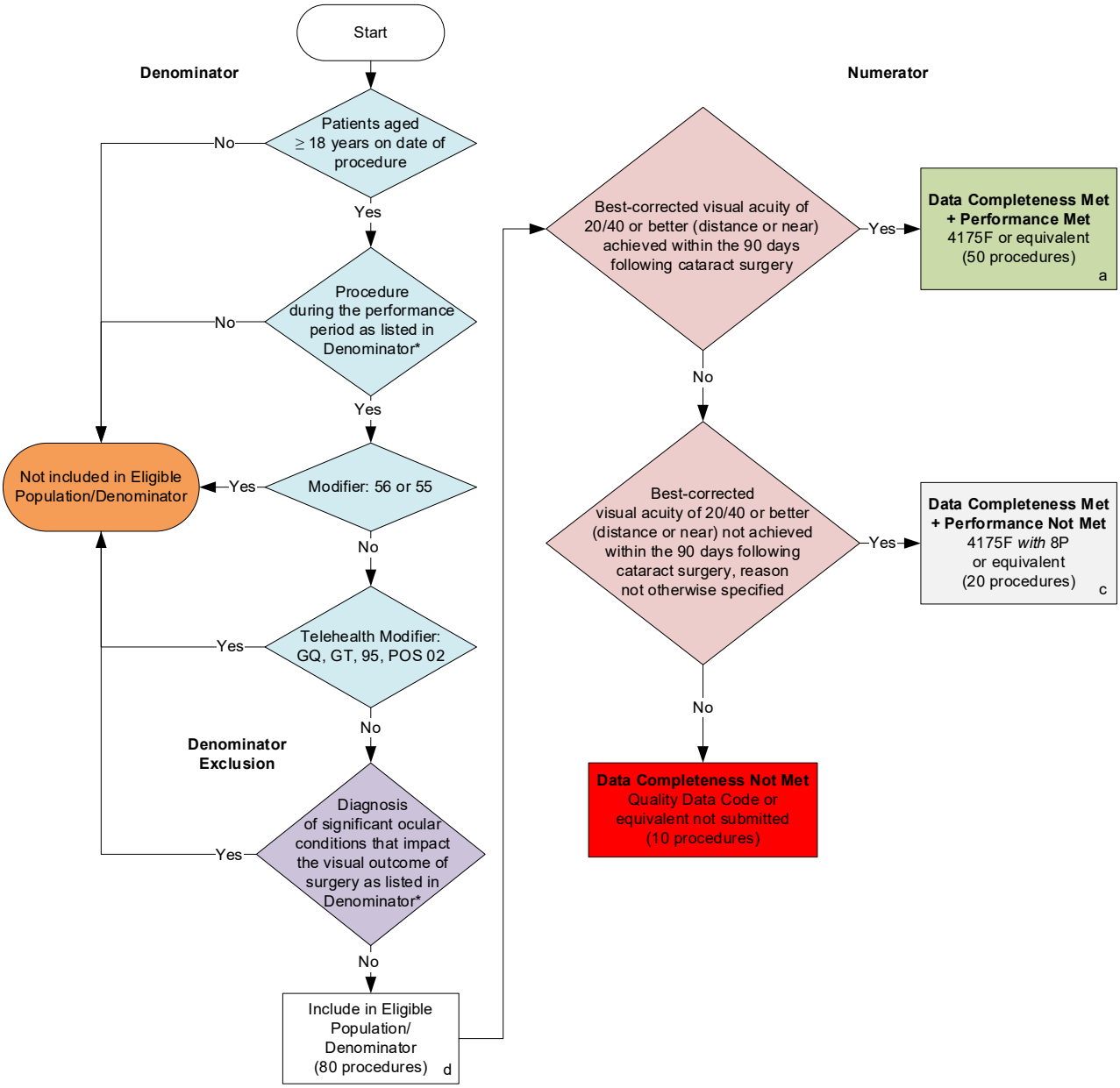
2023 Clinical Quality Measure Flow for Quality ID #191 (NQF 0565): Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a=50 procedures) + Performance Not Met (c=20 procedures) = 70 procedures = **87.50%**
Eligible Population / Denominator (d=80 procedures) = 80 procedures

Performance Rate=
Performance Met (a=50 procedures) = 50 procedures = **71.43%**
Data Completeness Numerator (70 procedures) = 70 procedures

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Procedure
NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

v7

2023 Clinical Quality Measure Flow Narrative for Quality ID #191 (NQF 0565): Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

***Disclaimer**: Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years on date of procedure*:
    a. If *Patients aged greater than or equal to 18 years on date of procedure* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years on date of procedure* equals Yes, proceed to check *Procedure during the performance period as listed in Denominator**.
3. Check *Procedure during the performance period as listed in Denominator*.*
    a. If *Procedure during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Procedure during the performance period as listed in Denominator** equals Yes, proceed to check *Modifier*.
4. Check *Modifier*:
    a. If *Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Modifier* equals No, proceed to check *Telehealth Modifier.*
5. Check *Telehealth Modifier:*
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, proceed to check *Diagnosis of significant ocular conditions that impact the visual outcome of surgery as listed in Denominator**.
6. Check *Diagnosis of significant ocular conditions that impact the visual outcome of surgery as listed in Denominator**:
    a. If *Diagnosis of significant ocular conditions that impact the visual outcome of surgery as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis of significant ocular conditions that impact the visual outcome of surgery as listed in Denominator** equals No, include in *Eligible Population/Denominator*.
7. Denominator Population:
    a. Denominator Population is all Eligible Procedures in the Denominator. The Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 procedures in the Sample Calculation.
8. Start Numerator
9. Check *Best-corrected visual acuity of 20/40 or better (distance or near) achieved within the 90 days following cataract surgery*:

a. If *Best-corrected visual acuity of 20/40 or better (distance or near) achieved within the 90 days following cataract surgery* equals Yes, include in *Data Completeness Met and Performance Met*.

    - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 50 procedures in the Sample Calculation.

b. If *Best-corrected visual acuity of 20/40 or better (distance or near) achieved within the 90 days following cataract surgery* equals No, proceed to check *Best-corrected visual acuity of 20/40 or better (distance or near) not achieved within the 90 days following cataract surgery, reason not otherwise specified*.

10. Check *Best-corrected visual acuity of 20/40 or better (distance or near) not achieved within the 90 days following cataract surgery, reason not otherwise specified*:

    a. If *Best-corrected visual acuity of 20/40 or better (distance or near) not achieved within the 90 days following cataract surgery, reason not otherwise specified* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 20 procedures in the Sample Calculation.

    b. If *Best-corrected visual acuity of 20/40 or better (distance or near) not achieved within the 90 days following cataract surgery, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 procedures have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a equals 50 procedures) plus Performance Not Met (c equals 20 procedures) divided by Eligible Population/Denominator (d equals 80 procedures). All equals 70 procedures divided by 80 procedures. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 50 procedures) divided by Data Completeness Numerator (70 procedures). All equals 50 procedures divided by 70 procedures. All equals 71.43 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure

NOTE: Telehealth modifiers **include but are not limited to**: GQ, GT, 95, POS 02

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within the measurement period **AND** who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who provided the measure-specific denominator coding.

This measure will be calculated with 3 performance rates:

1) Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within the measurement period
2) Percentage of patients aged 18 years and older who were identified as a tobacco user during the measurement period who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period
3) Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user

The denominator of submission criteria 2 is a subset of the resulting numerator for submission criteria 1, as submission criteria 2 is limited to assessing if patients identified as tobacco users received an appropriate tobacco cessation intervention. For all patients, submission criteria 1 and 3 are applicable, but submission criteria 2 will only be applicable for those patients who are identified as tobacco users. Therefore, data for every patient that meets the age and encounter requirements will only be submitted for submission criteria 1 and 3, whereas data submitted for submission criteria 2 will be for a subset of patients who meet the age and encounter requirements, as the denominator has been further limited to those who were identified as tobacco users.

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

Measure 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.

THERE ARE THREE SUBMISSION CRITERIA FOR THIS MEASURE:

1) All patients who were screened for tobacco use

AND

2) All patients who were identified as a tobacco user during the measurement period and who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period

AND

3) All patients who were screened for tobacco use and, if identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period, or identified as a tobacco non-user

This measure contains three submission criteria which aim to identify patients who were screened for tobacco use (submission criteria 1), patients who were identified as tobacco users during the measurement period and who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (submission criteria 2), and a comprehensive look at the overall performance on tobacco screening and cessation intervention (submission criteria 3). By separating this measure into various submission criteria, the MIPS eligible professional or MIPS eligible clinician will be able to better ascertain where gaps in performance exist, and identify opportunities for improvement. The overall rate (submission criteria 3) can be utilized to compare performance to published versions of this measure prior to the 2018 performance year, when the measure had a single performance rate. For accountability reporting in the CMS MIPS program, the rate for submission criteria 2 is used for performance.

SUBMISSION CRITERIA 1: ALL PATIENTS WHO WERE SCREENED FOR TOBACCO USE

DENOMINATOR (SUBMISSION CRITERIA 1):
All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

> ***DENOMINATOR NOTE:*** **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.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **At least two patient encounters during the performance period (CPT):** 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99024, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271
> **OR**
> **At least one preventive encounter during the performance period (CPT or HCPCS):** 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439
> **AND NOT**
> **DENOMINATOR EXCLUSION:**
> **Hospice services provided to patient any time during the measurement period:** M1159

NUMERATOR (SUBMISSION CRITERIA 1):
Patients who were screened for tobacco use at least once within the measurement period

> **Definition:**

Tobacco Use – use of any tobacco product

The 2021 USPSTF recommendation references the US Food and Drug Administration definition of tobacco which includes "any product made or derived from tobacco intended for human consumption (except products that meet the definition of drugs), including, but not limited to, cigarettes, cigars (including cigarillos and little cigars), dissolvables, hookah tobacco, nicotine gels, pipe tobacco, roll-your-own tobacco, smokeless tobacco products (including dip, snuff, snus, and chewing tobacco), vapes, electronic cigarettes (e-cigarettes), hookah pens, and other electronic nicotine delivery systems."

The 2021 USPSTF recommendation describes smoking as generally referring to "the inhaling and exhaling of smoke produced by combustible tobacco products such as cigarettes, cigars, and pipes."

The 2021 USPSTF recommendation describes vaping as "the inhaling and exhaling of aerosols produced by e-cigarettes." In addition, it states, "vaping products (i.e. , e-cigarettes) usually contain nicotine, which is the addictive ingredient in tobacco. Substances other than tobacco can also be used to smoke or vape. While the 2015 USPSTF recommendation statement used the term 'electronic nicotine delivery systems' or 'ENDS,' the USPSTF recognizes that the field has shifted to using the term 'e-cigarettes' (or 'e-cigs') and uses the term e-cigarettes in the current recommendation statement. e-Cigarettes can come in many shapes and sizes, but generally they heat a liquid that contains nicotine (the addictive drug in tobacco) to produce an aerosol (or 'vapor') that is inhaled ('vaped') by users."

NUMERATOR NOTE: *To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the measurement period. If a patient has multiple tobacco use screenings during the measurement period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.*

In the event that a patient is screened for tobacco use and tobacco status is unknown, submit G9905.

Numerator Options:

Performance Met:	Patient screened for tobacco use AND identified as a tobacco user **(G9902)**
OR	
Performance Met:	Patient screened for tobacco use AND identified as a tobacco non-user **(G9903)**
OR	
Performance Not Met:	Patient not screened for tobacco use **(G9905)**

SUBMISSION CRITERIA 2: ALL PATIENTS WHO WERE IDENTIFIED AS A TOBACCO USER AND WHO RECEIVED TOBACCO CESSATION INTERVENTION

DENOMINATOR (SUBMISSION CRITERIA 2):
All patients aged 18 years and older seen for at least two visits or at least one preventive visit who were screened for tobacco use during the measurement period and identified as a tobacco user

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
All eligible instances when **G9902** is submitted for Performance Met (patient screened for tobacco use and identified as a tobacco user) in the numerator of Submission Criteria 1

AND

At least two patient encounters during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99024, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439

AND NOT

DENOMINATOR EXCLUSION:

Hospice services provided to patient any time during the measurement period: M1159

NUMERATOR (SUBMISSION CRITERIA 2):

Patients who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period

Definition:

Tobacco Cessation Intervention - Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

Note: Concepts aligned with brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) are included in the numerator. Other concepts such as written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Counseling also may be of longer duration or be performed more frequently, as evidence shows that higher-intensity interventions are associated with higher tobacco cessation rates (U.S. Preventive Services Task Force, 2021).

NUMERATOR NOTE: *If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.*

This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code G9906.

Numerator Options:

Performance Met:	Patient identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy) **(G9906)**
OR	
Performance Not Met:	Patient identified as tobacco user did not receive tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy) (**G9908)**

SUBMISSION CRITERIA 3: ALL PATIENTS WHO WERE SCREENED FOR TOBACCO USE AND, IF IDENTIFIED AS A TOBACCO USER RECEIVED TOBACCO CESSATION INTERVENTION, OR IDENTIFIED AS A TOBACCO NON-USER

DENOMINATOR (SUBMISSION CRITERIA 3):
All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
At least two patient encounters during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99024, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271
OR
At least one preventive encounter during the performance period (CPT or HCPCS): 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439
AND NOT
DENOMINATOR EXCLUSION:
Hospice services provided to patient any time during the measurement period: M1159

NUMERATOR (SUBMISSION CRITERIA 3):
Patients who were screened for tobacco use at least once within the measurement period **AND** who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user

Definitions:
Tobacco Use – use of any tobacco product

The 2021 USPSTF recommendation references the US Food and Drug Administration definition of tobacco which includes "any product made or derived from tobacco intended for human consumption (except products that meet the definition of drugs), including, but not limited to, cigarettes, cigars (including cigarillos and little cigars), dissolvables, hookah tobacco, nicotine gels, pipe tobacco, roll-your-own tobacco, smokeless tobacco products (including dip, snuff, snus, and chewing tobacco), vapes, electronic cigarettes (e-cigarettes), hookah pens, and other electronic nicotine delivery systems."

The 2021 USPSTF recommendation describes smoking as generally referring to "the inhaling and exhaling of smoke produced by combustible tobacco products such as cigarettes, cigars, and pipes."

The 2021 USPSTF recommendation describes vaping as "the inhaling and exhaling of aerosols produced by e-cigarettes." In addition, it states, "vaping products (i.e. , e-cigarettes) usually contain nicotine, which is the addictive ingredient in tobacco. Substances other than tobacco can also be used to smoke or vape. While the 2015 USPSTF recommendation statement used the term 'electronic nicotine delivery systems' or 'ENDS,' the USPSTF recognizes that the field has shifted to using the term 'e-cigarettes' (or 'e-cigs') and uses the term e-cigarettes in the current recommendation statement. e-Cigarettes can come in many shapes and sizes, but generally they heat a liquid that contains nicotine (the addictive drug in tobacco) to produce an aerosol (or 'vapor') that is inhaled ('vaped') by users."

Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

Note: Concepts aligned with brief counseling (e.g., minimal and intensive advice/counseling interventions

conducted both in person and over the phone) are included in the numerator. Other concepts such as written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Counseling also may be of longer duration or be performed more frequently, as evidence shows that higher-intensity interventions are associated with higher tobacco cessation rates (U.S. Preventive Services Task Force, 2021).

NUMERATOR NOTE: *To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the measurement period. If a patient has multiple tobacco use screenings during the measurement period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.*

In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation intervention during the measurement period or in the six months prior to the measurement period or if tobacco status is unknown, submit G0029.

If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.

This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G0030.

Numerator Options:

Performance Met:	Patient screened for tobacco use AND received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling, pharmacotherapy, or both), if identified as a tobacco user **(G0030)**
OR	
Performance Met:	Current tobacco non-user **(1036F)**
OR	
Performance Not Met:	Tobacco screening not performed OR tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period **(G0029)**

RATIONALE:

This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop using tobacco lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:

The US Preventive Services Task Force (USPSTF) recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2021).

The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop

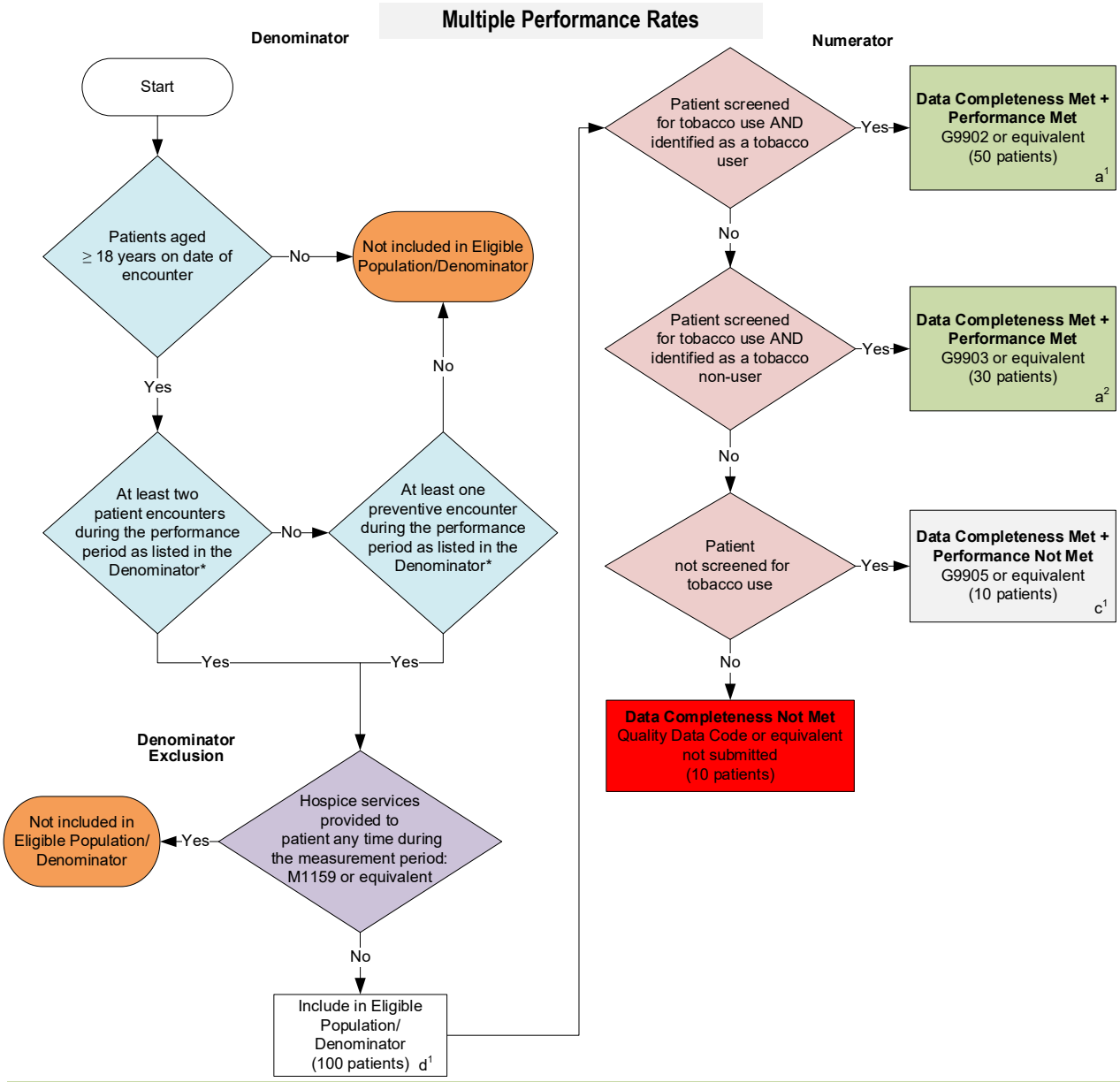
using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2015).

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women (Grade I Statement) (U.S. Preventive Services Task Force, 2021).

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of electronic cigarettes (e-cigarettes) for tobacco cessation in adults, including pregnant persons. The USPSTF recommends that clinicians direct patients who use tobacco to other tobacco cessation interventions with proven effectiveness and established safety (Grade I Statement) (U.S. Preventive Services Task Force, 2021).

2023 Clinical Quality Measure for Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Submission Criteria One

Disclaimer: *Refer to the measure specification for the specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=

Performance Met (a^1+a^2=80 patients) + Performance Not Met (c^1=10 patients) / Eligible Population / Denominator (d^1=100 patients) = 90 patients / 100 patients = **90.00%**

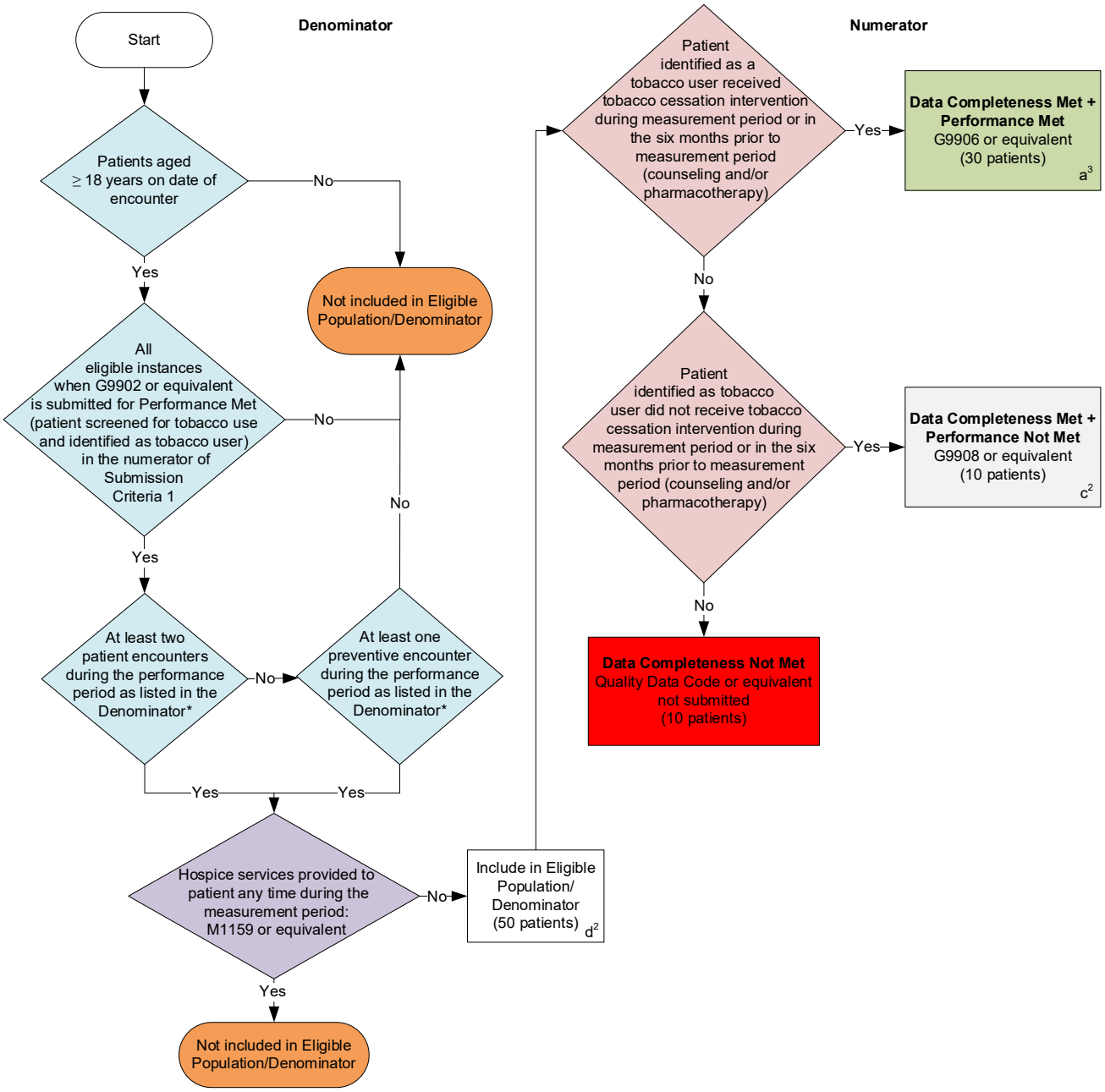
Performance Rate=

Performance Met (a^1+a^2=80 patients) / Data Completeness Numerator (90 patients) = 80 patients / 90 patients = **88.89%**

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

Submission Criteria Two



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness=

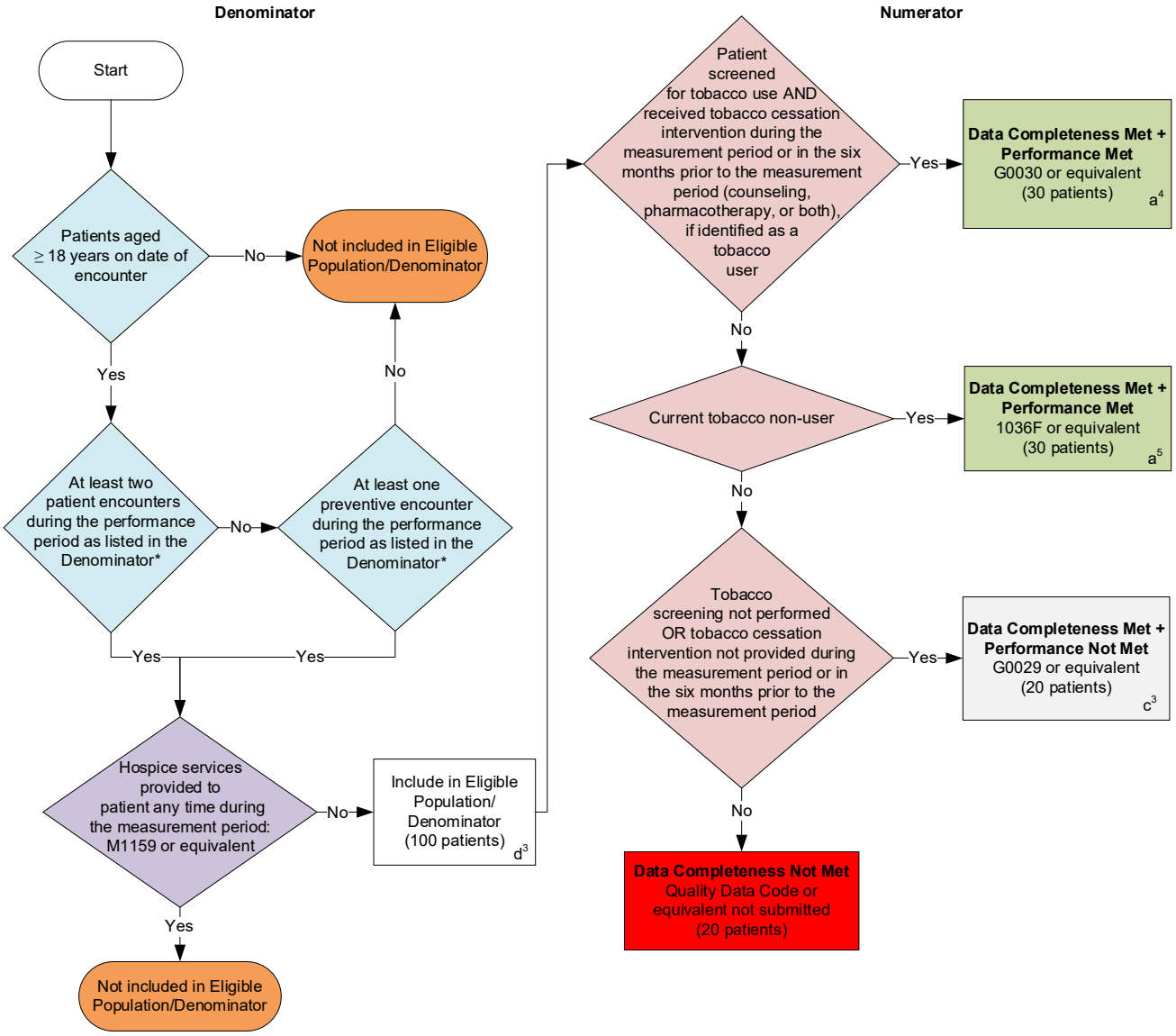
Performance Met (a^3=30 patients) + Performance Not Met (c^2=10 patients) / Eligible Population / Denominator (d^2=50 patients) = 40 patients / 50 patients = **80.00%**

Performance Rate=

Performance Met (a^3=30 patients) / Data Completeness Numerator (40 patients) = 30 patients / 40 patients = **75.00%**

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

Submission Criteria Three



SAMPLE CALCULATIONS: SUBMISSION CRITERIA THREE

Data Completeness=

Performance Met (a^4+a^5=60 patients) + Performance Not Met (c^3=20 patients) / Eligible Population / Denominator (d^3=100 patients) = 80 patients / 100 patients = **80.00%**

Performance Rate=

Performance Met (a^4+a^5=60 patients) / Data Completeness Numerator (80 patients) = 60 patients / 80 patients = **75.00%**

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

2023 Clinical Quality Measure Flow Narrative for Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

Multiple Performance Rates

Submission Criteria One:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years on date of encounter*:
    a. If *Patients aged greater than or equal to 18 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years on date of encounter* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in the Denominator**.
3. Check *At least two patient encounters during the performance period as listed in the Denominator**:
    a. If *At least two patient encounters during the performance period as listed in the Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in the Denominator**.
    b. If *At least two patient encounters during the performance period as listed in the Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during the measurement period*.
4. Check *At least one preventive encounter during the performance period as listed in the Denominator**:
    a. If *At least one preventive encounter during the performance period as listed in the Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *At least one preventive encounter during the performance period as listed in the Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during the measurement period*.
5. Check *Hospice services provided to patient any time during the measurement period*:
    a. If *Hospice services provided to patient any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*.
    b. If *Hospice services provided to patient any time during the measurement period* equals No, include in *Eligible Population/Denominator*.
6. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^1 equals 100 patients in the Sample Calculation.
7. Start Numerator
8. Check *Patient screened for tobacco use AND identified as a tobacco user*:
    a. If *Patient screened for tobacco use AND identified as a tobacco user* equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met letter* is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 50 patients in the Sample Calculation.

b. If *Patient screened for tobacco use AND identified as a tobacco user* equals No, proceed to check *Patient screened for tobacco use AND identified as a tobacco non-user*.

9. Check *Patient screened for tobacco use AND identified as a tobacco non-user*:

   a. If *Patient screened for tobacco use AND identified as a tobacco non-user* equals Yes, include in *Data Completeness Met and Performance Met*.

      - *Data Completeness Met and Performance Met letter* is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 30 patients in the Sample Calculation.

   b. If *Patient screened for tobacco use AND identified as a tobacco non-user* equals No, proceed to check *Patient not screened for tobacco use*.

10. Check *Patient not screened for tobacco use*:

    a. If *Patient not screened for tobacco use* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

       - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

    b. If *Patient not screened for tobacco use* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria One

Data Completeness equals Performance Met (a^1 plus a^2 equals 80 patients) plus Performance Not Met (c^1 equals 10 patients) divided by Eligible Population/Denominator (d^1 equals 100 patients). All equals 90 patients divided by 100 patients. All equals 90.00 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 80 patients) divided by Data Completeness Numerator (90 patients). All equals 80 patients divided by 90 patients. All equals 88.89 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Two:

1. Start with Denominator

2. Check *Patients aged greater than or equal to 18 years on date of encounter*:

    a. If *Patients aged greater than or equal to 18 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients aged greater than or equal to 18 years on date of encounter* equals Yes, proceed to check *All eligible instances when G9902 or equivalent is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 1*.

3. Check *All eligible instances when G9902 or equivalent is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 1*:

    a. If *All eligible instances when G9902 or equivalent is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 1* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *All eligible instances when G9902 or equivalent is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 1* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in the Denominator**.

4. Check *At least two patient encounters during the performance period as listed in the Denominator**:

    a. If *At least two patient encounters during the performance period as listed in Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in the Denominator**.

    b. If *At least two patient encounters during the performance period as listed in the Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during the measurement period*.

5. Check *At least one preventive encounter during the performance period as listed in the Denominator**:

    a. If *At least one preventive encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *At least one preventive encounter during the performance period as listed in the Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during the measurement period*.

6. Check *Hospice services provided to patient any time during the measurement period*:

    a. If *Hospice services provided to patient any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*.

    b. If *Hospice services provided to patient any time during the measurement period* equals No, include in *Eligible Population/Denominator*.

7. Denominator Population:

    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 50 patients in the Sample Calculation.

8. Start Numerator

9. Check *Patient identified as a tobacco user received tobacco cessation intervention during measurement period or in the six months prior to measurement period (counseling and/or pharmacotherapy)*:

a. If *Patient identified as a tobacco user received tobacco cessation intervention during measurement period or in the six months prior to measurement period (counseling and/or pharmacotherapy)* equals Yes, include in *Data Completeness Met and Performance Met*.

   - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^3 equals 30 patients in the Sample Calculation.

b. If *Patient identified as a tobacco user received tobacco cessation intervention during measurement period or in the six months prior to measurement period (counseling and/or pharmacotherapy)* equals No, proceed to check *Patient identified as tobacco user did not receive tobacco cessation intervention during measurement period or in the six months prior to measurement period (counseling and/or pharmacotherapy)*.

10. Check *Patient identified as tobacco user did not receive tobacco cessation intervention during measurement period or in the six months prior to measurement period (counseling and/or pharmacotherapy)*:

    a. If *Patient identified as tobacco user did not receive tobacco cessation intervention during measurement period or in the six months prior to measurement period (counseling and/or pharmacotherapy)* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

       - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    b. If *Patient identified as tobacco user did not receive tobacco cessation intervention during measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Two

Data Completeness equals Performance Met (a^3 equals 30 patients) plus Performance Not Met (c^2 equals 10 patients) divided by Eligible Population/Denominator (d^2 equals 50 patients). All equals 40 patients divided by 50 patients. All equals 80.00 percent.

Performance Rate equals Performance Met (a^3 equals 30 patients) divided by Data Completeness Numerator (40 patients). All equals 30 patients divided by 40 patients. All equals 75.00 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Three:

1. Start with Denominator

2. Check *Patient aged greater than or equal to 18 years on date of encounter*:

    a. If *Patient aged greater than or equal to 18 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patient aged greater than or equal to 18 years on date of encounter* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in the Denominator**.

3. Check *At least two patient encounters during the performance period as listed in the Denominator**:

    a. If *At least two patient encounters during the performance period as listed in the Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in Denominator**.

    b. If *At least two patient encounters during the performance period as listed in the Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during the measurement period*.

4. Check *At least one preventive encounter during the performance period as listed in Denominator**:

    a. If *At least one preventive encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *At least one preventive encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during the measurement period*.

5. Check *Hospice services provided to patient any time during the measurement period*:

    a. If *Hospice services provided to patient any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*.

    b. If *Hospice services provided to patient any time during the measurement period* equals No, include in *Eligible Population/Denominator*.

6. Denominator Population:

    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^3 equals 100 patients in the Sample Calculation.

7. Start Numerator

8. Check *Patient screened for tobacco use AND received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling, pharmacotherapy, or both), if identified as a tobacco user*:

    a. If *Patient screened for tobacco use AND received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling, pharmacotherapy, or both), if identified as a tobacco user* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^4 equals 30 patients in the Sample Calculation.

    b. If *Patient screened for tobacco use AND received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling, pharmacotherapy, or both), if identified as a tobacco user* equals No, proceed to check *Current tobacco*

non-user.

9. Check *Current tobacco non-user*:

    a. If *Current tobacco non-user* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^5 equals 30 patients in the Sample Calculation.

    b. If *Current tobacco non-user* equals No, proceed to check *Tobacco screening not performed OR tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period*.

10. Check *Tobacco screening not performed OR tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period*:

    a. If *Tobacco screening not performed OR tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^3 equals 20 patients in the Sample Calculation.

    b. If *Tobacco screening not performed OR tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 20 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Three

Data Completeness equals Performance Met (a^4 plus a^5 equals 60 patients) plus Performance Not Met (c^3 equals 20 patients) divided by Eligible Population/Denominator (d^3 equals 100 patients). All equals 80 patients divided by 100 patients. All equals 80.00 percent.

Performance Rate equals Performance Met (a^4 plus a^5 equals 60 patients) divided by Data Completeness Numerator (80 patients). All equals 60 patients divided by 80 patients. All equals 75.00 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #236: Controlling High Blood Pressure

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Intermediate Outcome – High Priority

DESCRIPTION:
Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients with hypertension seen during the performance period. The performance period for this measure is 12 months. The most recent quality code submitted will be used for performance calculation. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NOTE: *In reference to the numerator element, only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure. This includes blood pressures taken in person by a clinician and blood pressures measured remotely by electronic monitoring devices capable of transmitting the blood pressure data to the clinician. Blood pressure readings taken by a remote monitoring device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record.*

Do not include BP readings:
1) Taken during an acute inpatient stay or an ED visit
*2) Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests. BP readings taken on the same day that the member receives a common low-intensity or preventive procedure **are** eligible for use. For example, the following procedures are considered common low intensity or preventive (this list is just for reference, and is not exhaustive):*

- *Vaccinations.*
- *Injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone, lidocaine).*
- *TB test.*
- *IUD insertion.*
- *Eye exam with dilating agents.*
- *Wart or mole removal.*

3) Taken by the patient using a non-digital device such as with a manual blood pressure cuff and a stethoscope.
If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled".

If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading. Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance

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

modifiers) are allowable.

Measure 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.

The intent of the exclusion for individuals age 65 and older residing in long-term care facilities, including nursing homes, is to exclude individuals who may have limited life expectancy and increased frailty where the benefit of the process may not exceed the risks. This exclusion is not intended as a clinical recommendation regarding whether the measures process is inappropriate for specific populations, instead the exclusions allows clinicians to engage in shared decision making with patients about the benefits and risks of screening when an individual has limited life expectancy.

DENOMINATOR:
Patients 18-85 years of age who had a visit and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period.

> ***DENOMINATOR NOTE****: The diagnosis of essential hypertension must be present some time between 1 year prior to the measurement period and the first six months of the measurement period (January 1, 2022 - June 30, 2023).*
>
> *To assess the age for exclusions, the patient's age on the date of the encounter should be used.*
>
> **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.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients 18 to 85 years of age on date of encounter
> **AND**
> **Diagnosis for hypertension (ICD-10-CM):** I10
> **AND**
> **Patient encounter during performance period (CPT or HCPCS):** 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, G0438, G0439
> **AND NOT**
> **DENOMINATOR EXCLUSIONS:**
> **Hospice services given to patient any time during the measurement period:** G9740
> **OR**
> **Palliative care services given to patient any time during the measurement period:** G0031
> **OR**
> **Documentation of end stage renal disease (ESRD), dialysis, renal transplant before or during the measurement period or pregnancy during the measurement period:** G9231
> **OR**
> **Patients age 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period:** G9910

OR

Patients 66 - 80 years of age with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period: G2115

OR

Patients 66 - 80 years of age with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period: G2116

OR

Patients 81 years of age and older with at least one claim/encounter for frailty during the measurement period: G2118

Table: Dementia Exclusion Medications

Description	Prescription
Cholinesterase inhibitors	Donepezil Rivastigmine Galantamine
Miscellaneous central nervous system agents	Memantine

- **Codes to identify Frailty:** 99504, 99509, E0100, E0105, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0163, E0165, E0167, E0168, E0170, E0171, E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290, E0291, E0292, E0293, E0294, E0295, E0296, E0297, E0301, E0302, E0303, E0304, E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E0462, E0465, E0466, E0470, E0471, E0472, E0561, E0562, E1130, E1140, E1150, E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, E1296, E1297, E1298, G0162, G0299, G0300, G0493, G0494, S0271, S0311, S9123, S9124, T1000, T1001, T1002, T1003, T1004, T1005, T1019, T1020, T1021, T1022, T1030, T1031, L89.000, L89.001, L89.002, L89.003, L89.004, L89.006, L89.009, L89.010, L89.011, L89.012, L89.013, L89.014, L89.016, L89.019, L89.020, L89.021, L89.022, L89.023, L89.024, L89.026, L89.029, L89.100, L89.101, L89.102, L89.103, L89.104, L89.106, L89.109, L89.110, L89.111, L89.112, L89.113, L89.114, L89.116, L89.119, L89.120, L89.121, L89.122, L89.123, L89.124, L89.126, L89.129, L89.130, L89.131, L89.132, L89.133, L89.134, L89.136, L89.139, L89.140, L89.141, L89.142, L89.143, L89.144, L89.146, L89.149, L89.150, L89.151, L89.152, L89.153, L89.154, L89.156, L89.159, L89.200, L89.201, L89.202, L89.203, L89.204, L89.206, L89.209, L89.210, L89.211, L89.212, L89.213, L89.214, L89.216, L89.219, L89.220, L89.221, L89.222, L89.223, L89.224, L89.226, L89.229, L89.300, L89.301, L89.302, L89.303, L89.304, L89.306, L89.309, L89.310, L89.311, L89.312, L89.313, L89.314, L89.316, L89.319, L89.320, L89.321, L89.322, L89.323, L89.324, L89.326, L89.329, L89.40, L89.41, L89.42, L89.43, L89.44, L89.45, L89.46, L89.500, L89.501, L89.502, L89.503, L89.504, L89.506, L89.509, L89.510, L89.511, L89.512, L89.513, L89.514, L89.516, L89.519, L89.520, L89.521, L89.522, L89.523, L89.524, L89.526, L89.529, L89.600, L89.601, L89.602, L89.603, L89.604, L89.606, L89.609, L89.610, L89.611, L89.612, L89.613, L89.614, L89.616, L89.619, L89.620, L89.621, L89.622, L89.623, L89.624, L89.626, L89.629, L89.810, L89.811, L89.812, L89.813, L89.814, L89.816, L89.819, L89.890, L89.891, L89.892, L89.893, L89.894, L89.896, L89.899, L89.90, L89.91, L89.92, L89.93, L89.94, L89.95, L89.96, M62.50, M62.81, M62.84, R26.0, R26.1, R26.2, R26.89, R26.9, R41.81, R53.1, R53.81, R53.83, R54, R62.7, R63.4, R63.6, R64, W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS, W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S, W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS,

W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS, W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS, Y92.199, Z59.3, Z73.6, Z74.01, Z74.09, Z74.1, Z74.2, Z74.3, Z74.8, Z74.9, Z91.81, Z99.11, Z99.3, Z99.81, Z99.89

- **Codes to identify Advanced Illness:** A81.00, A81.01, A81.09, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C91.00, C91.02, C92.00, C92.02, C93.00, C93.02, C93.90, C93.92, C93.Z0, C93.Z2, C94.30, C94.32, F01.50, F01.51, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01.C18, F01.C2, F01.C3, F01.C4, F02.80, F02.81, F02.811, F02.818, F02.82, F02.83, F02.84, F02.A0, F02.A11, F02.A18, F02.A2, F02.A3, F02.A4, F02.B0, F02.B11, F02.B18, F02.B2, F02.B3, F02.B4, F02.C0, F02.C11, F02.C18, F02.C2, F02.C3, F02.C4, F03.90, F03.91, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A0, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, F04, F10.27, F10.96, F10.97, G10, G12.21, G20, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.170, J84.178, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6

NUMERATOR:
Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period

Numerator Instructions:
To describe both systolic and diastolic blood pressure values, **each must be submitted separately**. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

NUMERATOR NOTE: *In reference to the numerator element, only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure. This includes blood pressures taken in person by a clinician and blood pressures measured remotely by electronic monitoring devices capable of transmitting the blood pressure data to the clinician. Blood pressure readings taken by a remote monitoring device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record.*

Do not include BP readings:
1) Taken during an acute inpatient stay or an ED visit
*2) Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests. BP readings taken on the same day that the member receives a common low-intensity or preventive procedure **are** eligible for use. For example, the following procedures are considered common low intensity or preventive (this list is just for reference, and is not exhaustive):*

- *Vaccinations.*

- *Injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone, lidocaine).*
- *TB test.*
- *IUD insertion.*
- *Eye exam with dilating agents.*
- *Wart or mole removal.*

3) Taken by the patient using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled."

If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading. Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance.

Numerator Options:	
Performance Met:	Most recent systolic blood pressure < 140 mmHg **(G8752)**
OR	
Performance Not Met:	Most recent systolic blood pressure ≥ 140 mmHg **(G8753)**
AND	
Performance Met:	Most recent diastolic blood pressure < 90 mmHg **(G8754)**
OR	
Performance Not Met:	Most recent diastolic blood pressure ≥ 90 mmHg **(G8755)**
OR	
Performance Not Met:	No documentation of blood pressure measurement, reason not given **(G8756)**

RATIONALE:

High blood pressure (HBP), also known as hypertension, is when the pressure in blood vessels is higher than normal (Centers for Disease Control and Prevention [CDC], 2021). The causes of hypertension are multiple and multifaceted and can be based on genetic predisposition, environmental risk factors, being overweight and obese, sodium intake, potassium intake, physical activity, and alcohol use. High blood pressure is common; according to the American Heart Association, between 2013-2016, approximately 121.5 million US adults>=20 years of age had HBP and the prevalence of hypertension among US adults 65 and older was 77.0 percent (Virani et al, 2021).

HBP, known as the “silent killer,” increases risks of heart disease and stroke which are two of the leading causes of death in the U.S. ; a person who has HBP is four times more likely to die from a stroke and three times more likely to die from heart disease (CDC, 2012). The National Vital Statistics Systems reported that in 2014 there were approximately 73,300 deaths directly due to HBP and 410,624 deaths with any mention of HBP (CDC, 2014). Between 2008 and 2018 the number of deaths due to HBP rose by 57.2 percent (Virani et al, 2021). Managing and treating HBP would reduce cardiovascular disease mortality for males and females by 30.4 percent and 38.0 percent, respectively (Patel et al., 2015).

The estimated annual average direct and indirect cost of HBP from 2016 to 2017 was $52.4 billion (Virani et al, 2021). A study on cost-effectiveness on treating hypertension found that controlling HBP in patients with cardiovascular disease and systolic blood pressures of >= 160 mm Hg could be effective and cost-saving (Moran, 2015).

Many studies have shown that controlling high blood pressure reduces cardiovascular events and mortality. The Systolic Blood Pressure Intervention Trial (SPRINT) investigated the impact of obtaining a SBP goal of <120 mm Hg compared to a SBP goal of <140 mm Hg among patients 50 and older with established cardiovascular disease and

found that the patients with the former goal had reduced cardiovascular events and mortality (SPRINT Research Group et al., 2015).

Controlling HBP will significantly reduce the risks of cardiovascular disease mortality and lead to better health outcomes like reduction of heart attacks, stroke, and kidney disease (James et al., 2014). Thus, the relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established.

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (2015) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

American College of Cardiology/American Heart Association (2017)
-For adults with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher, a blood pressure target of less than 130/80 mmHg is recommended (Level of evidence: B-R (for systolic blood pressures), Level of evidence: C-EO (for diastolic blood pressure))
-For adults with confirmed hypertension, without additional markers of increased CVD risk, a blood pressure target of less than 130/80 mmHg may be reasonable (Note: clinical trial evidence is strongest for a target blood pressure of 140/90 mmHg in this population. However observational studies suggest that these individuals often have a high lifetime risk and would benefit from blood pressure control earlier in life) (Level of evidence: B-NR (for systolic blood pressure), Level of evidence: C-EO (for diastolic blood pressure))

American College of Physicians and the American Academy of Family Physicians (2017):
-Initiate or intensify pharmacologic treatment in some adults aged 60 years or older at high cardiovascular risk, based on individualized assessment, to achieve a target systolic blood pressure of less than 140 mmHg (Grade: weak recommendation, Quality of evidence: low)
-Initiate or intensify pharmacologic treatment in adults aged 60 years or older with a history of stroke or transient ischemic attack to achieve a target systolic blood pressure of less than 140 mmHg to reduce the risk of recurrent stroke (Grade: weak recommendation, Quality of evidence: moderate)

American Diabetes Association (2021):
For individuals with diabetes and hypertension at higher cardiovascular risk (existing atherosclerotic cardiovascular disease or 10-year atherosclerotic cardiovascular disease risk >=15%), blood pressure target of <130/80 mmHg may be appropriate, if it can be safely attained (Level of evidence: C).

For individuals with diabetes and hypertension at lower risk for cardiovascular disease (10-year atherosclerotic cardiovascular disease risk <15%), treat to a blood pressure target of <140/90 mmHg (Level of evidence: A)

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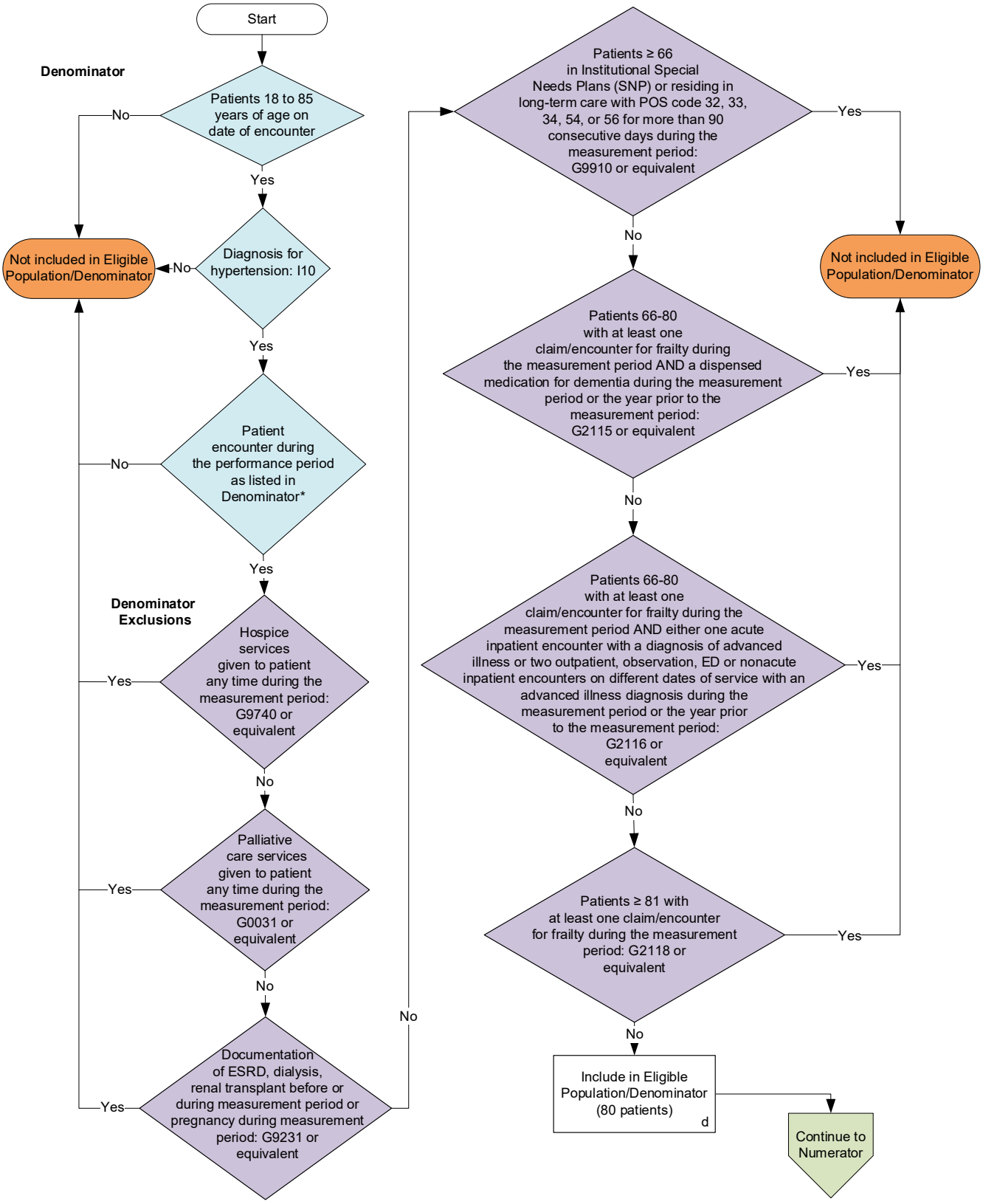
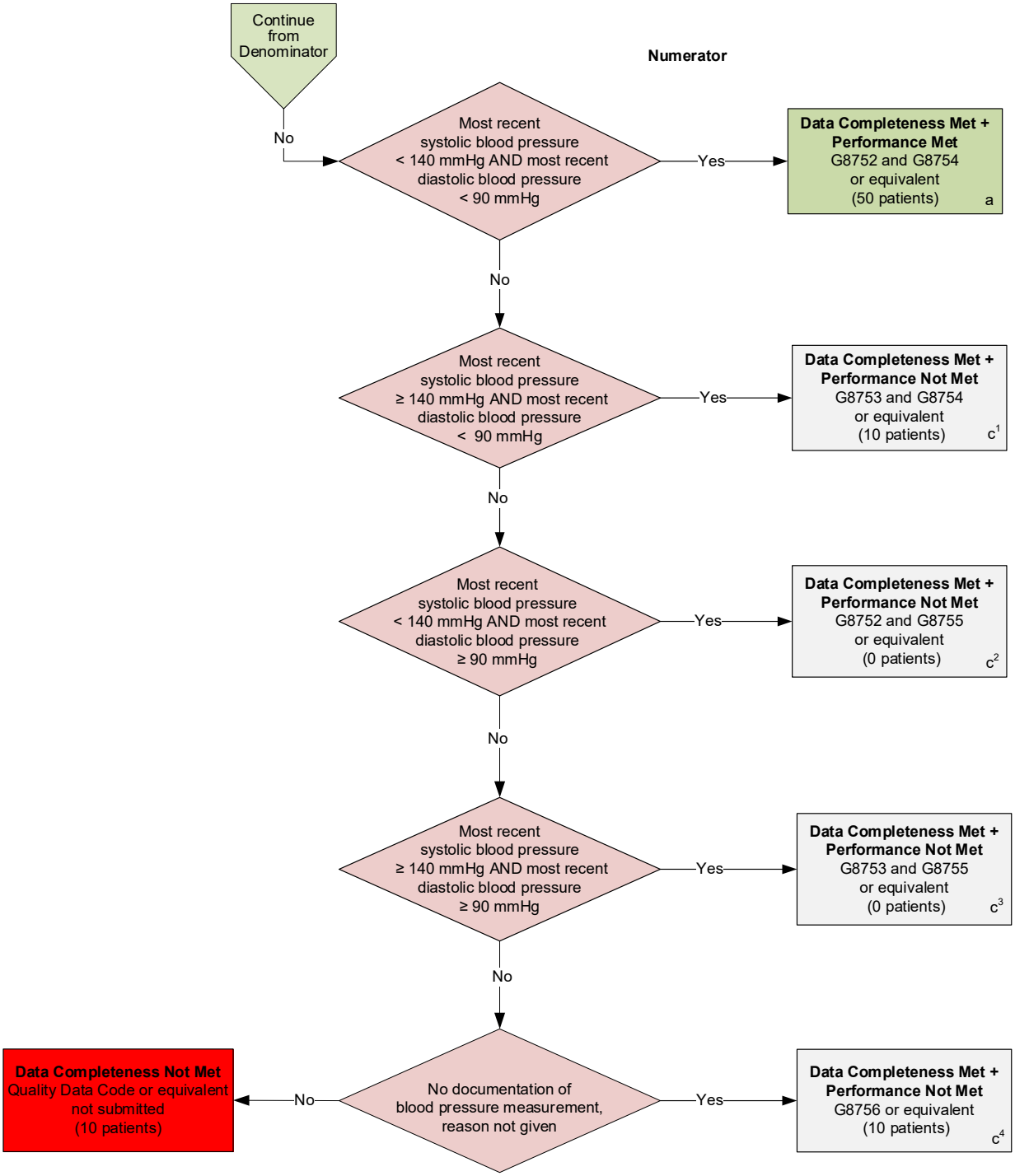
2023 Clinical Quality Measure Flow for Quality ID #236: Controlling High Blood Pressure

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*





SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=50 patients) + Performance Not Met ($c^1+c^2+c^3+c^4$=20 patients) / Eligible Population / Denominator (d=80 patients) = 70 patients / 80 patients = **87.50%**

Performance Rate=

Performance Met (a=50 patients) / Data Completeness Numerator (70 patients) = 50 patients / 70 patients = **71.43%**

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Intermediate

2023 Clinical Quality Measure Flow Narrative for Quality ID #236: Controlling High Blood Pressure

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients 18 to 85 years of age on date of encounter*:
    a. If *Patients 18 to 85 years of age on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients 18 to 85 years of age on date of encounter* equals Yes, proceed to check *Diagnosis for hypertension*.
3. Check *Diagnosis for hypertension*:
    a. If *Diagnosis for hypertension* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis for hypertension* equals Yes, proceed to *Patient encounter during the performance period as listed in Denominator**.
4. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Hospice services given to patient any time during the measurement period*.
5. Check *Hospice services given to patient any time during the measurement period*:
    a. If *Hospice services given to patient any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Hospice services given to patient any time during the measurement period* equals No, proceed to check *Palliative care services given to patient any time during the measurement period.*
6. Check *Palliative care services given to patient any time during the measurement period*:
    a. If *Palliative care services given to patient any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Palliative care services given to patient any time during the measurement period* equals No, proceed to check *Documentation of ESRD, dialysis, renal transplant before or during measurement period or pregnancy during measurement period.*
7. Check *Documentation of ESRD, dialysis, renal transplant before or during measurement period or pregnancy during measurement period*:
    a. If *Documentation of ESRD, dialysis, renal transplant before or during measurement period or pregnancy during measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Documentation of ESRD, dialysis, renal transplant before or during measurement period or pregnancy during measurement period* equals No, proceed to check *Patients greater than or equal to 66 in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period*.

8. Check *Patients greater than or equal to 66 in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period*:

    a. If *Patients greater than or equal to 66 in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients greater than or equal to 66 in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period* equals No, proceed to check *Patients 66-80 with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period*.

9. Check *Patients 66-80 with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period*:

    a. If *Patients 66-80 with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients 66-80 with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period* equals No proceed to check *Patients 66-80 with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period*.

10. Check *Patients 66-80 with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period*:

    a. If *Patients 66-80 with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients 66-80 with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates or service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period* equals No, proceed to check *Patients greater than or equal to 81 with at least one claim/encounter for frailty during the measurement period*

11. Check *Patients greater than or equal to 81 with at least one claim/encounter for frailty during the measurement period*:

    a. If *Patients greater than or equal to 81 with at least one claim/encounter for frailty during the measurement period* equals Yes, do not include in *Eligible Population*/*Denominator*.

    b. If *Patients greater than or equal to 81 with at least one claim/encounter for frailty during the measurement period* equals No, include in *Eligible Population*/*Denominator*.

12. Denominator Population:

    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.

13. Start Numerator

14. Check *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg*:

    a. If *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 50 patients in Sample Calculation.

    b. If *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg* equals No, proceed to check *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg*.

15. Check to *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg*:

    a. If to *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

    b. If to *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg* equals No, proceed to check *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg*.

16. Check *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg*:

    a. If *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 0 patients in the Sample Calculation.

    b. If *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg* equals No, proceed to check *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg*.

17. Check *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg*:

    a. If *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^3 equals 0 patients in the Sample Calculation.

    b. If *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood*

pressure greater than or equal to 90 mmHg equals No, proceed to check *No documentation of blood pressure measurement, reason not given*.

18. Check *No documentation of blood pressure measurement, reason not given*:

    a. If *No documentation of blood pressure measurement, reason not given* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^4 equals 10 patients in the Sample Calculation.

    b. If *No documentation of blood pressure measurement, reason not given* equals No, proceed to *Data Completeness Not Met*.

19. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 50 patients) plus Performance Not Met (c^1 plus c^2 plus c^3 plus c^4 equals 20 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 50 patients) divided by Data Completeness Numerator (70 patients). All equals 50 patients divided by 70 patients. All equals 71.43 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Intermediate

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #238 (NQF 0022): Use of High-Risk Medications in Older Adults

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients 65 years of age and older who were ordered at least two high-risk medications from the same drug class.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. There is no diagnosis associated with this measure. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

The measure reflects potentially inappropriate medication use in older adults, both for medications where any use is inappropriate and for medications where use under all but specific indications is potentially inappropriate.

This measure will be calculated with 2 performance rates:
1. Percentage of patients 65 years of age and older who were ordered at least two high-risk medications from the same drug class.
2. Percentage of patients 65 years of age and older who were ordered at least two high-risk medications from the same drug class, except for appropriate diagnoses.

For accountability reporting in the CMS MIPS program, the rate for submission criteria 1 is used for performance.

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

Measure 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.

SUBMISSION CRITERIA 1: PERCENTAGE OF PATIENTS 65 YEARS OF AGE AND OLDER WHO WERE ORDERED AT LEAST TWO HIGH-RISK MEDICATIONS FROM THE SAME DRUG CLASS

DENOMINATOR NOTE*: *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.*

DENOMINATOR (SUBMISSION CRITERIA 1):
Patients 65 years and older who had a visit during the measurement period

Denominator Criteria:
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during performance period (CPT or HCPCS): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99387*, 99397*, G0438, G0439
AND NOT
DENOMINATOR EXCLUSIONS:
Patients who use hospice services any time during the measurement period: G9741
OR
Patients receiving palliative care during the measurement period: G0034

NUMERATOR (SUBMISSION CRITERIA 1):
Patients ordered at least two high-risk medications from the same drug class during the measurement year.

Definitions:
The intent of the measure is to assess if the eligible clinician ordered high-risk medication(s). The intent of the numerator is to assess if the patient has either been ordered:

- At least two high-risk medications from the same drug class (grouped by row) in Table 1 on different dates of service, or
- At least two high-risk medications from the same drug class (grouped by row) in Table 2 on different dates of service, where the sum of days supply exceeds 90 days
- At least two high-risk medications from the same drug class in Table 3 on different dates of service, each exceeding average daily dose criteria.

If the patient had a high-risk medication previously prescribed by another provider, they would not be counted towards the numerator unless the submitting provider also ordered a high-risk medication for them from the same drug class.

Calculate average daily dose for each prescription event. To calculate average daily dose, multiply the quantity of pills prescribed by the dose of each pill and divide by the days supply. For example, a prescription for the 30-days supply of digoxin containing 15 pills, 0.25 mg each pill, has an average daily dose of 0.125 mg. To calculate average daily dose for elixirs and concentrates, multiply the volume prescribed by daily dose and divide by the days supply. Do not round when calculating average daily dose.

Cumulative Medication Duration – an individual's total number of medication days over a specific period; the period counts multiple prescriptions with gaps in between, but does not count the gaps during which a medication was not dispensed.

To determine the "cumulative medication duration", determine first the number of the Medication Days for each prescription in the period: the number of doses divided by the dose frequency per day. Then add the Medication Days for each prescription without counting any days between the prescriptions.

For example, there is an original prescription for 30 days with 2 refills for thirty days each. After a gap of 3 months, the medication was ordered again for 60 days with 1 refill for 60 days. The "cumulative medication duration" is (30 x 3) + (60 x 2) = 210 days over the 10 month period.

Table 1 - High-Risk Medications at any Dose or Duration

Description	Prescription	
Anticholinergics, first-generation antihistamines	Brompheniramine Carbinoxamine Chlorpheniramine Clemastine Cyproheptadine Dexbrompheniramine Dexchlorpheniramine Dimenhydrinate	Diphenhydramine (oral) Doxylamine Hydroxyzine Meclizine Promethazine Pyrilamine Triprolidine
Anticholinergics, anti-Parkinson agents	Benztropine (oral)	Trihexyphenidyl
Antispasmodics	Atropine (exclude ophthalmic) Belladonna alkaloids Chlordiazepoxide-clidinium Dicyclomide	Hyoscyamine Methscopolamine Propantheline Scopolamine
Antithrombotics	Dipyridamole, oral short-acting	
Cardiovascular, alpha agonists, central	Methyldopa	Guanfacine
Cardiovascular, other	Disopyramide	Nifedipine, immediate release
Central nervous system, antidepressants	Amitriptyline Clomipramine Amoxapine Desipramine	Imipramine Trimipramine Nortriptyline Paroxetine Protriptyline
Central nervous system, barbiturates	Amobarbital Butabarbital Butalbital	Pentobarbital Phenobarbital Secobarbital
Central nervous system, vasodilators	Ergot mesylates	Isoxsuprine
Central nervous system, other		Meprobamate
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	Conjugated estrogen Estropipate	Estradiol Esterified estrogen
Endocrine system, sulfonylureas, long-duration	Chlorpropamide Glimepiride	Glyburide
Endocrine system, other	Desiccated thyroid	Megestrol
Nonbenzodiazepine hypnotics	Eszopiclon Zaleplon	Zolpidem
Pain medications, skeletal muscle relaxants	Carisoprodol Chlorzoxazone Cyclobenzaprine	Metaxalone Methocarbamol Orphenadrine

Description	Prescription	
Pain medications, other	Indomethacin Meperidine	Ketorolac, includes parenteral

*The registry version of the measure specifications only indicates the classes of drugs that are considered high-risk and do not include the specific coding of RxNorm. However, this measure aligns with the eCQM measure (CMS 156) and providers may review the RxNorm codes in the applicable eCQM value sets for submission.

Table 2 - High-Risk Medications With Days Supply Criteria

Description	Prescription		Days Supply Criteria
Anti-Infectives, other	Nitrofurantoin Nitrofurantoin macrocrystals	Nitrofurantoin macrocrystals-monohydrate	>90 days

Table 3 – High-Risk Medications With Average Daily Dose Criteria

Prescription	Average Daily Dose Criteria
Reserpine	> 0.1 mg per day
Digoxin	> 0.125 mg per day
Doxepin/Doxepin hydrochloride	> 6 mg per day

Numerator Instructions:

INVERSE MEASURE – A lower calculated performance rate for this measure indicates better clinical care or control. The "Performance Not Met" numerator option for this measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.

A high-risk medication is identified by either of the following:

- A prescription for medications classified as high risk at any dose and for any duration listed in Table 1
- Prescriptions for medications classified as high risk at any dose with greater than a 90 day cumulative medication duration listed in Table 2
- A prescription for medications classified as high risk exceeding average daily dose criteria listed in Table 3

Numerator Options:

Performance Met: At least two orders for high-risk medications from the same drug class **(G9367)**

OR

Performance Not Met: At least two orders for high-risk medications from the same drug class not ordered **(G9368)**

SUBMISSION CRITERIA 2: PERCENTAGE OF PATIENTS 65 YEARS OF AGE AND OLDER WHO WERE ORDERED AT LEAST TWO HIGH-RISK MEDICATIONS FROM THE SAME DRUG CLASS, EXCEPT FOR APPROPRIATE DIAGNOSES

DENOMINATOR NOTE*: *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.*

DENOMINATOR (SUBMISSION CRITERIA 2):

Patients 65 years and older who had a visit during the measurement period

Denominator Criteria:
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during performance period (CPT or HCPCS): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205,99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99387*, 99397*, G0438, G0439
AND NOT
DENOMINATOR EXCLUSIONS:
Patients who use hospice services any time during the measurement period: G9741
OR
Patients receiving palliative care during the measurement period: G0034

NUMERATOR (SUBMISSION CRITERIA 2):

Patients with at least two orders of high-risk medications from the same drug class (i.e., antipsychotics and benzodiazepines), except for appropriate diagnoses.

Definitions:
The intent of the numerator is to assess if the patient has been ordered at least two high-risk medications from the same drug class (grouped by row) in Table 4 on different dates or service. The intent of the measure is to assess if the submitting provider ordered the high-risk medication(s). If the patient had a high-risk medication previously prescribed by another provider, they would not be counted towards the numerator unless the submitting provider also ordered a high-risk medication for them from the same drug class.

Index Prescription Start Date (IPSD) – The start date of the earliest prescription ordered for a high-risk medication during the measurement period.

Table 4 - High-Risk Medications

Description	Prescription	
Antipsychotics, first (conventional) and second (atypical) generation	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Chlorpromazine • Clozapine • Fluphenazine • Haloperidol • Iloperidone • Loxapine • Lurasidone	• Molindone • Olanzapine • Paliperidone • Perphenazine • Pimavanserin • Pimozide • Quetiapine • Risperidone • Thioridazine • Thiothixene • Trifluoperazine • Ziprasidone
Benzodiazepines, long, short and intermediate acting	• Alprazolam • Chlordiazepoxide	• Lorazepam • Midazolam

Description	Prescription	
	• Clonazepam	• Oxazepam
	• Clorazepate	• Quazepam
	• Diazepam	• Temazepam
	• Estazolam	• Triazolam
	• Flurazepam	

*The registry version of the measure specifications only indicates the classes of drugs that are considered high-risk and do not include the specific coding of RxNorm. However, this measure aligns with the eCQM measure (CMS 156) and providers may review the RxNorm codes in the applicable eCQM value sets for submission.

Numerator Instructions:

INVERSE MEASURE – A lower calculated performance rate for this measure indicates better clinical care or control. The "Performance Not Met" numerator option for this measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.

A high-risk medication is identified by:

- A prescription for medications classified as high risk at any dose and for any duration listed in Table 4

Numerator Options:

Performance Met: At least two orders for high-risk medications from the same drug class, (Table 4), without appropriate diagnoses **(M1209)**

OR

Performance Not Met: At least two orders for high-risk medications from the same drug class, (Table 4), not ordered **(M1210)**

OR

Performance Not Met: Two or more antipsychotic prescriptions ordered for patients who had a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder on or between January 1 of the year prior to the measurement period and the Index Prescription Start Date (IPSD) for antipsychotics **(G0032)**

OR

Performance Not Met: Two or more benzodiazepine prescriptions ordered for patients who had a diagnosis of seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, or severe generalized anxiety disorder on or between January 1 of the year prior to the measurement period and the IPSD for benzodiazepines **(G0033)**

RATIONALE:

Certain medications (MacKinnon & Hepler, 2003) are associated with increased risk of harm from drug side-effects and drug toxicity and pose a concern for patient safety. There is clinical consensus that these drugs pose increased risks in older adults (Kaufman, Brodin, & Sarafian, 2005. Potentially inappropriate medication use in older adults has been connected to significantly longer hospital stay lengths and increased hospitalization costs (Hagstrom et al., 2015) as well as increased risk of death (Lau et al. 2004). Use of specific high-risk medications such as hypnotics, including benzodiazepine receptor agonists, and nonsteroidal anti-inflammatory drugs (NSAIDS) can result in increased risk of

delirium, falls, fractures, gastrointestinal bleeding and acute kidney injury (Merel et al., 2017). Long-term use of benzodiazepines in older adults has been associated with increased risk of dementia (Zhong et al., 2015; Takada et al., 2016). Additionally, the use of antipsychotics can lead to increased risk of stroke and greater cognitive decline in older adults with dementia (Tampi et al., 2016).

Older adults receiving inappropriate medications are more likely to report poorer health status at follow-up, compared to those who receive appropriate medications (Lau et al. 2004). A study of the prevalence of potentially inappropriate medication use in older adults found that 40 percent of individuals 65 and older filled at least one prescription for a potentially inappropriate medication and 13 percent filled two or more (Fick et al. 2008). While some adverse drug events (ADEs) are unavoidable, studies estimate that between 30 and 80 percent of ADEs in older adults are preventable (MacKinnon and Hepler 2003). More recently with the onset of the COVID-19 pandemic, several studies have shown an increase in anxiety, insomnia and depression rates, which could result in an increase in the use of high-risk medications in order to treat these conditions (Agrawal, 2020).

Reducing the number of inappropriate prescriptions can lead to improved patient safety and significant cost savings. Conservative estimates of extra costs due to potentially inappropriate medications in older adults average $7.2 billion a year (Fu et al. 2007). Medication use by older adults will likely increase further as the U.S. population ages, new drugs are developed, and new therapeutic and preventive uses for medications are discovered (Rothberg et al. 2008). The annual direct costs of preventable ADEs in the Medicare population have been estimated to exceed $800 million (IOM, 2007). By the year 2030, nearly one in five U.S. residents is expected to be aged 65 years or older; this age group is projected to more than double from 38.7 million in 2008 to more than 88.5 million in 2050. Likewise, the population aged 85 years or older is expected to increase almost four-fold, from 5.4 million to 19 million between 2008 and 2050. As the older adult population continues to grow, the number of older adults who present with multiple medical conditions for which several medications are prescribed will likely continue to increase, resulting in polypharmacy concerns (Gray and Gardner 2009).

CLINICAL RECOMMENDATION STATEMENTS:

The measure is based on recommendations from the American Geriatrics Society Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (2019). The criteria were developed through key clinical expert consensus processes by Beers in 1997, Zahn in 2001 and an updated process by Fick in 2003, 2012, 2015 and 2019. The Beers Criteria identifies lists of drugs that are potentially inappropriate for all older adults, except for those with certain conditions for which some high-risk medications may be warranted, and drugs that are potentially inappropriate in older adults based on various high-risk factors such as dosage, days' supply and underlying diseases or conditions. NCQA's Geriatric Measurement Advisory Panel recommended a subset of drugs that should be used with caution in older adults for inclusion in the proposed measure based upon the recommendations in the Beers Criteria.

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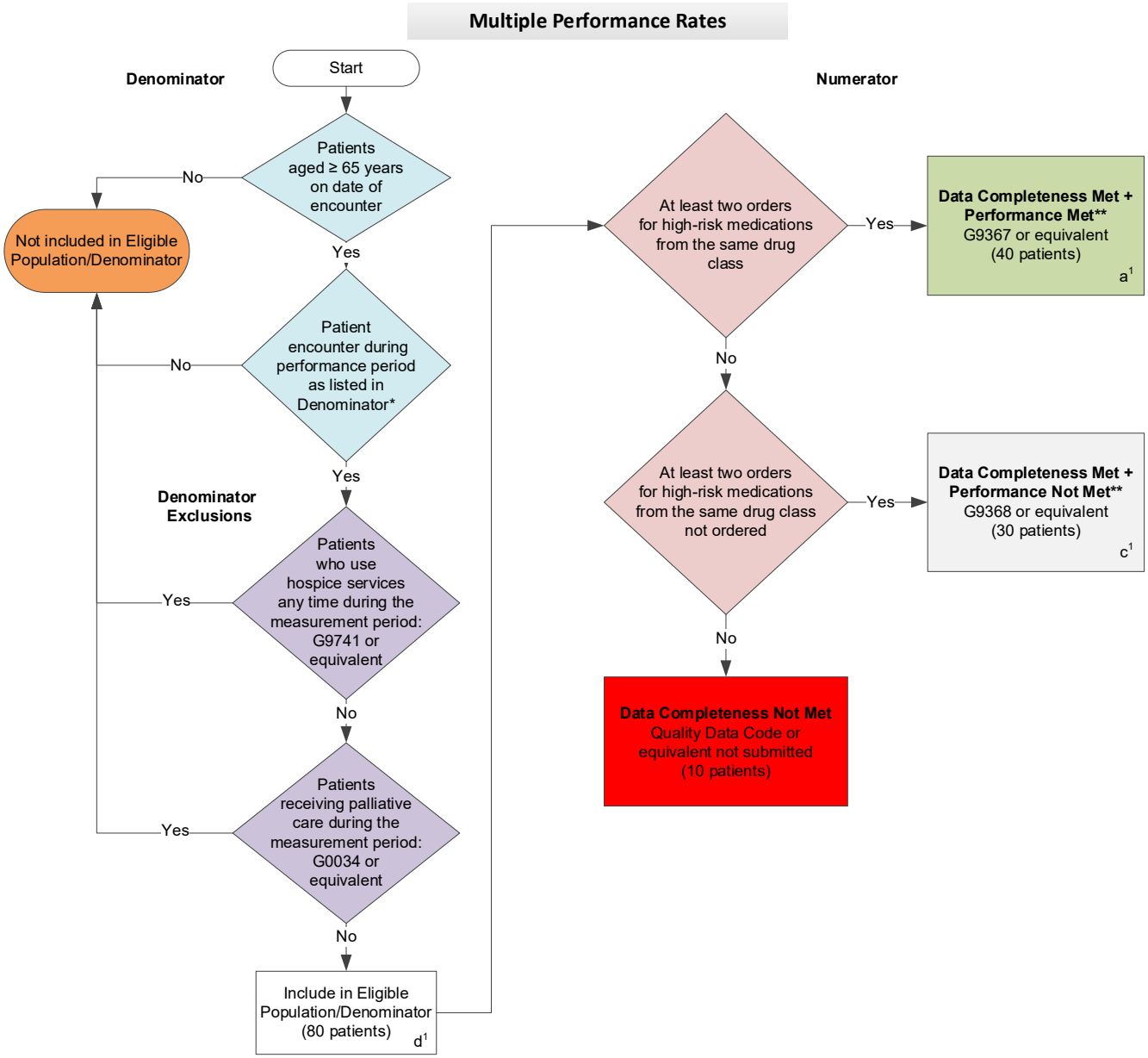
2023 Clinical Quality Measure Flow for Quality ID #238 (NQF 0022): Use of High-Risk Medications in Older Adults Submission Criteria One

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



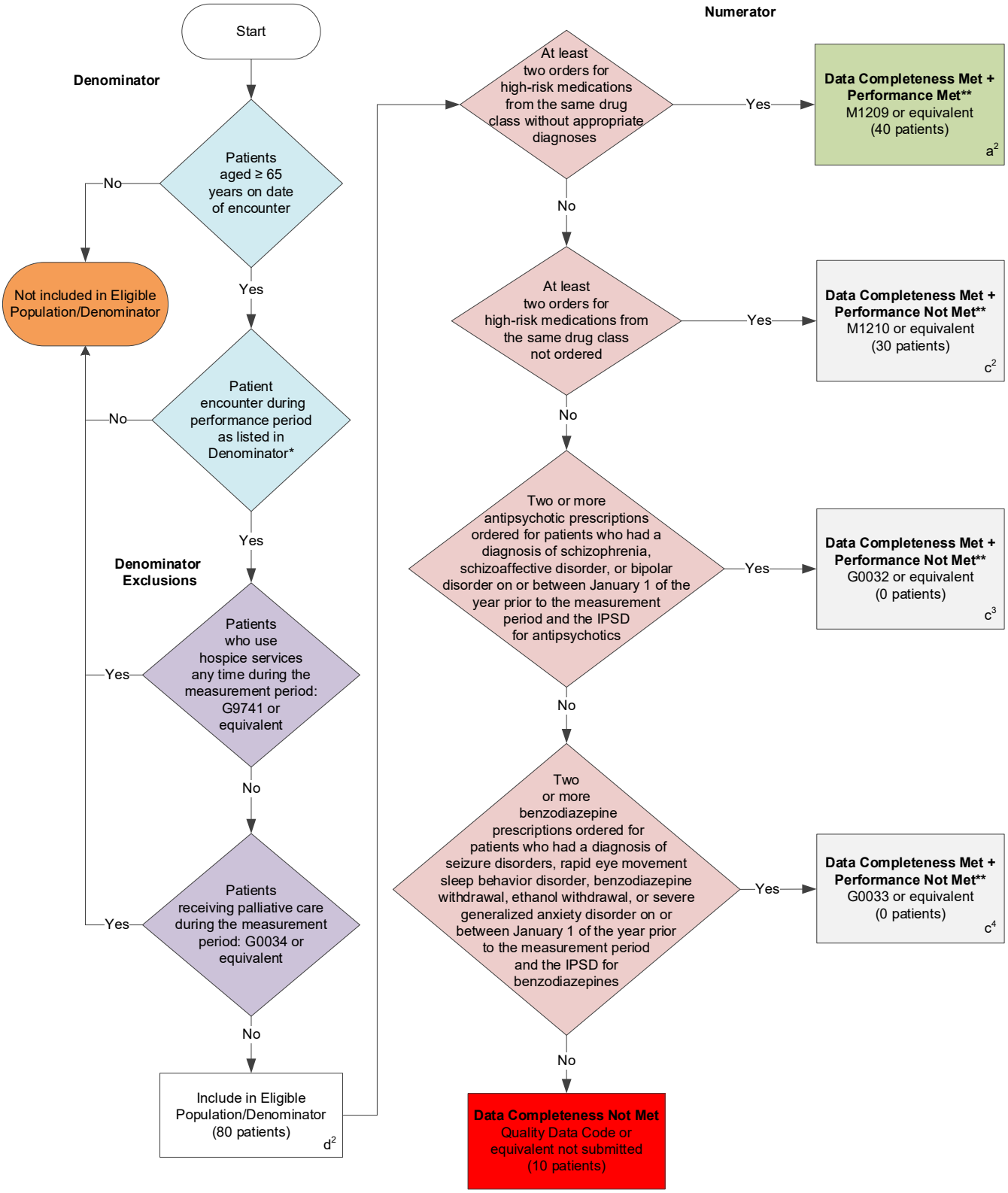
SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=
Performance Met (a^1=40 patients) + Performance Not Met (c^1=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d^1=80 patients) = 80 patients

Performance Rate=
Performance Met (a^1=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

* See the posted measure specification for specific coding and instructions to submit this measure.
**A lower calculated performance rate for this measure indicates better clinical care or control.
NOTE: Submission Frequency: Patient-Process

Submission Criteria Two



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness=

Performance Met (a^2=40 patients) + Performance Not Met ($c^2+c^3+c^4$=30 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d^2=80 patients) = 80 patients

Performance Rate=

Performance Met (a^2=40 patients) = 40 patients = **57.14%**

Data Completeness Numerator (70 patients) = 70 patients

* See the posted measure specification for specific coding and instructions to submit this measure.
**A lower calculated performance rate for this measure indicates better clinical care or control.
NOTE: Submission Frequency: Patient-Process

v7

2023 Clinical Quality Measure Flow Narrative for Quality ID #238 (NQF 0022): Use of High-Risk Medications in Older Adults

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

Submission Criteria One:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 65 years on date of encounter*:
    a. If *Patients aged greater than or equal to 65 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 65 years on date of encounter* equals Yes, proceed to check *Patient encounter during performance period as listed in Denominator**.
3. Check *Patient encounter during performance period as listed in Denominator**:
    a. If *Patient encounter during performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during performance period as listed in Denominator** equals Yes, proceed to check *Patients who use hospice services any time during the measurement period*.
4. Check *Patients who use hospice services any time during the measurement period*:
    a. If *Patients who use hospice services any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients who use hospice services any time during the measurement period* equals No, proceed to check *Patients receiving palliative care during the measurement period*.
5. Check *Patients receiving palliative care during the measurement period*:
    a. If *Patients receiving palliative care during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients receiving palliative care during the measurement period* equals No, include in *Eligible Population/Denominator*.
6. Denominator Population:
    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d[1] equals 80 patients in the Sample Calculation.
7. Start Numerator
8. Check *At least two orders for high-risk medications from the same drug class*:
    a. If *At least two orders for high-risk medications from the same drug class* equals Yes, include in *Data Completeness Met and Performance Met***.
    - *Data Completeness Met and Performance Met*** letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[1] equals 40 patients in Sample Calculation.

b. If *At least two orders for high-risk medications from the same drug class* equals No, proceed to check *At least two orders for high-risk medications from the same drug class not ordered*.

9. Check *At least two orders for high-risk medications from the same drug class not ordered*:

    a. If *At least two orders for high-risk medications from the same drug class not ordered* equals Yes, include in *Data Completeness Met and Performance Not Met***.

        - *Data Completeness Met and Performance Not Met*** letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 30 patients in the Sample Calculation.

    b. If *At least two orders for high-risk medications from the same drug class not ordered* equals No, proceed to check *Data Completeness Not Met*.

10. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria One

Data Completeness equals Performance Met (a^1 equals 40 patients) plus Performance Not Met (c^1 equals 30 patients) divided by Eligible Population / Denominator (d^1 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

* See the posted measure specification for specific coding and instructions to submit this measure.

**A lower calculated performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Two:

1. Start with Denominator

2. Check *Patients aged greater than or equal to 65 years on date of encounter*:

    a. If *Patients aged greater than or equal to 65 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients aged greater than or equal to 65 years on date of encounter* equals Yes, proceed to check *Patient encounter during performance period as listed in Denominator**.

3. Check *Patient encounter during performance period as listed in Denominator**:

    a. If *Patient encounter during performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

b. If *Patient encounter during performance period as listed in Denominator** equals Yes, proceed to check *Patients who use hospice services any time during the measurement period*.

4. Check *Patients who use hospice services any time during the measurement period*:

   a. If *Patients who use hospice services any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Patients who use hospice services any time during the measurement period* equals No, proceed to check *Patients receiving palliative care during the measurement period*.

5. Check *Patients receiving palliative care during the measurement period*:

   a. If *Patients receiving palliative care during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Patients receiving palliative care during the measurement period* equals No, include in *Eligible Population/Denominator*.

6. Denominator Population:

   - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 80 patients in the Sample Calculation.

7. Start Numerator

8. Check *At least two orders for high-risk medications from the same drug class*:

   a. If *At least two orders for high-risk medications from the same drug class* equals Yes, include in *Data Completeness Met and Performance Met***.

      - *Data Completeness Met and Performance Met*** letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 40 patients in Sample Calculation.

   b. If *At least two orders for high-risk medications from the same drug class* equals No, proceed to check *At least two orders for high-risk medications from the same drug class not ordered*.

9. Check *At least two orders for high-risk medications from the same drug class not ordered*:

   a. If *At least two orders for high-risk medications from the same drug class not ordered* equals Yes, include in *Data Completeness Met and Performance Not Met***.

      - *Data Completeness Met and Performance Not Met*** letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 30 patients in the Sample Calculation.

   b. If *At least two orders for high-risk medications from the same drug class not ordered* equals No, proceed to check *Two or more antipsychotic prescriptions ordered for patients who had a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder on or between January 1 of the year prior to the measurement period and the IPSD for antipsychotics*.

10. Check *Two or more antipsychotic prescriptions ordered for patients who had a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder on or between January 1 of the year prior to the measurement period and the IPSD for antipsychotics*:

a. If *Two or more antipsychotic prescriptions ordered for patients who had a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder on or between January 1 of the year prior to the measurement period and the IPSD for antipsychotics* equals Yes, include in *Data Completeness Met and Performance Not Met***.

   - *Data Completeness Met and Performance Not Met*** letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^3 equals 0 patients in the Sample Calculation.

b. If *Two or more antipsychotic prescriptions ordered for patients who had a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder on or between January 1 of the year prior to the measurement period and the IPSD for antipsychotics* equals No, proceed to check *Two or more benzodiazepine prescriptions ordered for patients who had a diagnosis of seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, or severe generalized anxiety disorder on or between January 1 of the year prior to the measurement period and the IPSD for benzodiazepines*.

11. Check *Two or more benzodiazepine prescriptions ordered for patients who had a diagnosis of seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, or severe generalized anxiety disorder on or between January 1 of the year prior to the measurement period and the IPSD for benzodiazepines*:

    a. If *Two or more benzodiazepine prescriptions ordered for patients who had a diagnosis of seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, or severe generalized anxiety disorder on or between January 1 of the year prior to the measurement period and the IPSD for benzodiazepines* equals Yes, include in *Data Completeness Met and Performance Not Met***.

       - *Data Completeness Met and Performance Not Met*** letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^4 equals 0 patients in the Sample Calculation.

    b. If *Two or more benzodiazepine prescriptions ordered for patients who had a diagnosis of seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, or severe generalized anxiety disorder on or between January 1 of the year prior to the measurement period and the IPSD for benzodiazepines* equals No, proceed to check *Data Completeness Not Met*.

12. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Two

Data Completeness equals Performance Met (a^2 equals 40 patients) plus Performance Not Met (c^2 plus c^3 plus c^4 equals 30 patients) divided by Eligible Population / Denominator (d^2 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

* See the posted measure specification for specific coding and instructions to submit this measure.

**A lower calculated performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patient visits for patients aged 18 years and older seen during the measurement period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is elevated or hypertensive.

INSTRUCTIONS:
This measure is to be submitted at **each visit** for patients seen during the measurement period. Merit-based Incentive Payment System (MIPS) eligible clinicians who submit the measure must perform the blood pressure (BP) screening at each patient visit by a MIPS eligible clinician and may not obtain measurements from external sources.

This measure may be submitted by MIPS eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The intent of this measure is to screen patients for high blood pressure and provide recommended follow-up as indicated. Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple blood pressures on the same date of service, use the most recent (last reading documented) as the representative blood pressure. The documented follow-up plan must be related to the current BP reading as indicated, example: "Patient referred to primary care provider for BP management".

Measure 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:
All patient visits for patients aged 18 years and older at the beginning of the measurement period

Definition:
Not Eligible for High Blood Pressure Screening (Denominator Exclusion) –

- Patient has an active diagnosis of hypertension prior to the current encounter

***DENOMINATOR NOTE*: ****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.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years at the beginning of the measurement period
AND
Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012,

92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99236, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99424, 99491, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, G0101, G0402, G0438, G0439

WITHOUT

Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02, FQ, 93

AND NOT

DENOMINATOR EXCLUSION:

Patient not eligible due to active diagnosis of hypertension: G9744

NUMERATOR:

Patient visits where patients were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is elevated or hypertensive

Definitions:

Blood Pressure (BP) Classification – BP is defined by four (4) BP reading classifications: Normal, Elevated, First Hypertensive, and Second Hypertensive Readings

- Normal BP: Systolic BP (SBP) < 120 mmHg AND Diastolic BP (DBP) < 80 mmHg
- Elevated BP: SBP of 120-129 mmHg AND DBP < 80 mmHg
- First Hypertensive Reading: SBP of >= 130 mmHg OR DBP of >= 80 mmHg without a previous SBP of >= 130 mmHg OR DBP of >= 80 mmHg during the 12 months prior to the encounter
- Second Hypertensive Reading: Requires a SBP >= 130 mmHg OR DBP >= 80 mmHg during the current encounter AND a most recent BP reading within the last 12 months SBP >= 130 mmHg OR DBP >= 80 mmHg

Recommended BP Follow-Up – The 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults from the American College of Cardiology and American Heart Association (2017 Guideline) recommends BP screening and thresholds as defined under Blood Pressure Classifications and recommends interventions based on the current BP reading as listed in the "Recommended Blood Pressure Follow- Up" Table below.

Recommended Nonpharmacologic Interventions (Lifestyle Modifications) – The 2017 Guideline outlines nonpharmacologic interventions which must include one or more of the following as indicated:

- Weight Reduction
- Dietary Approaches to Stop Hypertension (DASH) Eating Plan
- Dietary Sodium Restriction
- Increased Physical Activity
- Moderation in alcohol (ETOH) Consumption

Recommended Blood Pressure Follow-Up Table

BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up *(must include all indicated actions for each BP Classification)*
Normal BP Reading	< 120	AND < 80	No Follow-Up required
Elevated BP Reading	120-129	AND < 80	Rescreen BP in 2 to 6 months **AND** recommended nonpharmacologic interventions **OR** Referral to Alternate/Primary Care Provider

BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up *(must include all indicated actions for each BP Classification)*
First Hypertensive BP Reading	>=130	OR >= 80	Rescreen BP > 1 day and < 4 weeks **AND** recommended nonpharmacologic interventions **OR** Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	130-139 and NOT >=140	OR 80-89 and NOT >=90	Recommended nonpharmacologic intervention **AND** reassessment in 2 to 6 months **AND** an order for laboratory test or ECG for hypertension **OR** Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	>=140	OR >=90	Recommended nonpharmacologic intervention **AND** BP-lowering medication **AND** reassessment within 4 weeks **AND** an order for laboratory test or ECG for hypertension **OR** Referral to Alternate/Primary Care Provider

Patients with a Documented Reason for not Screening or no Follow-Up Plan for High Blood Pressure (Denominator Exceptions) –

- Documentation of medical reason(s) for not screening for high blood pressure (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status).
- Documentation of patient reason(s) for not screening for blood pressure measurements or for not ordering an appropriate follow-up intervention if patient BP is elevated or hypertensive (e.g., patient refuses).

NUMERATOR NOTE: *Although the recommended screening interval for a normal BP reading is every year, to meet the intent of this measure, BP screening and follow-up must be performed at every patient visit. For patients with Normal blood pressure, a follow-up plan is not required* ***(G8783)****. Denominator Exception(s) are determined on the date of the denominator eligible encounter.*

Numerator Options:

Performance Met: Normal blood pressure reading documented, follow-up not required **(G8783)**

OR

Performance Met: Elevated or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented **(G8950)**

OR

Denominator Exception: Documented reason for not screening or recommending a follow-up for high blood pressure **(G9745)**

OR

Performance Not Met: Blood pressure reading not documented, reason not given **(G8785)**

OR

Performance Not Met: Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given **(G8952)**

RATIONALE:

Hypertension is a prevalent condition that affects approximately 66.9 million people in the United States. It is estimated that about 20-40% of the adult population has hypertension; the majority of people over age 65 have a hypertension diagnosis (1,2). Winter noted that 1 in 3 American adults have hypertension and the lifetime risk of developing hypertension is 90% (3). The African American population or non-Hispanic Blacks, the elderly, diabetics and those with chronic kidney disease are at increased risk of stroke, myocardial infarction and renal disease. Non-Hispanic Blacks have the highest prevalence at 38.6% (3). Hypertension is a major risk factor for ischemic heart disease, left ventricular hypertrophy, renal failure, stroke and dementia (2). Prevention of hypertension and the treatment of established hypertension are complementary approaches to reducing CVD risk in the population, but prevention of hypertension provides the optimal means of reducing risk and avoiding harmful consequences. Periodic BP screening can identify individuals who develop elevated BP over time. More frequent BP screening may be particularly important for individuals with elevated ASCVD risk (4).

Hypertension is the most common reason for adult office visits other than pregnancy. Garrison stated that in 2007, 42 million ambulatory visits were attributed to hypertension (5). It also has the highest utilization of prescription drugs. Numerous resources and treatment options are available, yet only about 40- 50% of the hypertensive patients have their blood pressure under control (<140/90) (1,2). In addition to medication non-compliance, poor outcomes are also attributed to poor adherence to lifestyle changes such as a low-sodium diet, weight loss, increased exercise and limiting alcohol intake. Many adults find it difficult to continue medications and lifestyle changes when they are asymptomatic. Symptoms of elevated blood pressure usually do not occur until secondary problems arise such as with vascular diseases (myocardial infarction, stroke, heart failure and renal insufficiency) (2).

Appropriate follow-up after blood pressure measurement is a pivotal component in preventing the progression of hypertension and the development of heart disease. Detection of marginally or fully elevated blood pressure by a specialty clinician warrants referral to a provider familiar with the management of hypertension and prehypertension. The 2010 ACCF/AHA Guideline for the Assessment of Cardiovascular Risk in Asymptomatic Adults continues to support using a global risk score such as the Framingham Risk Score, to assess risk of coronary heart disease (CHD) in all asymptomatic adults (6). Lifestyle modifications have demonstrated effectiveness in lowering blood pressure (7). The synergistic effect of several lifestyle modifications results in greater benefits than a single modification alone. Baseline diagnostic/laboratory testing establishes if a co-existing underlying condition is the etiology of hypertension and evaluates if end organ damage from hypertension has already occurred. Landmark trials such as ALLHAT have repeatedly proven the efficacy of pharmacologic therapy to control blood pressure and reduce the complications of hypertension. A review of 35 studies found that the pharmacist-led interventions involved medication counseling and patient education. Twenty-nine of the 35 studies showed statistically significant improvement in BP levels of the intervention groups at follow-up (8). Follow-up intervals based on blood pressure control have been established by the 2017 ACC/AHA guideline and the USPSTF.

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CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation. (1)

References

1. U.S. Preventive Services Task Force (USPSTF) (2007). Screening for high blood pressure: U.S. Preventive Services Task Force reaffirmation recommendation statement. Annals of Internal Medicine; 147(11):783-6

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These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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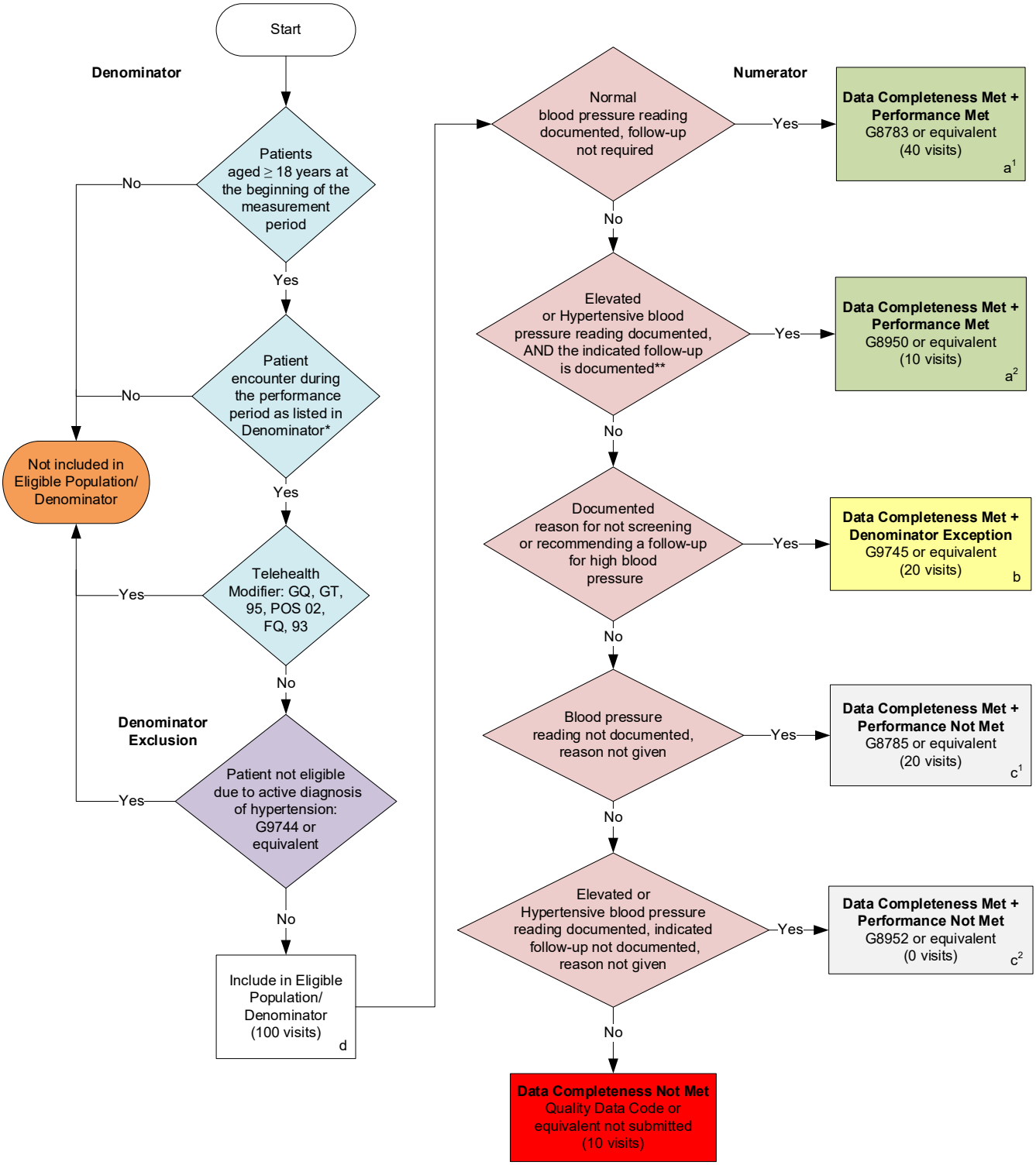
Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.

2023 Clinical Quality Measure Flow #317:
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a^1+a^2=50 visits) + Denominator Exception (b=20 visits) + Performance Not Met (c^1+c^2=20 visits) = 90 visits = **90.00%**

Eligible Population / Denominator (d=100 visits) = 100 visits

Performance Rate=

Performance Met (a^1+a^2=50 visits) = 50 visits = **71.43%**

Data Completeness Numerator (90 visits) – Denominator Exception (b=20 visits) = 70 visits

*See the posted measure specification for specific coding and instructions to submit this measure.
**See the posted measure specification for classifications of blood pressure values and corresponding follow-up plans.
NOTE: Submission Frequency: Visit
NOTE: Telehealth modifiers **include but are not limited to**: GQ, GT, 95, POS 02, FQ, 93

v7

2023 Clinical Quality Measure Flow Narrative For Quality ID #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years at the beginning of the measurement period*:
    a. If *Patients aged greater than or equal to 18 years at the beginning of the measurement period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years at the beginning of the measurement period* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator*.*
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Telehealth Modifier*.
4. Check *Telehealth Modifier*:
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, proceed to check *Patient not eligible due to active diagnosis of hypertension.*
5. Check *Patient not eligible due to active diagnosis of hypertension*:
    a. If *Patient not eligible due to active diagnosis of hypertension* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient not eligible due to active diagnosis of hypertension* equals No, include in *Eligible Population/Denominator.*
6. Denominator Population:
    a. Denominator Population is all Eligible Visits in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 100 visits in the Sample Calculation.
7. Start Numerator
8. Check *Normal blood pressure reading documented, follow-up not required*:
    a. If *Normal blood pressure reading documented, follow-up not required* equals Yes, include in *Data Completeness Met and Performance Met.*
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 40 visits in the Sample Calculation.
    b. If *Normal blood pressure reading documented, follow-up not required* equals No, proceed to check

*Elevated or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented***.*

9. Check *Elevated or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented***:

   a. If *Elevated or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented*** equals Yes, include in *Data Completeness Met and Performance Met.*

      - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 10 visits in the Sample Calculation.

   b. If *Elevated or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented*** equals No, proceed to check *Documented reason for not screening or recommending a follow-up for high blood pressure.*

10. Check *Documented reason for not screening or recommending a follow-up for high blood pressure*:

   a. If *Documented reason for not screening or recommending a follow-up for high blood pressure* equals Yes, include in *Data Completeness Met and Denominator Exception.*

      - *Data Completeness Met and Denominator Exception* is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 20 visits in the Sample Calculation.

   b. If *Documented reason for not screening or recommending a follow-up for high blood pressure* equals No, proceed to check *Blood pressure reading not documented, reason not given*.

11. Check *Blood pressure reading not documented, reason not given*:

   a. If *Blood pressure reading not documented, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met.*

      - *Data Completeness Met and Performance Not Met* is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 20 visits in the Sample Calculation.

   b. If *Blood pressure reading not documented, reason not given* equals No, proceed to check *Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given.*

12. Check *Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given*:

   a. If *Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met.*

      - *Data Completeness Met and Performance Not Met* is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 0 visits in the Sample Calculation.

   b. If *Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given* equals No, proceed to check *Data Completeness Not Met.*

13. Check *Data Completeness Not Met:*

- If *Data Completeness Not Met,* the Quality Data Code or equivalent was not submitted. 10 visits have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a^1 plus a^2 equals 50 visits) plus Denominator Exception (b equals 20 visits) plus Performance Not Met (c^1 plus c^2 equals 20 visits) divided by Eligible Population/Denominator (d equals 100 visits). All equals 90 visits divided by 100 visits. All equals 90.00 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 50 visits) divided by Data Completeness Numerator (90 visits) minus Denominator Exception (b equals 20 visits). All equals 50 visits divided by 70 visits. All equals 71.43 percent.

* See the posted measure specification for specific coding and instructions to submit this measure.

**See the posted measure specification for classifications of blood pressure values and corresponding follow-up plans.

NOTE: Submission Frequency: Visit

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02, FQ, 93

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

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

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for the first referral for all patients during the measurement 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 measurement period based on the services provided and the measure-specific denominator coding. The clinician who refers the patient to another clinician is the clinician who should be held accountable for the performance of this measure. All MIPS 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, however, only first referrals made between January 1 - October 31 (the measurement period) will count towards the denominator to allow adequate time for the referring clinician to collect the consult report by the end of the performance period. When clinicians to whom patients are referred communicate the consult report as soon as possible with the referring clinicians, 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.*

Measure 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:
Number of patients, regardless of age, who had an encounter during the performance period and were referred by one clinician to another clinician on or before October 31

> ***DENOMINATOR NOTE*****:** *If there are multiple referrals for a patient during the measurement period, use the first referral.*
>
> **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.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients regardless of age on the date of the encounter

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*

AND

Patient was referred to another clinician or specialist during the measurement period: G9968

NUMERATOR:

Number of patients with a referral on or before October 31, for which the referring clinician received a report from the clinician to whom the patient was referred

Definitions:

Referral – A request from one clinician to another clinician for evaluation, treatment, or co-management of a patient's condition. This term encompasses "referral" and consultation as defined by Centers for Medicare & 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, provides 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 successfully close the referral loop should be related to the first referral for a patient during the measurement period. If there are multiple consultant reports received by the referring clinician which pertain to a particular referral, use the first consultant report to satisfy the measure.*

The clinician to whom the patient was referred is responsible for sending the consultant report that will fulfill the communication. Note: this is not the same clinician who would report on the measure.

Numerator Options:

Performance Met:	Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred **(G9969)**
OR	
Performance Not Met:	Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred **(G9970)**

RATIONALE:

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 [1,2,3]. 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 pediatricians scheduled appointments with specialists for only 39% and sent patient information to the specialists for only 51% of referrals [2].

In a 2006 report to Congress, the Medicare Payment Advisory Commission (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 [4].

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,

van't Hooft, van der Wouden, Moorman & van Bemmel (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 [5]. 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 [2].

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 (2008) recently highlighted care coordination as one of the most critical areas for development of quality measurement and improvement [6].

References:

1. Gandhi, T. K., Sittig, D. F., Franklin, M., Sussman, A. J., Fairchild, D. G., & Bates, D. W. (2000). Communication breakdown in the outpatient referral process. *Journal of General Internal Medicine*, 15(9), 626-631. doi: 10.1046/j.1525-1497.2000.91119.x

2. Forrest, C. B., Glade, G. B., Baker, A. E., Bocian, A., von Schrader, S., & Starfield, B. (2000). Coordination of specialty referrals and physician satisfaction with referral care. *Archives of Pediatrics and Adolescent Medicine*, 154(5), 499-506. doi: 10.1001/archpedi.154.5.499

3. Stille, C. J., Jerant, A., Bell, D., Meltzer, D., & Elmore, J. G. (2005). Coordinating care across diseases, settings, and clinicians: A key role for the generalist in practice. *Annals of Internal Medicine*, 142(8), 700-708. doi: 10.7326/0003-4819-142-8-200504190-00038

4. MedPAC. (2006). Report to the Congress: Medicare payment policy. Retrieved from https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Mar06_EntireReport.pdf

5. Branger, P. J., van't Hooft, A., van der Wouden, J. C., Moorman, P. W., & van Bemmel, J. H. (1999). Shared care for diabetes: Supporting communication between primary and secondary care. *International Journal of Medical Informatics*, 53(2-3), 133-142. doi: 10.1016/s1386-5056(98)00154-3

6. National Priorities Partnership. (2008). National priorities and goals: Aligning our efforts to transform America's healthcare. Washington, DC: National Quality Forum.

CLINICAL RECOMMENDATION STATEMENTS:
None

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These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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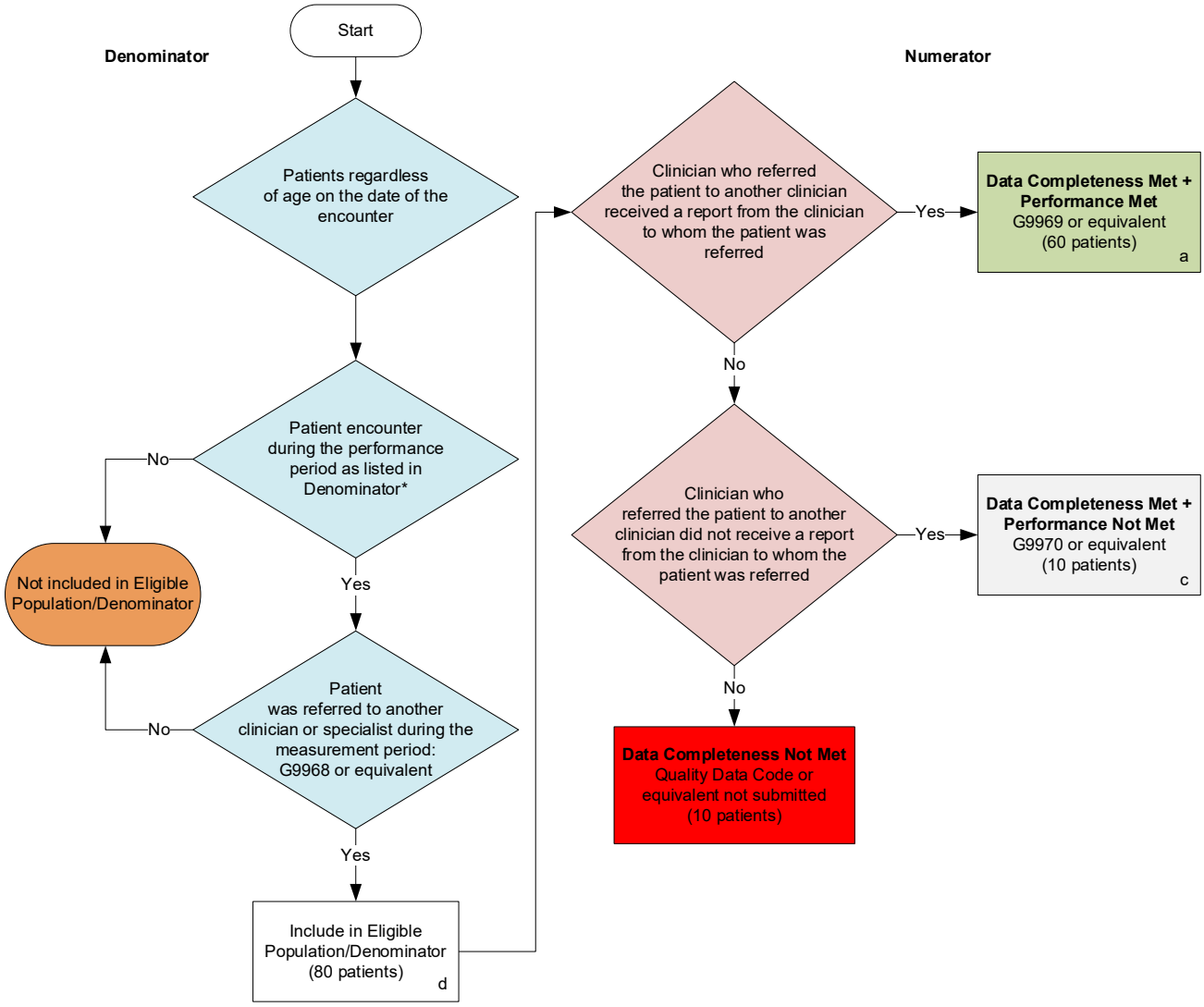
2023 Clinical Quality Measure Flow for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a=60 patients) + Performance Not Met (c=10 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=
Performance Met (a=60 patients) = 60 patients = **85.71%**
Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

2023 Clinical Quality Measure Flow Narrative for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. *Patients regardless of age on the date of the encounter*
3. Check *Patient encounter during the performance period as listed in Denominator*:*
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Patient was referred to another clinician or specialist during the measurement period.*
4. Check *Patient was referred to another clinician or specialist during the measurement period*:
    a. If *Patient was referred to another clinician or specialist during the measurement period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient was referred to another clinician or specialist during the measurement period* equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population
        - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
6. Start Numerator
7. Check *Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred*:
    a. If *Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 60 patients in the Sample Calculation.
    b. If *Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred* equals No, proceed to check *Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred.*
8. Check *Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred:*
    a. If *Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred* equals Yes, include in *Data Completeness Met and Performance Not Met.*
        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 10 patients in the Sample Calculation.

b. If *Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred was referred* equals No, proceed to *Data Completeness Not Met.*

9. Check *Data Completeness Not Met:*

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 60 patients) plus Performance Not Met (c equals 10 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 60 patients) divided by Data Completeness Numerator (70 patients). All equals 60 patients divided by 70 patients. All equals 85.71 percent.

* See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #384: Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Outcome – High Priority

DESCRIPTION:
Patients aged 18 years and older who had surgery for primary rhegmatogenous retinal detachment who did not require a return to the operating room within 90 days of surgery.

INSTRUCTIONS:
This measure is to be submitted **each time** a procedure for primary rhegmatogenous retinal detachment is performed during the performance period. This measure is intended to reflect the quality of services provided for the patient receiving primary rhegmatogenous retinal detachment surgery.

NOTE: *This is an outcome measure and will be calculated solely using Merit-based Incentive Payment System (MIPS) eligible clinician, group, or third-party intermediary submitted data.*

- *For patients who receive the surgical procedures specified in the denominator coding, it should be submitted whether or not the patient had to return to the operating room within 90 days of surgery.*
- *Include only procedures performed through **September 30** of the performance period. This will allow the post- operative period to occur before third party intermediaries must submit data to CMS.*

Measure 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:
Patients aged 18 years or older who had surgery for primary rhegmatogenous retinal detachment

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on the date of the procedure
AND
Patient procedure during the performance period (CPT): 67107, 67108, 67110
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02
AND NOT
DENOMINATOR EXCLUSION:
Surgical procedures that included the use of silicone oil: G9756

NUMERATOR:
Patients who did not return to the operating room within 90 days for complications within the operative eye

Numerator Options:

Performance Met: Patient did not require a return to the operating room within 90 days of surgery **(G9515)**

OR

Performance Not Met: Patient required a return to the operating room within 90 days of surgery **(G9514)**

RATIONALE:

The goal of treatment for retinal breaks is to create a firm chorioretinal adhesion in the attached retina immediately adjacent to and surrounding the retinal tear using cryotherapy or laser photocoagulation to halt the progression of subretinal fluid from detaching the neurosensory retina. Treatment of peripheral horseshoe tears should be extended to the ora serrata if the tear cannot be surrounded using laser or cryotherapy. The most common cause of failure in treating horseshoe tears is failure to adequately treat the tear, particularly the anterior border. Continued vitreous traction may extend the tear beyond the treated area and allow fluid to dissect through the subretinal space to cause a clinical retinal detachment. Treatment of dialyses must extend over the entire length of the dialysis, reaching the ora serrata beyond each horn or end of the dialysis.

Sufficient evidence exists for treating acute, symptomatic horseshoe tears. There is insufficient evidence for management of other vitreoretinal abnormalities. A Cochrane systematic review found that in making the decision to treat other vitreoretinal abnormalities, including lattice degeneration and asymptomatic retinal breaks, the risks that treatment will be unnecessary, ineffective, or harmful must be weighed against the possible benefit of reducing the rate of subsequent retinal detachment.

In a study published in 2011, Schall and colleagues studied the success rate with 4 surgical techniques. Initial success rate for retinal reattachment was 86% for scleral buckling only, 90% for vitrectomy only, 94% for the combination of scleral buckling and vitrectomy, and 63% for pneumatic retinopexy surgery. Patients undergoing pneumatic retinopexy had a lower initial success rate, however there was no statistically significant difference in initial reattachment rates between the other three groups. In a 2002 study, Ling and colleagues reported an 85% success rate with a single procedure. Of the 15% that initially failed, 97% were successful with one additional surgery.

References:

American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Posterior Vitreous Detachment, Retinal Breaks, and Lattice Degeneration. San Francisco, CA: American Academy of Ophthalmology; 2019. Available at: www.aao.org/ppp

Schall S, Sherman MP, Barr CC, Kaplan HJ, Primary retinal detachment repair: comparison of 1-year outcomes of four surgical techniques. Retina 2011 Sep; 31(8):1500-4.

Ling, et al, Retinal detachment surgery in district general hospitals: An Audit of Changing Practice, Br J Ophthalmology 2002; 86:827-833,

Sullivan PM, Luff AJ, Aylward GW. Results of primary retinal reattachment surgery: a prospective audit. Eye 1997; 11:869-71.

Day S, Grossman DS, Mruthyunjaya P, Sloan FA, Lee PP. One year outcomes after retinal detachment surgery among Medicare beneficiaries. Am J Ophthalmol 2010; 150(3):338-45, Massachusetts Eye and Ear Infirmary, Harvard Medical School. Ophthalmology Quality & Outcomes Report 2012.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcome measure. As such, no clinical recommendations are included.

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The American Association of Eye and Ear Centers of Excellence's (AAEECE) significant past efforts and contributions to the development and updating of the measure is acknowledged. The Academy is solely responsible for the review and enhancement ("Maintenance") of the measure as of June 5, 2015.

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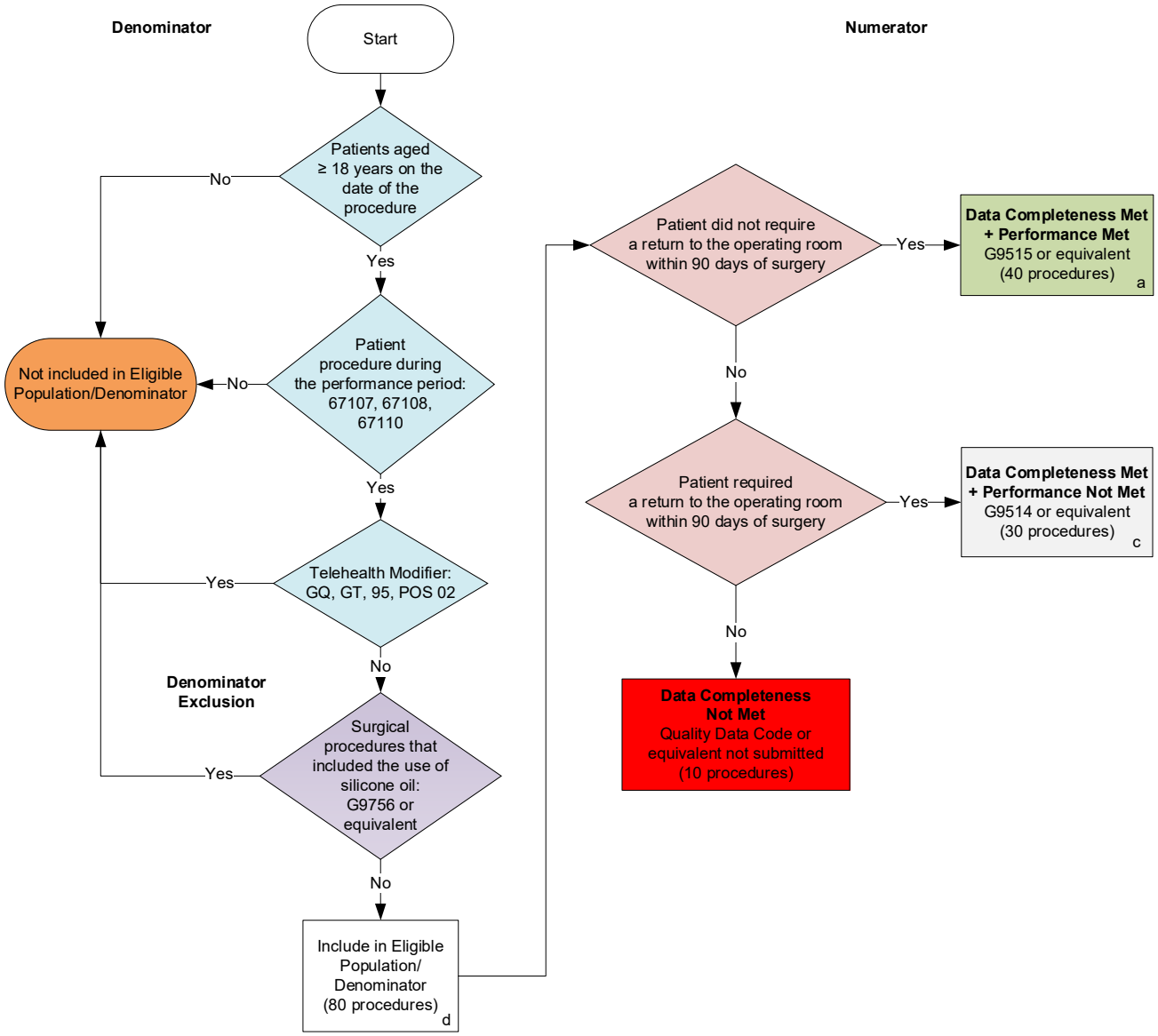
2023 Clinical Quality Measure Flow for Quality ID #384: Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 procedures) + Performance Not Met (c=30 procedures) = 70 procedures = **87.50%**

Eligible Population / Denominator (d=80 procedures) = 80 procedures

Performance Rate=

Performance Met (a=40 procedures) = 40 procedures = **57.14%**

Data Completeness Numerator (70 procedures) = 70 procedures

See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Procedure
NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

2023 Clinical Quality Measure Flow Narrative for Quality ID #384: Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years on the date of the procedure*:
    a. If *Patients aged greater than or equal to 18 years on the date of the procedure* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years on the date of the procedure* equals Yes, proceed to check *Patient procedure during the performance period*.
3. Check *Patient procedure during the performance period*:
    a. If *Patient procedure during the performance period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient procedure during the performance period* equals Yes, proceed to check *Telehealth Modifier*.
4. Check *Telehealth Modifier.*
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth* Modifier equals No proceed to check *Surgical procedures that included the use of silicone oil*.
5. Check *Surgical procedures that included the use of silicone oil*:
    a. If *Surgical procedures that included the use of silicone oil* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Surgical procedures that included the use of silicone oil* equals No, include in *Eligible Population/Denominator*.
6. Denominator Population
    a. Denominator Population is all Eligible Procedures in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 procedures in the Sample Calculation.
7. Start Numerator
8. Check *Patient did not require a return to the operating room within 90 days of surgery*:
    a. If *Patient did not require a return to the operating room within 90 days of surgery* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this

document. Letter a equals 40 procedures in the Sample Calculation.

b. If *Patient did not require a return to the operating room within 90 days of surgery* equals No, proceed to check *Patient required a return to the operating room within 90 days of surgery*.

9. Check *Patient required a return to the operating room within 90 days of surgery*:

   a. If *Patient required a return to the operating room within 90 days of surgery* equals Yes, include in *Data Completeness Met and Performance Not Met*.

      - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 procedures in the Sample Calculation.

   b. If *Patient required a return to the operating room within 90 days of surgery* equals No, proceed to check *Data Completeness Not Met*.

10. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 procedures have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a equals 40 procedures) plus Performance Not Met (c equals 30 procedures) divided by Eligible Population / Denominator (d equals 80 procedures). All equals 70 procedures divided by 80 procedures. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 procedures) divided by Data Completeness Numerator (70 procedures). All equals 40 procedures divided by 70 procedures. All equals 57.14 percent.

See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure
NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Outcome – High Priority

DESCRIPTION:
Patients aged 18 years and older who had surgery for primary rhegmatogenous retinal detachment and achieved an improvement in their visual acuity, from their preoperative level, within 90 days of surgery in the operative eye.

INSTRUCTIONS:
This measure is to be submitted **each time** a procedure for primary rhegmatogenous retinal detachment is performed during the performance period. This measure is intended to reflect the quality of services provided for the patient receiving primary rhegmatogenous retinal detachment surgery.

***Note**: This is an outcome measure and will be calculated solely using MIPS eligible clinician, group, or third party intermediary submitted data.*

- *For patients who receive the surgical procedures specified in the denominator coding, it should be submitted whether or not the patient achieved an improvement of their visual acuity within 90 days of surgery.*
- *Include only procedures performed through **September 30** of the performance period. This will allow the post-operative period to occur before third party intermediaries must submit data to CMS.*

Measure 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:
Patients aged 18 years and older who had surgery for primary rhegmatogenous retinal detachment

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on the date of the procedure
AND
Patient procedure during the performance period (CPT): 67107, 67108, 67110
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02
AND NOT
DENOMINATOR EXCLUSIONS:
Patients with a pre-operative visual acuity better than 20/40
OR
Surgical procedures that included the use of silicone oil: G9757

NUMERATOR:

Patients who achieved an improvement in their visual acuity, from their preoperative level, within 90 days of surgery in the operative eye

Numerator Options:

Performance Met: Patient achieved an improvement in visual acuity, from their preoperative level, within 90 days of surgery **(G9516)**

OR

Performance Not Met: Patient did not achieve an improvement in visual acuity, from their preoperative level, within 90 days of surgery, reason not given **(G9517)**

RATIONALE:

For management and treatment for PVD and RRD, the following apply (for goals of treatment):

- Prevention of visual loss and functional impairment
- Maintenance of quality of life

All patients with risk factors should be instructed to notify their ophthalmologist as soon as possible if they have a substantial change in symptoms, such as an increase in floaters, loss of visual field, or decrease in visual acuity develop.

Studies demonstrate that the success rate increases with the recognition of risk factors and the practice of retina subspecialization. International studies report primary rhegmatogenous retinal surgery success rates ranging from 64 to 91%.

References:

American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Posterior Vitreous Detachment, Retinal Breaks, and Lattice Degeneration. San Francisco, CA: American Academy of Ophthalmology; 2019, Available at: www.aao.org/ppp

Wickham, BC, Wong, D, Charteris, DG, Retinal detachment repair by vitrectomy: simplified formulae to estimate the risk of failure, Br J Ophthalmology 2011 Feb 16

Sullivan PM, Luff AJ, Aylward GW. Results of primary retinal reattachment surgery: a prospective audit. Eye 1997; 11:869-71

Day S, Grossman DS, Mruthyunjaya P, Sloan FA, Lee PP. One year outcomes after retinal detachment surgery among Medicare beneficiaries. Am J Ophthalmol 2010; 150(3):338-45

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcome measure. As such, no clinical recommendations are included.

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The American Association of Eye and Ear Centers of Excellence (AAEECE) significant past efforts and contributions to the development and updating of the measure is acknowledged. The Academy is solely responsible for the review and enhancement ("Maintenance") of the measure as of June 5, 2015.

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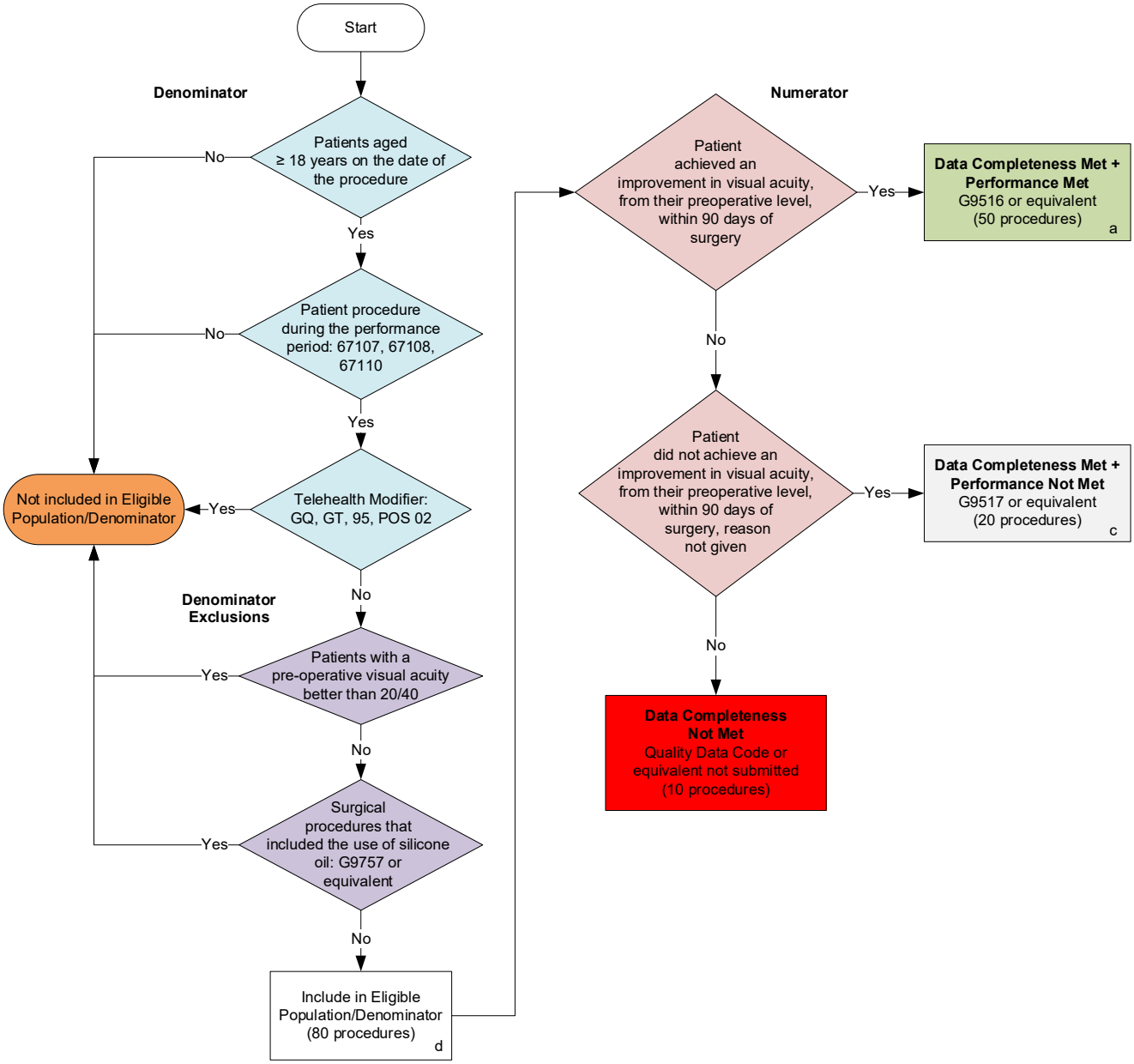
2023 Clinical Quality Measure Flow for Quality ID #385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=50 procedures) + Performance Not Met (c=20 procedures) = 70 procedures = **87.50%**

Eligible Population / Denominator (d=80 procedures) = 80 procedures

Performance Rate=

Performance Met (a=50 procedures) = 50 procedures = **71.43%**

Data Completeness Numerator (70 procedures) = 70 procedures

See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Procedure
NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

2023 Clinical Quality Measure Flow Narrative for Quality ID #385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years on the date of the procedure*:
    a. If *Patients aged greater than or equal to 18 years on the date of the procedure* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years on the date of the procedure* equals Yes, proceed to check *Patient procedure during the performance period*.
3. Check *Patient procedure during the performance period*:
    a. If *Patient procedure during the performance period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient procedure during the performance period* equals Yes, proceed to check *Telehealth Modifier.*
4. Check *Telehealth Modifier.*
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, proceed to check *Patients with a pre-operative visual acuity better than 20/40*.
5. Check *Patients with a pre-operative visual acuity better than 20/40*:
    a. If *Patients with a pre-operative visual acuity better than 20/40* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing
    b. If *Patients with a pre-operative visual acuity better than 20/40* equals No, check *Surgical procedures that included the use of silicone oil*.
6. Check *Surgical procedures that included the use of silicone oil*:
    a. If *Surgical procedures that included the use of silicone oil* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Surgical procedures that included the use of silicone oil* equals No, include in *Eligible Population/Denominator*.
7. Denominator Population:
    a. Denominator Population is all Eligible Procedures in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 procedures in the Sample Calculation.
8. Start Numerator
9. Check *Patient achieved an improvement in visual acuity, from their preoperative level, within 90 days of*

surgery:

a. If *Patient achieved an improvement in visual acuity, from their preoperative level, within 90 days of surgery* equals Yes, include in *Data Completeness Met and Performance Met*.

    - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 50 procedures in the Sample Calculation.

b. If *Patient achieved an improvement in visual acuity, from their preoperative level, within 90 days of surgery* equals No, proceed to check *Patient did not achieve an improvement in visual acuity, from their preoperative level, within 90 days of surgery, reason not given*.

10. Check *Patient did not achieve an improvement in visual acuity, from their preoperative level, within 90 days of surgery, reason not given*:

    a. If *Patient did not achieve an improvement in visual acuity, from their preoperative level, within 90 days of surgery, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 20 procedures in the Sample Calculation.

    b. If *Patient did not achieve an improvement in visual acuity, from their preoperative level, within 90 days of surgery, reason not given* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 procedures have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a equals 50 procedures) plus Performance Not Met (c equals 20 procedures) divided by Eligible Population/Denominator (d equals 80 procedures). All equals 70 procedures divided by 80 procedures. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 50 procedures) divided by Data Completeness Numerator (70 procedures). All equals 50 procedures divided by 70 procedures. All equals 71.43 percent.

See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure
NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #389: Cataract Surgery: Difference Between Planned and Final Refraction

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Outcome – High Priority

DESCRIPTION:
Percentage of patients aged 18 years and older who had cataract surgery performed and who achieved a final refraction within +/- 1.0 diopters of their planned (target) refraction.

INSTRUCTIONS:
This measure is to be submitted **each time** a cataract procedure is performed during the performance period. This measure is intended to reflect the quality of services provided for the patient receiving cataract surgery.

Note: *This is an outcome measure and will be calculated solely using Merit-based Incentive Payment System (MIPS) eligible clinician, group, or third-party intermediary submitted data.*

- *For patients who receive the surgical procedures specified in the denominator coding, it should be reported whether or not the patient had a difference between planned and final refraction.*
- *Include only procedures performed through **September 30** of the performance period. This will allow the post-operative period to occur before third party intermediaries must submit data to CMS.*

Measure 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 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:
All patients aged 18 years and older who had cataract surgery

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the performance period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984, 66987, 66988
WITHOUT
Modifier: 55 or 56
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02

NUMERATOR:
Patients who achieved a final refraction (spherical equivalent) of +/- 1.0 diopters of their planned (target) refraction (spherical equivalent) within 90 days following cataract surgery. The refraction planned and final refraction values should correspond to the eye that underwent the cataract procedure

Numerator Options:

Performance Met: Patient achieves final refraction (spherical equivalent) +/- 1.0 diopters of their planned refraction within 90 days of surgery **(G9519)**

OR

Performance Not Met: Patient does not achieve final refraction (spherical equivalent) +/- 1.0 diopters of their planned refraction within 90 days of surgery **(G9520)**

RATIONALE:

Refractive outcome is important to the patient and to the surgeon. Planned refraction is something the surgeon and patient discuss at the time of assessment for cataract surgery and is a way to align patient and surgeon expectations of the outcome. The surgeon should consider the patient's desires and needs when selecting a postoperative refractive target outcome. Comparing actual outcome to predicted outcome is a valuable measure of success.

Results of multiple large studies of cataract surgery have repeatedly demonstrated positive outcomes. The ASCRS National Cataract Database reported that at 3 months postoperatively 74.6% of patients were within ±1.0 D of target spherical equivalent. The American Academy of Ophthalmology National Eyecare Outcomes Network (NEON) database (n=7626) also found similar rates of success, with 78% of patients within ±1.0 D of target spherical equivalent. Kugelberg and Lundstrom published outcomes data from the Swedish registry and found in routine cataract surgeries 75% to 90% of patients ended up with refraction within 1 diopter of the target refraction. The study describes factors that influenced refractive outcome as older age and use of a clear corneal incision.
Another 2009 study by Gale and colleagues reported outcomes improving from 79.7% to 87% within 3 measurement cycles and the authors suggested that a benchmark standard of 85% be established. The European Society of Cataract and Refractive Surgeons femtosecond laser-assisted cataract surgery (FLACS) study compared 2814 consecutive cases from high-volume surgeons with 4987 control patients matched by characteristics such as age, preoperative CDVA, ocular comorbidities, and surgical comorbidities from the 2014 European Registry of Quality Outcomes for Cataract and Refractive Surgery. The mean refractive error was 0.40 D versus 0.43 D for FLACS, $P < 0.05$, with 74.3% of control eyes being within 0.5 D and 94.1% being within 1 D of target.

References:

Miller KM, Oetting TA, Tweeten JP et al. Cataract in the Adult Eye Preferred Practice Pattern®. Ophthalmology 2022; in press.

Lum F, Schein O, Schachat AP, Abbott RL, Hoskins HD, Steinberg EP. Initial two years of experience with the AAO Nation Eyecare Outcomes Network (NEON) cataract surgery database. Ophthalmology 2000; 107:691-97

Gale, RP, Johnston, RL, Zuberbuhler, B, McKibbin, M. Benchmark standards for refractive Outcomes After Cataract Surgery, Eye (London) 2009 Jan; 23 (1):149-52

Kugelberg M, Lundstrom M. Factors related to the degree of success in achieving target refraction in cataract surgery. J Cat Refr Surg 2008; 34(11):1935-39

Manning S, Barry P, Henry Y, et al. Femtosecond laser-assisted cataract surgery versus standard phacoemulsification cataract surgery: Study from the European Registry of Quality Outcomes for Cataract and Refractive Surgery. *J Cataract Refract Surg.* 2016;42:1779-1790

CLINICAL RECOMMENDATION STATEMENTS:

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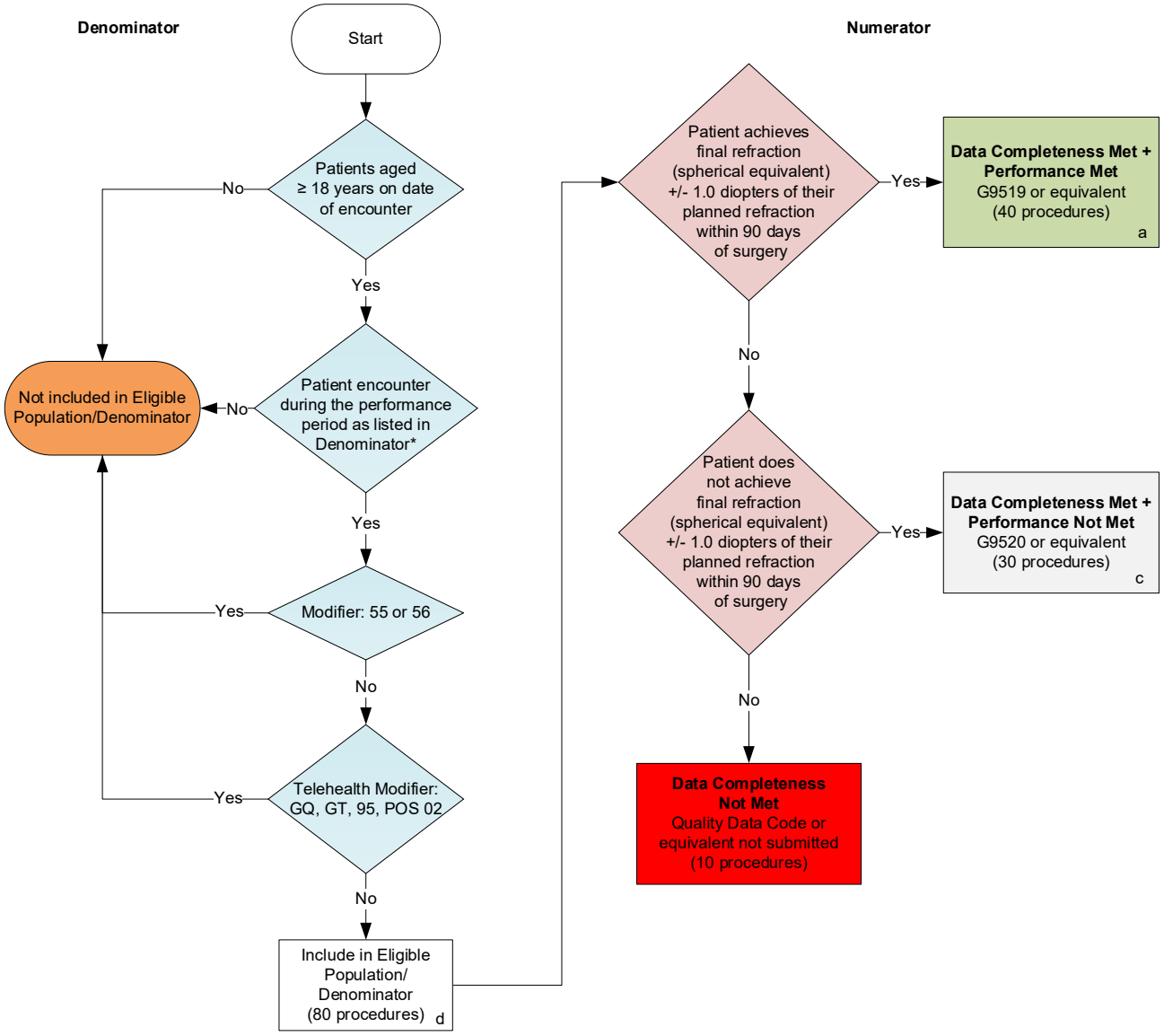
2023 Clinical Quality Measure Flow for Quality ID #389: Cataract Surgery: Difference Between Planned and Final Refraction

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 procedures) + Performance Not Met (c=30 procedures) / Eligible Population / Denominator (d=80 procedures) = 70 procedures / 80 procedures = **87.50%**

Performance Rate=

Performance Met (a=40 procedures) / Data Completeness Numerator (70 procedures) = 40 procedures / 70 procedures = **57.14%**

*See the posted measure specification for specific coding and instructions to submit this measure

NOTE: Submission Frequency: Procedure

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

2023 Clinical Quality Measure Flow Narrative for Quality ID #389: Cataract Surgery: Difference Between Planned and Final Refraction

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years on date of encounter*:
    a. If *Patients aged greater than or equal to 18 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years on date of encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Modifier*.
4. Check *Modifier*:
    a. If *Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Modifier* equals No, proceed to check *Telehealth Modifier.*
5. Check *Telehealth Modifier:*
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, include in *Eligible Population/Denominator*.
6. Denominator Population:
    a. Denominator Population is all Eligible Procedures in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 procedures in the Sample Calculation.
7. Start Numerator
8. Check *Patient achieves final refraction (spherical equivalent) plus or minus 1.0 diopters of their planned refraction within 90 days of surgery*:
    a. If *Patient achieves final refraction (spherical equivalent) plus or minus 1.0 diopters of their planned refraction within 90 days of surgery* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 procedures in the Sample Calculation.
    b. If *Patient achieves final refraction (spherical equivalent) plus or minus 1.0 diopters of their planned refraction within 90 days of surgery* equals No, proceed to check *Patient does not achieve final refraction*

(spherical equivalent) plus or minus 1.0 diopters of their planned refraction within 90 days of surgery.

9. Check *Patient does not achieve final refraction (spherical equivalent) plus or minus 1.0 diopters of their planned refraction within 90 days of surgery*:

    a. If *Patient does not achieve final refraction (spherical equivalent) plus or minus 1.0 diopters of their planned refraction within 90 days of surgery* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 procedures in the Sample Calculation.

    b. If *Patient does not achieve final refraction (spherical equivalent) plus or minus 1.0 diopters of their planned refraction within 90 days of surgery* equals No, proceed to check *Data Completeness Not Met*.

10. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 procedures have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a equals 40 procedures) plus Performance Not Met (c equals 30 procedures) divided by Eligible Population / Denominator (d equals 80 procedures). All equals 70 procedures divided by 80 procedures. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 procedures) divided by Data Completeness Numerator (70 procedures). All equals 40 procedures divided by 70 procedures. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure

NOTE: Submission Frequency: Procedure
NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #397: Melanoma Reporting

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Pathology reports for primary malignant cutaneous melanoma that include the pT category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors.

INSTRUCTIONS:
This measure is to be submitted **each time** a patient's pathology report addresses specimens with a diagnosis of malignant cutaneous melanoma; however, only one quality data code (QDC) per date of service for a patient is required. In instances where multiple specimens from different/unique lesions are submitted and resulted in a single report, each eligible specimen must be Met in order for the case to be considered Met (Denominator Exclusions and Denominator Exceptions are not considered eligible specimens). If any eligible specimen is Not Met, the quality data code for Not Met should be submitted for this report. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure 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:
All pathology reports for primary malignant cutaneous melanoma covering biopsies and excisions to include wide excisions and re-excisions

Denominator Instructions:
The intent of the measure is to only include pathology reports for primary malignant cutaneous melanoma that may be staged with the following components: pT category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors. Melanoma in situ cases do not meet the criteria for this denominator. In the instance a pathology report meets the denominator criteria, but represents a diagnosis of Melanoma in situ G9430 should be utilized.

Denominator Criteria (Eligible Cases):
Patients ≥ 18 years of age on date of service
AND
Diagnosis for malignant cutaneous melanoma (ICD-10-CM): C43.0, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9
AND

Patient procedureduring performance period (CPT): 88305
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02
AND NOT
DENOMINATOR EXCLUSION:
Specimen site other than anatomic cutaneous location: G9430

NUMERATOR:
Pathology reports for primary malignant cutaneous melanoma that include the pT category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors

Numerator Options:

Performance Met:	Pathology report includes the pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors **(G9428)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not including pT Category,thickness,ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors (e.g., negative skin biopsies, insufficient tissue, or other documented medical reasons) **(G9429)**
OR	
Performance Not Met:	Pathology report does not include the pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors **(G9431)**

RATIONALE:
Research and the publication of new guidelines in 2017 indicate newer tumor characteristics for more precise staging, with implications for treatment outcomes. In 2017, the American Joint Committee on Cancer (AJCC) Melanoma Expert Panel introduced several important changes to the Tumor, Nodes, Metastasis (TNM) classification. The relevant change for this measure in the eighth edition AJCC Cancer Staging Manual include: 1) tumor thickness measurements to be recorded to the nearest 0.1 mm, not 0.01 mm; 2) definitions of T1a and T1b are revised (T1a, <0.8 mm without ulceration; T1b, 0.8-1.0 mm with or without ulceration or <0.8 mm with ulceration), with mitotic rate no longer a T category criterion. (Gershenwald et al.)

The new guidelines state: “As supported by this univariate analysis and previous reports, the mitotic rate is likely an important prognostic determinant when evaluated using its dynamic range across melanomas of all tumor thickness categories. Therefore, the AJCC Melanoma Expert Panel strongly recommends that mitotic rate be assessed and recorded for all primary melanomas, although it is not used for T1 staging in the eighth edition. The mitotic rate will likely be an important parameter for inclusion in the future development of prognostic models applicable to individual patients..” (http://onlinelibrary.wiley.com/doi/10.3322/caac.21409/pdf)

The American Academy of Dermatology recently updated guidelines for management of primary cutaneous melanoma. In addition to re-affirming the importance of pT, thickness, ulceration and mitotic rate (“There is strong evidence that at least 3 histologic features of the primary tumor are dominant predictors of outcome: Breslow thickness, ulceration, and dermal mitotic rate”), these guidelines also emphasized the importance of other elements include peripheral and deep margin status, microsatellitosis and lymphovascular invasion (Swetter et al). For margin status, the guidelines note that “An additional essential element of the pathology report is the status of the peripheral and deep margins (positive or negative) of the specimen. Presence or absence of tumor at the surgical margin indicates whether the entire lesion was available for histologic evaluation and provides guidance for further management.” Microsatellites, or tumors nests in the vicinity of

the main invasive tumor, are an important component of the eighth edition of the AJCC staging system and per the AAD guideline “the presence or absence of microscopic satellites must be reported for accurate staging.”

The 2023 measure has been revised to conform with AJCC requirements, recent AAD guidelines and College of American Pathologists (CAP) Cancer Protocol recommendations that went into effect August 2021.(Shon et al).

Gershenwald, J. E., Scolyer, R. A., Hess, K. R., Sondak, V. K., Long, G. V., Ross, M. I., Lazar, A. J., Faries, M. B., Kirkwood, J. M., McArthur, G. A., Haydu, L. E., Eggermont, A. M. M., Flaherty, K. T., Balch, C. M., Thompson, J. F. and for members of the American Joint Committee on Cancer Melanoma Expert Panel and the International Melanoma Database and Discovery Platform (2017), Melanoma staging: Evidence-based changes in the American Joint Committee on Cancer eighth edition cancer staging manual. CA: A Cancer Journal for Clinicians, 67: 472–492 http://onlinelibrary.wiley.com/doi/10.3322/caac.21409/full

Swetter SM, Tsao H, Bichakjian CK, Curiel-Lewandrowski C, Elder DE, Gershenwald JE, Guild V, Grant-Kels JM, Halpern AC, Johnson TM, Sober AJ, Thompson JA, Wisco OJ, Wyatt S, Hu S and Lamina T. (2018) Guidelines of care for the management of primary cutaneous melanoma. J Am Acad Dermatol 80 (1): 208-250. https://www.jaad.org/article/S0190-9622(18)32588-X/fulltext

Wonwoo Shon; David P. Frishberg; Jeffrey E. Gershenwald; Pavandeep Gill; Jeffrey North; Victor G. Prieto; Richard A. Scolyer; Bonnie L. Balzer; Thomas J. Flotte; Timothy H. McCalmont; Bruce Robert Smoller (2021). Protocol for the Examination of Excision Specimens From Patients With Melanoma of the Skin. College of American Pathologists. https://documents.cap.org/protocols/Skin.Melanoma_4.3.0.1.REL_CAPCP.pdf

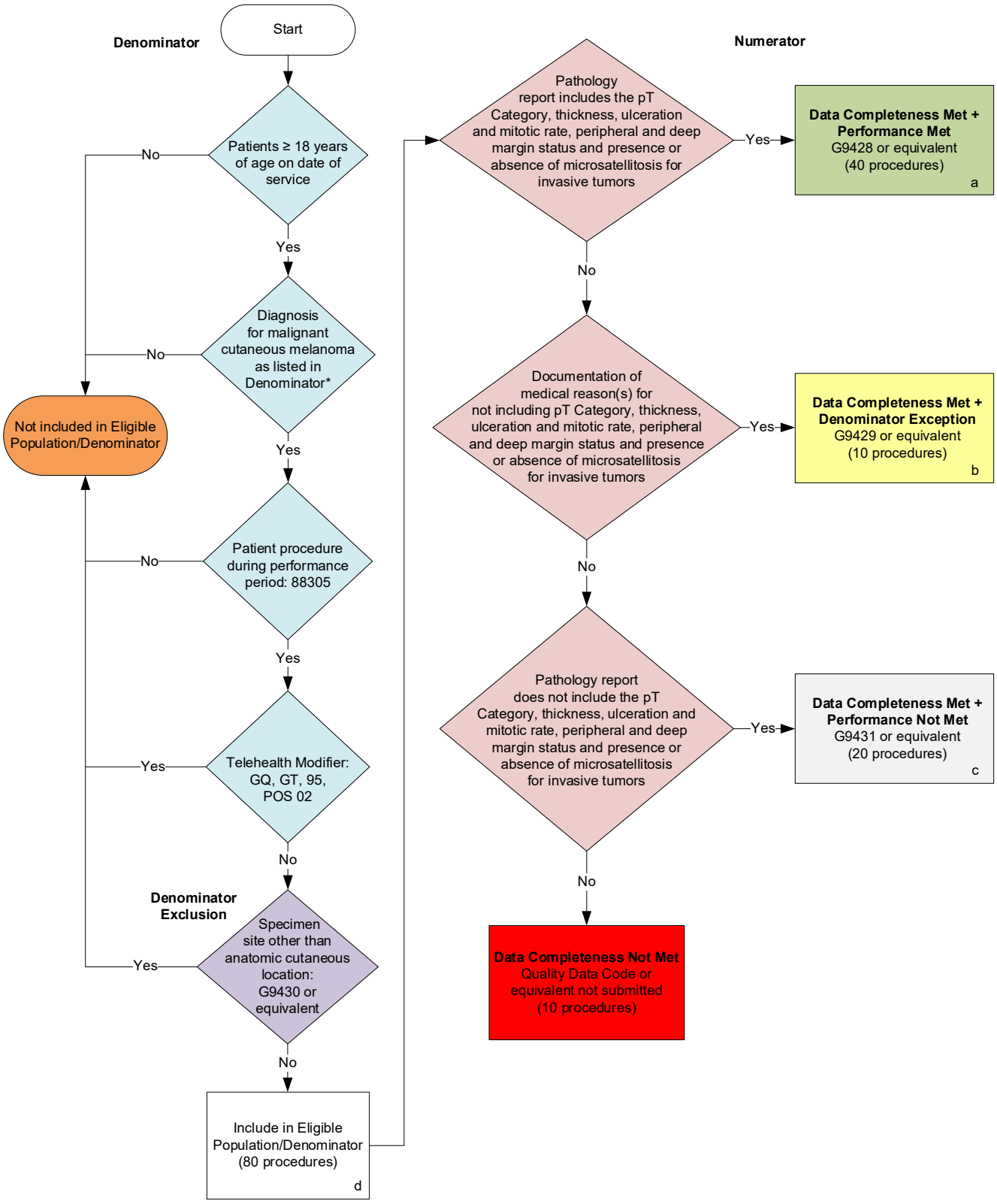
Wonwoo Shon; David P. Frishberg; Jeffrey E. Gershenwald; Pavandeep Gill; Jeffrey North; Victor G. Prieto; Richard A. Scolyer; Bonnie L. Balzer; Thomas J. Flotte; Timothy H. McCalmont; Bruce Robert Smoller (2021). Protocol for the Examination of Biopsy Specimens From Patients With Melanoma of the Skin. College of American Pathologists. https://documents.cap.org/protocols/Skin.Melanoma.Bx_4.3.0.1.REL_CAPCP.pdf

CLINICAL RECOMMENDATION STATEMENT:

There is strong evidence that at least 3 histologic features of the primary tumor are dominant predictors of outcome: Breslow thickness, ulceration, and dermal mitotic rate.
An additional essential element of the pathology report is the status of the peripheral and deep margins (positive or negative) of the specimen.
Depending on the specific T- and N-category criteria, such patients would be staged as either stage IIIC or IIID. Therefore, the presence or absence of microscopic satellites must be reported for accurate staging.

2023 Clinical Quality Measure Flow for Quality ID #397: Melanoma Reporting

Disclaimer: *Refer to measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 procedures) + Denominator Exception (b=10 procedures) + Performance Not Met (c=20 procedures) = 70 procedures = **87.50%**

Eligible Population / Denominator (d=80 procedures) = 80 procedures

Performance Rate=

Performance Met (a=40 procedures) = 40 procedures = **66.67%**

Data Completeness Numerator (70 procedures) – Denominator Exception (b=10 procedures) = 60 procedures

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

2023 Clinical Quality Measure Flow Narrative for Quality ID #397: Melanoma Reporting

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients greater than or equal to 18 years of age on date of service*:
    a. If *Patients greater than or equal to 18 years of age on date of service* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients greater than or equal to 18 years of age on date of service* equals Yes, proceed to check *Diagnosis for malignant cutaneous melanoma as listed in the Denominator**.
3. Check *Diagnosis for malignant cutaneous melanoma as listed in the Denominator**:
    a. If *Diagnosis for malignant cutaneous melanoma as listed in the Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis for malignant cutaneous melanoma as listed in the Denominator** equals Yes, proceed to check *Patient procedure during performance period*.
4. Check *Patient procedure during performance period* :
    a. If *Patient procedure during performance period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient procedure during performance period* equals Yes, proceed to check *Telehealth Modifier*.
5. Check *Telehealth Modifier*:
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, proceed to check *Specimen site other than anatomic cutaneous location.*
6. Check *Specimen site other than anatomic cutaneous location*:
    a. If *Specimen site other than anatomic cutaneous location* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Specimen site other than anatomic cutaneous location* equals No, include in *Eligible Population/Denominator*.
7. Denominator Population:
    - Denominator Population is all Eligible Procedures in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 procedures in the Sample Calculation.
8. Start Numerator
9. Check *Pathology report includes the pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors*:
    a. If *Pathology report includes the pT Category, thickness, ulceration and mitotic rate, peripheral and*

deep margin status and presence or absence of microsatellitosis for invasive tumors equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 procedures in Sample Calculation.

b. If *Pathology report includes the pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors* equals No, proceed to check *Documentation of medical reason(s) for not including pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors*.

10. Check *Documentation of medical reason(s) for not including pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors*:

    a. If *Documentation of medical reason(s) for not including pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors* equals Yes, include in the *Data Completeness Met and Denominator Exception*.

    - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 10 procedures in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not including pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors* equals No, proceed to check *Pathology report does not include the pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors*.

11. Check *Pathology report does not include the pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors*:

    a. If *Pathology report does not include the pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors* equals Yes, include in *Data Completeness Met and Performance Not Met*.

    - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 20 procedures in the Sample Calculation.

    b. If *Pathology report does not include the pT Category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors* equals No, proceed to check *Data Completeness Not Met*.

12. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 procedures have been subtracted from the Data Completeness Numerator in Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a equals 40 procedures) plus Denominator Exception (b equals 10 procedures) plus Performance Not Met (c equals 20 procedures) divided by Eligible Population / Denominator (d equals 80

procedures). All equals 70 procedures divided by 80 procedures. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 procedures) divided by Data Completeness Numerator (70 procedures) minus Denominator Exception (b equals 10 procedures). All equals 40 procedures divided by 60 procedures. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #402: Tobacco Use and Help with Quitting Among Adolescents

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user

INSTRUCTIONS:
This measure is to be submitted **once per performance period** for patients seen during the performance period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

Measure 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:
All patients aged 12-20 years with a visit during the measurement period

> **Denominator Criteria (Eligible Cases):**
> Patients aged 12-20 years on date of encounter
> **AND**
> **Patient encounter during the performance period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96156, 96158, 97165, 97166, 97167, 97168, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

NUMERATOR:
Patients who were screened for tobacco use at least once within 18 months (during the measurement period or the six months prior to the measurement period) **AND** who received tobacco cessation counseling intervention if identified as a tobacco user

> **Definitions:**
> **Tobacco Use Status** – Any documentation of smoking or "tobacco use status", including 'never' or 'non-use'.
> **Tobacco User** – Any documentation of active or current use of tobacco products, including smoking.
>
> ***NUMERATOR NOTE:*** *In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling, submit* ***G9460****.*

Numerator Options:

Performance Met: Patient documented as tobacco user AND received tobacco cessation intervention (must include at least one of the following: advice given to quit smoking or tobacco use, counseling on the benefits of quitting smoking or tobacco use, assistance with or referral to external smoking or tobacco cessation support programs, or current enrollment in smoking or tobacco use cessation program) if identified as a tobacco user **(G9458)**

OR

Performance Met: Currently a tobacco non-user **(G9459)**

OR

Performance Not Met: Tobacco assessment OR tobacco cessation intervention not performed, reason not given **(G9460)**

RATIONALE:

This measure is intended to promote adolescent tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines:

The U.S. Preventive Services Task Force recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents. (Strength of Recommendation = B) (U.S. Preventive Services Task Force, 2013)

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

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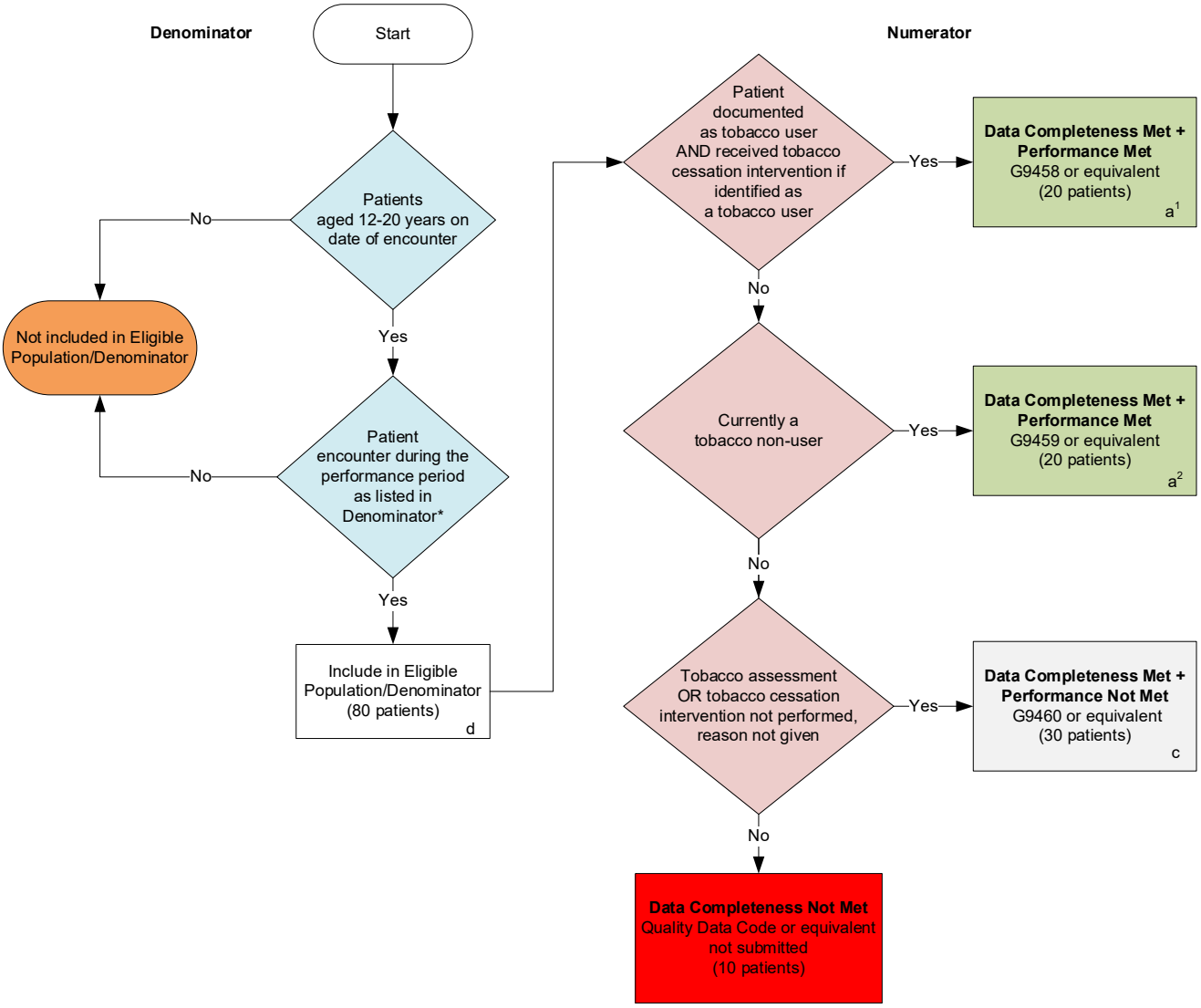
2023 Clinical Quality Measure Flow for Quality ID #402: Tobacco Use and Help with Quitting Among Adolescents

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a^1+a^2=40 patients) + Performance Not Met (c=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=
Performance Met (a^1+a^2=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

2023 Clinical Quality Measure Flow Narrative for Quality ID #402: Tobacco Use and Help with Quitting Among Adolescents

***Disclaimer**: Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients aged 12-20 years on date of encounter*:
    a. If *Patients aged 12-20 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged 12-20 years on date of encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Denominator Population:
    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
5. Start Numerator
6. Check *Patient documented as tobacco user AND received tobacco cessation intervention if identified as a tobacco user*:
    a. If *Patient documented as tobacco user AND received tobacco cessation intervention if identified as a tobacco user* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 20 patients in Sample Calculation.
    b. If *Patient documented as tobacco user AND received tobacco cessation intervention if identified as a tobacco user* equals No, proceed to check *Currently a tobacco non-user*.
7. Check *Currently a tobacco non-user*:
    a. If *Currently a tobacco non-user* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 20 patients in the Sample Calculation.
    b. If *Currently a tobacco non-user* equals No, proceed to check *Tobacco assessment OR tobacco cessation intervention not performed, reason not given.*
8. Check *Tobacco assessment OR tobacco cessation intervention not performed, reason not given*:

a. If *Tobacco assessment OR tobacco cessation intervention not performed, reason not given* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

    - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.

b. If *Tobacco assessment OR tobacco cessation intervention not performed, reason not given* equals No, proceed to check *Data Completeness Not Met*.

9. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a^1 plus a^2 equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #419: Overuse of Imaging for the Evaluation of Primary Headache

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients for whom imaging of the head (CT or MRI) is obtained for the evaluation of primary headache when clinical indications are not present.

INSTRUCTIONS:
This measure is to be submitted at **each denominator eligible visit** for patients with a diagnosis of primary headache 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 based on the services provided and the measure-specific denominator coding.

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

Measure 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:
All patients seen for evaluation of primary headache

Definition:
Change in headache - A significant change in severity of the headache including changes in location or quality. Other criteria take into account most red flag symptoms and also may reflect change (if a stable primary headache were previously present) but do not reflect a previously tolerated headache that now becomes suddenly disabling in severity. Change also includes any and all new symptoms that may be associated with a headache: arm numbness, speech disturbance, etc.

DENOMINATOR NOTE: **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.*

Denominator Criteria (Eligible Cases):
All patients, regardless of age
AND
Diagnosis for Primary Headache (ICD-10-CM): G43.001, G43.009, G43.011, G43.019, G43.101, G43.109, G43.111, G43.119, G43.401, G43.409, G43.411, G43.501, G43.509, G43.511, G43.519, G43.601, G43.609, G43.611, G43.619, G43.701, G43.709, G43.711, G43.719, G43.801, G43.809,

G43.811, G43.819, G43.821, G43.829, G43.831, G43.839, G43.901, G43.909, G43.911, G43.919, G44.019, G44.029, G44.039, G44.1, G44.209, G44.219, G44.221, G44.229, G44.52, G44.59, G44.81, G44.82, G44.89, , R51.0, R51.9, G44.009, G44.049, G44.059, G44.099, G44.51, G44.53, G44.83, G44.84, G44.85

AND

Patient encounter during the performance period (CPT): 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*

AND NOT

DENOMINATOR EXCLUSION:

Patients with clinical indications for imaging of the head:

- Head trauma: G2187
- New or change in headache above 50 years of age: G2188
- Abnormal neurologic exam: G2189
- Headache radiating to the neck: G2190
- Positional headaches: G2191
- Temporal headaches in patients over 55 years of age: G2192
- New onset headache in pre-school children or younger (<6 years of age): G2193
- New onset headache in pediatric patients with disabilities for which headache is a concern as inferred from behavior: G2194
- Occipital headache in children: G2195
- Thunderclap headache: G44.53
- Trigeminal pain: G50.0
- Persistent headaches: G44.52

NUMERATOR:

Patients for whom imaging of the head (Computed Tomography (CT) or Magnetic Resonance Imaging (MRI)) is obtained for the evaluation of primary headache when clinical indications are not present

Numerator Instruction:

INVERSE MEASURE - A lower calculated performance rate for this measure indicates better clinical care or control. The "Performance Not Met" numerator option for this measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures, a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.

Numerator Options:

Performance Met:	Imaging of the head (CT or MRI) was obtained **(M1027)**
OR	
Denominator Exception:	Documentation of patients with primary headache diagnosis and imaging other than CT or MRI obtained **(M1028)**
OR	
Denominator Exception:	Imaging needed as part of a clinical trial; or other clinician ordered the study **(G9537)**
OR	
Performance Not Met:	Imaging of the head (CT or MRI) was NOT obtained, Reason not given **(M1029)**

RATIONALE:
Imaging headache patients absent specific risk factors for structural disease is not likely to change management or improve outcome. Those patients with a significant likelihood of structural disease requiring immediate attention are detected by clinical screens that have been validated in many settings. Many studies and clinical practice guidelines concur. Also, incidental findings lead to additional medical procedures and expense that do not improve patient well-being.

Overuse of neuroimaging in pediatric patients was reported over a 13-year study period ranging from 41-47% in a study by Graf, et. al. Combining the results of the previous eight studies performed in children with recurrent headaches (7 in clinic-based population, 1 in children referred for neuroimaging), neuroimaging was undertaken in 38.1% of the study populations (1,072/2,815; range 17.5–100%).

You, et al. determined the indications for CT and MRI in Ontario. They studied 11,824 CT and 11,867 MRI scans from a random sample of 40 hospitals in Ontario. Hospital sampling was stratified by region and hospital teaching status. The publication reports that of the 11,824 CT scans completed, 3,930 (33%) were of the head and 1,055 (26.8%) of these were for the indication of headache. Because the CT scans were done for more than one indication the actual proportion of CT scans done solely for the purpose of headache was 16%. Similarly, 4,038 (34%) of all MRI scans were head scans of which 523 (13%) were for the indication of headache. However, similar to CT scans, the MRI scans were requested for multiple indications and the actual proportion of MRI scans done solely for the purpose of headache was estimated to be 4% (Unpublished data, personal communication with author, April 29, 2010).

Information concerning the workup of headache in the ambulatory setting is limited. In actual practice, only about 3% of patients who present with a new headache in the office setting have neuroimaging ordered. When neuroimaging is performed, about 4% of CT scans find a significant and treatable lesion (in one sample of 293 CT scans, there were 12 true-positive scans and 2 false-positive scans). Expert guidelines regarding headaches among ambulatory patients recommend neuroimaging for migraine patients only in the presence of persistent focal abnormal neurological findings.

Opportunity for Improvement:
There is a marked need to reduce the unnecessary use of neuroimaging for atraumatic primary headache disorders. This measure is intended to reduce the use of these unnecessary tests, reduce treatment costs, and improve patient safety by reducing the exposure to unnecessary radiation and testing.

CLINICAL RECOMMENDATION STATEMENTS:
Neuroimaging recurrent headache: Obtaining a neuroimaging study on a routine basis is not indicated in children with recurrent headaches and a normal neurologic examination. (Level B)

Neuroimaging is not usually warranted for patients with migraine and normal neurological examination. (Level B)

Neuroimaging is not indicated in patients with a clear history of migraine, without red flag features for potential secondary headache, and a normal neurological examination. (Level D)* Only included because it supports neuroimaging overuse in normal exam patients with migraine. But low level evidence. *deemed by guideline group to be one of the most clinically important recommendations.

Do not refer people diagnosed with TTH, migraine, CH or medication overuse headache (MOH) for neuroimaging solely for reassurance.

In adult and pediatric patients with migraine, with no recent change in pattern, no history of seizures, and no other focal neurological signs or symptoms, the routine use of neuroimaging is not warranted. (Grade B)

Don't do imaging for uncomplicated headache.

The US Headache Consortium identified three consensus-based (not evidence-based) general principles of management for making decisions regarding neuroimaging in patients with headache: 1) testing should be avoided if it will not lead to a change in management; 2) testing is not recommended if the patient is not significantly more likely than anyone else in the general population to have a significant abnormality; and 3) testing that normally may not be recommended as a population policy may make sense at an individual level, resources notwithstanding.

Scottish Intercollegiate Guidelines Network – Diagnosis and management of headache in adults:

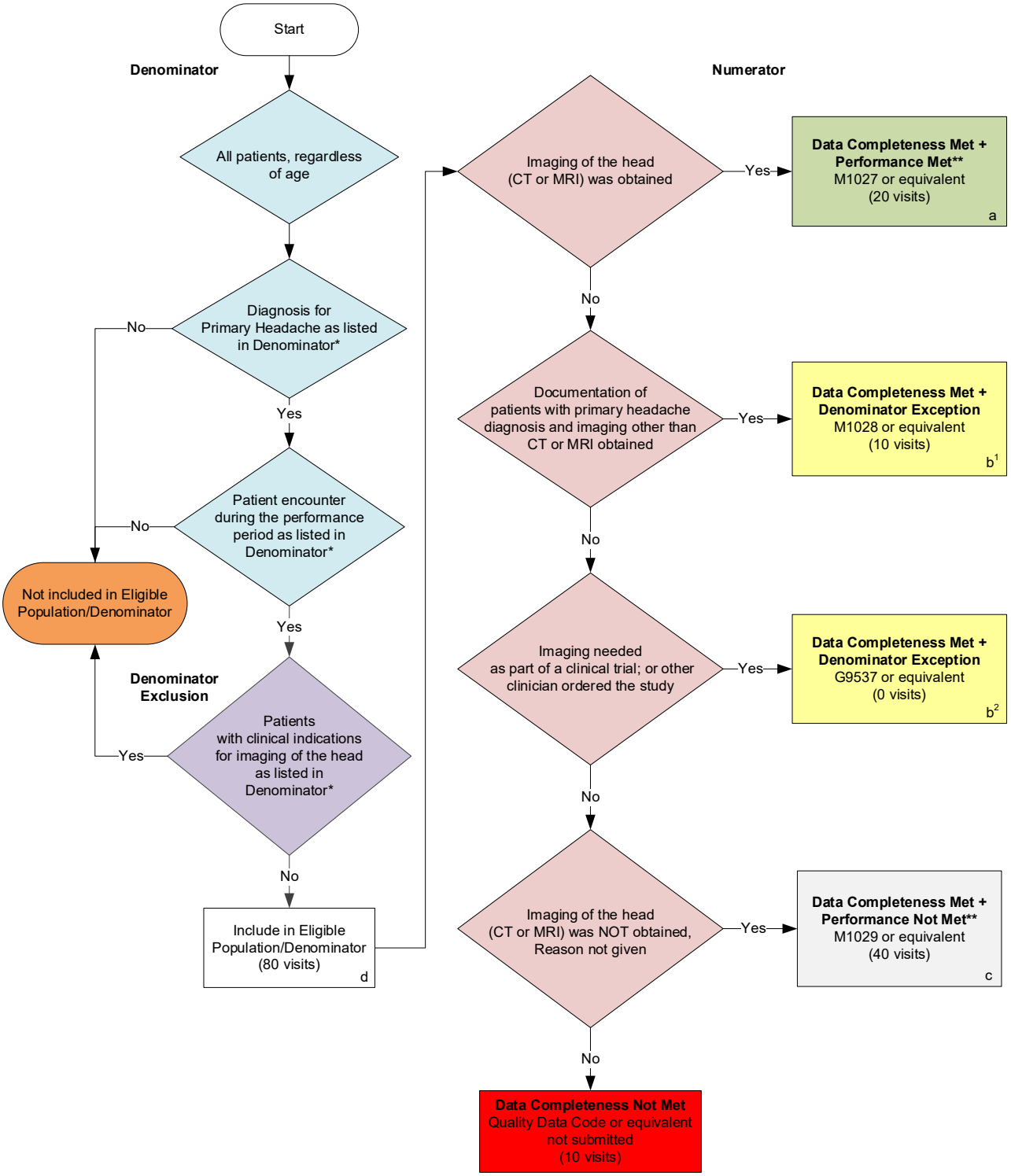
- Neuroimaging is not indicated in patients with a clear history of migraine, without red flag features for potential secondary headache, and a normal neurological examination.
- Clinicians requesting neuroimaging should be aware that both MRI and CT can identify incidental neurological abnormalities which may result in patient anxiety as well as practical and ethical dilemmas with regard to management.
- Brain CT should be performed in patients with headache who have unexplained abnormal neurological signs, unless the clinical history suggests MRI is indicated.

Institute for Clinical Systems Improvement – Diagnosis and Treatment of Headache:

- Clinicians should use a detailed headache history that includes duration of attacks and the exclusion of secondary causes as the principal means to diagnose primary headache. Additional testing in patients without atypical symptoms or an abnormal neurologic examination is unlikely to be helpful. There are, as yet, no tests that confirm the diagnosis of primary headache. The diagnosis of primary headache is dependent on the clinician. The work group recommends careful consideration before proceeding with neuroimaging (CT or MRI).

2023 Clinical Quality Measure Flow for Quality ID #419: Overuse of Imaging for the Evaluation of Primary Headache

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=20 visits) + Denominator Exceptions (b^1+b^2=10 visits) + Performance Not Met (c=40 visits) = 70 visits = **87.50%**

Eligible Population / Denominator (d=80 visits) = 80 visits

Performance Rate=**

Performance Met (a=20 visits) = 20 visits = **33.33%**

Data Completeness Numerator (70 visits) – Denominator Exceptions (b^1+b^2=10 visits) = 60 visits

*See the posted measure specification for specific coding and instructions to submit this measure.

**A lower calculated performance rate for this measure indicates better clinical care or control

NOTE: Submission Frequency: Visit

v7

2023 Clinical Quality Measure Flow Narrative for Quality ID #419: Overuse of Imaging for the Evaluation of Primary Headache

***Disclaimer**: Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. *All patients, regardless of age*
3. Check *Diagnosis for Primary Headache as listed in Denominator**:
    a. If *Diagnosis for Primary Headache as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis for Primary Headache as listed in Denominator** equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
4. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Patients with clinical indications for imaging of the head as listed in Denominator**.
5. Check *Patients with clinical indications for imaging of the head as listed in Denominator**:
    a. If *Patients with clinical indications for imaging of the head as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients with clinical indications for imaging of the head as listed in Denominator** equals No, include in *Eligible Population/Denominator*.
6. Denominator Population:
    - Denominator Population is all Eligible Visits in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 visits in the Sample Calculation.
7. Start Numerator
8. Check *Imaging of the head (CT or MRI) was obtained*:
    a. If *Imaging of the head (CT or MRI) was obtained* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 20 visits in the Sample Calculation.
    b. If *Imaging of the head (CT or MRI) was obtained* equals No, proceed to check *Documentation of patients with primary headache diagnosis and imaging other than CT or MRI obtained*.
9. Check *Documentation of patients with primary headache diagnosis and imaging other than CT or MRI obtained*:

a. If *Documentation of patients with primary headache diagnosis and imaging other than CT or MRI obtained* equals Yes, include in *Data Completeness Met and Denominator Exception*.

- *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 visits in the Sample Calculation.

b. If *Documentation of patients with primary headache diagnosis and imaging other than CT or MRI obtained* equals No, proceed to check *Imaging needed as part of a clinical trial; or other clinician ordered the study*.

10. Check *Imaging needed as part of a clinical trial; or other clinician ordered the study*:

a. If *Imaging needed as part of a clinical trial; or other clinician ordered the study* equals Yes, include in *Data Completeness Met and Denominator Exception*.

- *Data Completeness and Denominator Exception* is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 0 visits in the Sample Calculation.

b. If *Imaging needed as part of a clinical trial; or other clinician ordered the study* equals No, proceed to check *Imaging of the head (CT or MRI) was NOT obtained, Reason not given*.

11. Check *Imaging of the head (CT or MRI) was NOT obtained, Reason not given*:

a. If *Imaging of the head (CT or MRI) was NOT obtained, Reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met*.

- *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 40 visits in the Sample Calculation.

b. If *Imaging of the head (CT or MRI) was NOT obtained, Reason not given* equals No, proceed to check *Data Completeness Not Met*.

12. Check *Data Completeness Not Met*:

- If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 visits have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a equals 20 visits) plus Denominator Exceptions (b^1 plus b^2 equals 10 visits) plus Performance Not Met (c equals 40 visits) divided by Eligible Population/Denominator (d equals 80 visits). All equals 70 visits divided by 80 visits. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 20 visits) divided by Data Completeness Numerator (70 visits) minus Denominator Exceptions (b^1 plus b^2 equals 10 visits). All equals 20 visits divided by 60 visits. All equals 33.33 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Visit

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #440: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of biopsies with a diagnosis of cutaneous basal cell carcinoma (BCC) and squamous cell carcinoma (SCC), or melanoma (including in situ disease) in which the pathologist communicates results to the clinician within 7 days from the time when the tissue specimen was received by the pathologist.

INSTRUCTIONS:
This measure is to be submitted **each time** a biopsy is performed during the performance period. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians providing the pathology services for procedures will submit this measure.

NOTE: *To be eligible for this measure, the denominator must be met during the measurement period of 01/01/2023 to 12/24/2023. This is to provide sufficient time for the pathology results to be received by the biopsying clinician and for the performance of the numerator to be met within the performance period.*

Measure 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:
All pathology reports generated by the Pathologist/Dermatopathologist consistent with cutaneous basal cell carcinoma, squamous cell carcinoma, or melanoma (to include in situ disease)

Denominator Criteria (Eligible Cases):
Diagnosis for cutaneous basal carcinoma or squamous cell carcinoma (ICD-10-CM): C44.01, C44.02, C44.111, C44.1121, C44.1122, C44.1191, C44.1192, C44.121, C44.1221, C44.1222, C44.1291, C44.1292, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.41, C44.42, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.81, C44.82, C44.91, C44.92, D00.01, D04.0, D04.10, D04.111, D04.112, D04.121, D04.122, D04.20, D04.21, D04.22, D04.30, D04.39, D04.4, D04.5, D04.60, D04.61, D04.62, D04.70, D04.71, D04.72, D04.8, D04.9
OR
Diagnosis for melanoma (ICD-10-CM): C43.0, C43.10, C43.111, C43.112, C43.121, C43.122, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.111, D03.112, D03.121, D03.122, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
OR
Other malignant diagnosis (ICD-10-CM): C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C44.90, C44.99,

C46.0, C46.1, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9
AND
Patient procedure during the performance period (CPT): 88304, 88305
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02
AND NOT
DENOMINATOR EXCLUSIONS:
Pathologists/Dermatopathologists providing a second opinion on a biopsy: G9784
OR
Pathologists/Dermatopathologists is the same clinician who performed the biopsy: G9939

NUMERATOR:
Number of final pathology reports diagnosing cutaneous basal cell carcinoma or squamous cell carcinoma or melanoma (to include in situ disease) sent from the Pathologist/Dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist

Numerator Instructions:
Requirements for calculating the numerator include the following documentation in the pathologist/ dermopathologist's tracking system:
- Date tissue specimen received
- Date pathology report was sent to the biopsying clinician

Numerator Options:

Performance Met:	Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, or melanoma (to include in situ disease) sent from the Pathologist/ Dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist **(G9785)**
OR	
Denominator Exception:	Pathology report for tissue specimens produced from wide local excisions or re-excisions **(M1166)**
OR	
Performance Not Met:	Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, or melanoma (to include in situ disease) was not sent from the Pathologist/ Dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist **(G9786)**

RATIONALE:
Effective communication through the biopsy report between pathologist and referring physician is essential; as delay may directly affect patient care. Furthermore, lack of timely delivery of results can increase the cost of medical care, error and the anxiety the patient experiences in waiting for results. This measure seeks to ensure timely communication and effective treatment for the patient.

CLINICAL RECOMMENDATION STATEMENTS:
"[Pathology] reports should be issued in a timely manner. Failure to report results promptly may delay patient care (thus uselessly adding to the cost of medical care), [and] lead to error and confusion…" (Holland Frei Cancer Medicine Vol. 8, 2010)

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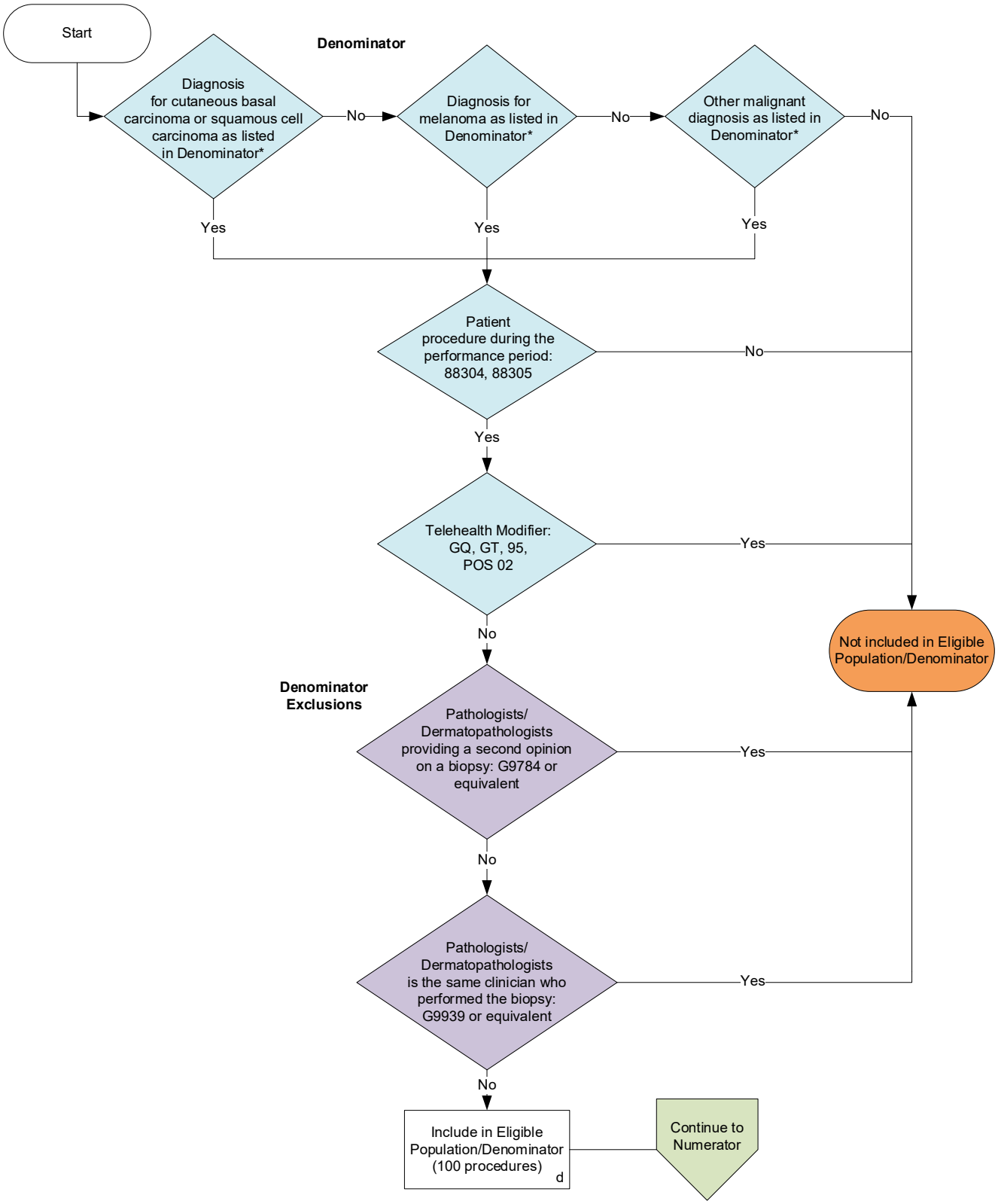
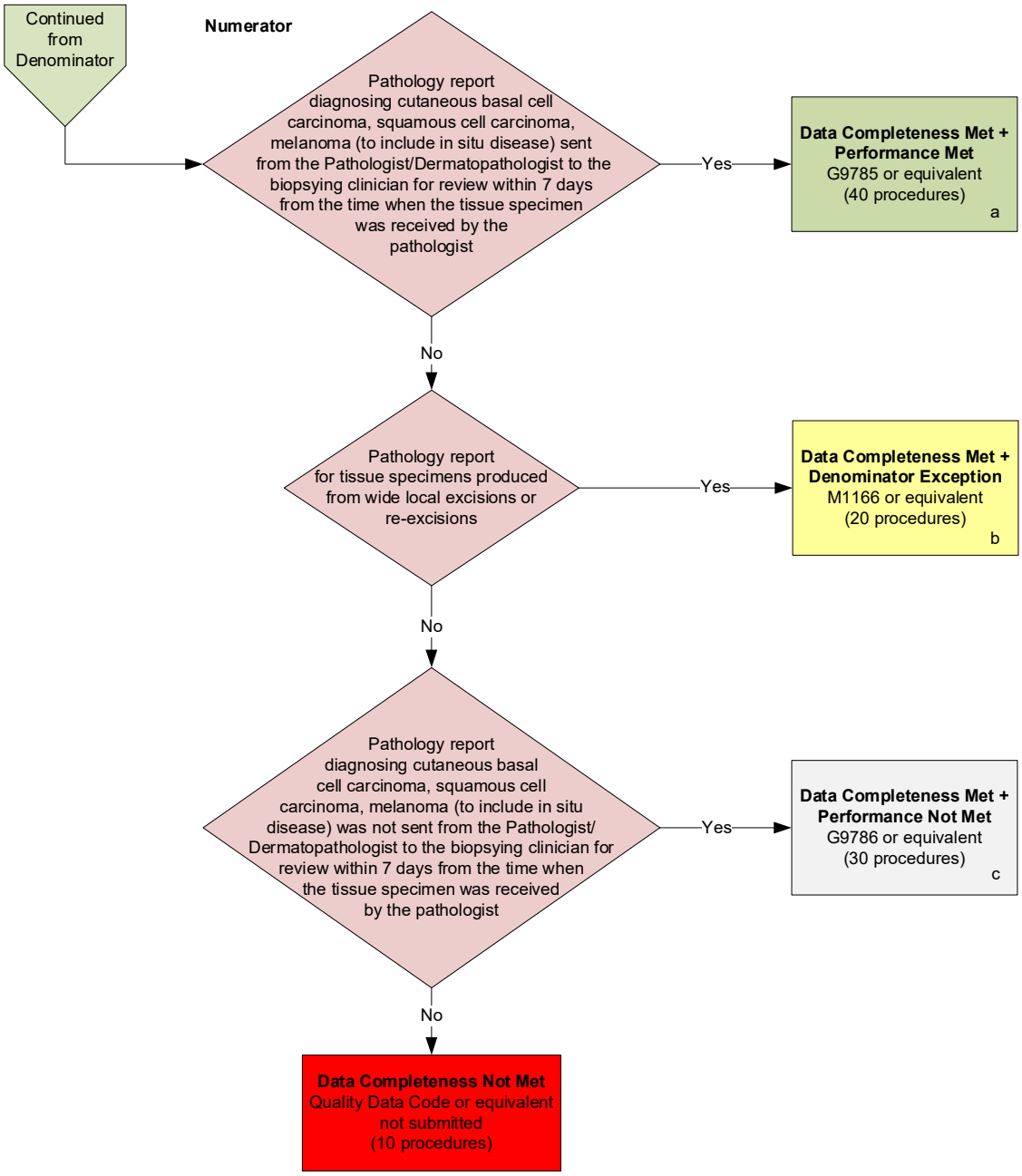
2023 Clinical Quality Measure Flow for Quality ID #440: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*





SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 procedures) + Denominator Exceptions (b=20 procedures) + Performance Not Met (c=30 procedures) / Eligible Population / Denominator (d=100 procedures) = 90 procedures / =100 procedures = **90.00%**

Performance Rate=

Performance Met (a=40 procedures) / Data Completeness Numerator (90 procedures) – Denominator Exceptions (b=20 procedures) = 40 procedures / 70 procedures = **57.14%**

* See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Procedure
NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

2023 Clinical Quality Measure Flow Narrative for Quality ID #440: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Diagnosis for cutaneous basal carcinoma or squamous cell carcinoma as listed in Denominator**:
    a. If *Diagnosis for cutaneous basal carcinoma or squamous cell carcinoma as listed in Denominator** equals No, proceed to check *Diagnosis for melanoma as listed in Denominator*.*
    b. If *Diagnosis for cutaneous basal carcinoma or squamous cell carcinoma as listed in Denominator** equals Yes, proceed to check *Patient procedure during the performance period.*
3. Check *Diagnosis for melanoma as listed in Denominator*:*
    a. If *Diagnosis for melanoma as listed in Denominator** equals No, proceed to check *Other malignant diagnosis as listed in Denominator*.*
    b. If *Diagnosis for melanoma as listed in Denominator** equals Yes, proceed to check *Patient procedure during the performance period*.
4. Check *Other malignant diagnosis as listed in Denominator**:
    a. If *Other malignant diagnosis as listed in Denominator** equals No, do not include in *Eligible Population/Denominator.* Stop processing.
    b. If *Other malignant diagnosis as listed in Denominator** equals Yes, proceed to check *Patient procedure during the performance period.*
5. Check *Patient procedure during the performance period*:
    a. If *Patient procedure during the performance period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient procedure during the performance period* equals Yes, proceed to check *Telehelath Modifier*.
6. Check *Telehealth Modifier*:
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, proceed to check *Pathologists/Dermatopathologists providing a second opinion on a biopsy*.
7. Check *Pathologists/Dermatopathologists providing a second opinion on a biopsy*:
    a. If *Pathologists/Dermatopathologists providing a second opinion on a biopsy* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Pathologists/Dermatopathologists providing a second opinion on a biopsy* equals No, proceed to check *Pathologists/Dermatopathologists is the same clinician who performed the biopsy*.
8. Check *Pathologists/Dermatopathologists is the same clinician who performed the biopsy:*
    a. If *Pathologists/Dermatopathologists is the same clinician who performed the biopsy* equals Yes, do not

include in *Eligible Population/Denominator*. Stop processing.

b. If *Pathologists/Dermatopathologists is the same clinician who performed the biopsy* equals No, include in *Eligible Population/Denominator*.

9. Denominator Population:

   a. Denominator Population is all Eligible Procedures in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 100 procedures in the Sample Calculation.

10. Start Numerator

11. Check *Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, melanoma (to include in situ disease) sent from the Pathologist/Dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist*:

    a. If *Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, melanoma (to include in situ disease) sent from the Pathologist/Dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist* equals Yes, include in *Data Completeness Met and Performance Met*.

       - *Data Completeness Met and Performance Met* is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 procedures in the Sample Calculation.

    b. If *Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, melanoma (to include in situ disease) sent from the Pathologist/Dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist* equals No, proceed to check *Pathology report for tissue specimens produced from wide local excisions or re-excisions*.

12. Check *Pathology report for tissue specimens produced from wide local excisions or re-excisions:*

    a. If *Pathology report for tissue specimens produced from wide local excisions or re-excisions* equals Yes, include in *Data Completeness Met and Denominator Exception*.

       - *Data Completeness Met and Denominator Exception* is represented as Denominator Exceptions in the Sample Calculation listed at the end of this document. Letter b equals 20 procedures in the Sample Calculation.

    b. If *Pathology report for tissue specimens produced from wide local excisions or re-excisions* equals No, proceed to check *Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, melanoma (to include in situ disease) was not sent from the Pathologist/Dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist.*

13. Check *Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, melanoma (to include in situ disease) was not sent from the Pathologist/Dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist*:

    a. If *Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, melanoma (to include in situ disease) was not sent from the Pathologist/Dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist* equals Yes, include in *Data Completeness Met and Performance Not Met*.

       - *Data Completeness Met and Performance Not Met is represented as Data Completeness in the*

Sample Calculation listed at the end of this document. Letter c equals 30 procedures in the Sample Calculation.

b. If *Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, melanoma (to include in situ disease) was not sent from the Pathologist/Dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist* equals No, proceed to check *Data Completeness Not Met*.

14. Check *Data Completeness Not Met*:

- If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 procedures have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a equals 40 procedures) plus Denominator Exceptions (b equals 20 procedures) plus Performance Not Met (c equals 30 procedures) divided by Eligible Population/Denominator (d equals 100 procedures). All equals 90 procedures divided by 100 procedures. All equals 90.00 percent.

Performance Rate equals Performance Met (a equals 40 procedures) divided by Data Completeness Numerator (90 procedures) minus Denominator Exceptions (b equals 20 procedures). All equals 40 procedures divided by 70 procedures. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #487: Screening for Social Drivers of Health

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients seen 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 based on the services provided and the measure-specific denominator coding.

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

Measure 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:
Number of patients 18 years and older

DENOMINATOR NOTE: **Signifies that this CPT Category I or HCPCS 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.*

Denominator Criteria (Eligible Cases):
Patients aged 18 and older on date of encounter
AND
Patient encounter during the performance period (CPT): 59400, 59510, 59610, 59618, 78012, 78070, 78075, 78102, 78140, 78185, 78195, 78202, 78215, 78261, 78290, 78300, 78305, 78315, 78414, 78428, 78456, 78458, 78579, 78580, 78582, 78597, 78601, 78630, 78699, 78708, 78725, 78740, 78801, 78803, 78999, 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 92002, 92004, 92012, 92014, 92507, 92508, 92521, 92522, 92523, 92524, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92548, 92549, 92550, 92557, 92567, 92568, 92570, 92588, 92625, 92626, 92650*, 92651, 92652, 92653, 96116, 96156, 96158, 97129, 97161, 97162, 97163, 97164, 97802, 97803, 97804, 98960, 98961, 98962, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99236, 99242*, 99243*, 99244*, 99245*, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99381*, 99382*, 99383*, 99384*, 99385*, 99386*, 99387*, 99391*, 99392*, 99393*, 99394*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, 99495, 99496, 99512*, D0120*, D0140*,

D0145*, D0150, D0160*, D0170*, D0180*, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447, G0473, G9054

NUMERATOR:

Number of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

NUMERATOR NOTE: The patient is required to have a standardized health-related social needs (HRSN) screening done once per performance period. Documentation that a review of a previous performed standardized HRSN screening during the performance period is acceptable for meeting the numerator criteria.

Examples of standardized HRSN screening tools include but are not limited to:

Accountable Health Communities Health-Related Social Needs Screening Tool (2017)

Accountable Health Communities Health-Related Social Needs Screening Tool (2021)

The Protocol for Responding to and Assessing Patients' Risks and Experiences (PRAPARE) Tool (2016)

WellRx Questionnaire (2014)

American Academy of Family Physicians (AAFP) Screening Tool (2018)

Numerator Options:

Performance Met:	Number of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety **(M1207)**
OR	
Performance Not Met:	Number of patients not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. **(M1208)**

RATIONALE:

An estimated 20 percent of health outcomes are linked to medical care; the remaining 80 percent stem from socioeconomic, environmental and behavioral factors referred to as drivers of health (DOH) (Magnan, 2017). These factors such as homelessness, food insecurity, and exposure to intimate partner violence (IPV)–are linked to poorer health, disproportionately impact communities of color, and have escalated due to COVID-19. Research demonstrates that 66 percent of physician practices are screening for one or more of the 5 DOH domains specified in this measure (Fraze et al., 2019). A 2022 survey by the Physicians Foundation found that 65 percent of U.S. physicians believe that implementing DOH quality measures are important to improve health outcomes and to ensure high-quality and cost-efficient care (Physicians Foundation, 2022). In a cross-sectional analysis of physicians who participated in the first year of the MIPS program, physicians caring for patients with increased social risk had significantly lower MIPS scores compared with other physicians (Khullar et al., 2020). Given MIPS's intent to implement performance-based payment adjustments, not accounting for DOH – which are associated with approximately 38 percent of the geographic variation in per beneficiary Medicare spending (Zhang et al., 2021) – in MIPS is likely confounding these adjustments (Byrd &Chung, 2021).

CLINICAL RECOMMENDATION STATEMENTS:

In COVID-19's wake, food insecurity, housing instability, IPV, and other basic DOH have reached unprecedented levels – and revealed searing racial disparities. In 2021, 17 percent of Black adults and 16 percent of Latino adults reported that their household did not get enough to eat, compared to 6 percent of white adults. Likewise, 28 percent of Black, 18 percent of Latino, and 20 percent of Asian renters are not caught up on rent, compared to 12 percent of white renters (Center for Budget and Policy Priorities, 2021).

Secretary Becerra has pledged "to take a department-wide approach to the advancement of equity, consistent with President Biden's charge to federal departments and agencies, and this would include examination of ways to address the social determinants of health" (Senate Finance Committee, 2021). In particular, he has noted the importance of collecting more robust DOH data to address the disparities exposed by COVID-19 and leveraging the data and experience from the

CMMI Accountable Health Community (AHC) model, which has screened nearly one million beneficiaries (Senate Health Committee, 2021).

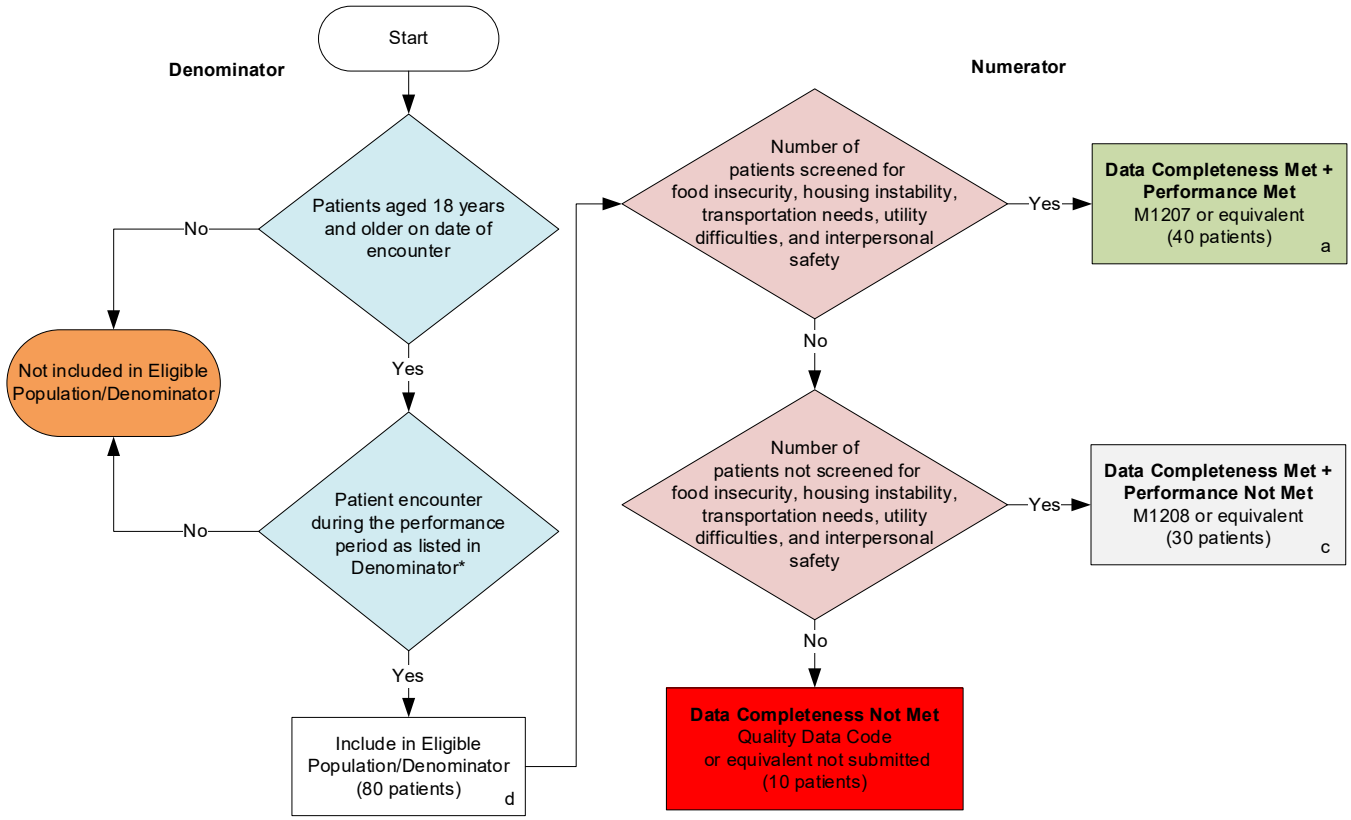
CMS has recognized the importance of making DOH measures standard across programs, identifying the development and implementation of "measures that reflect social and economic determinants" as a key priority and measurement gap to be addressed through Meaningful Measures 2.0 (Centers for Medicare & Medicaid Services, 2022).

A growing set of constituencies have called on CMS to provide leadership in measuring and addressing DOH, citing various rationales for doing so. Healthcare experts have increasingly recognized that equity is unachievable without addressing DOH (Dutton et al., 2021), calling for CMS to require program "participants to uniformly screen for and document drivers of health" and "build DOH measures into MIPS and all APMs" (Navathe et al., 2021). The Health Care Payment Learning & Action Network (LAN) – a group of public and private health care leaders providing thought leadership, strategic direction, and ongoing support to accelerate adoption of APMs – has identified promoting equity and addressing DOH as key facets of APM resiliency (Health Care Payment Learning & Action Network, 2020).

Likewise, physicians and other providers have called on CMS to create standard patient-level DOH measures – beyond socioeconomic status (SES), hierarchical condition category (HCC) score, or duals status – recognizing that these risk factors transcend specific subpopulations (Berkowitz et al., 2017); drive demand for healthcare services (Physicians Foundation, 2020**)**; and escalate physician burnout (Marchis et al., 2019).

2023 Clinical Quality Measure Flow for Quality ID #487: Screening for Social Drivers of Health

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 patients) + Performance Not Met (c=30 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a=40 patients) = 40 patients = **57.14%**

Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

2023 Clinical Quality Measure Flow Narrative Quality ID #487: Screening for Social Drivers of Health

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients 18 years and older on date of encounter*:
   a. If *Patients 18 years and older on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
   b. If *Patients 18 years and older on date of encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator*.*
3. Check *Patient encounter during the performance period as listed in Denominator**:
   a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
   b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Denominator Population:
   - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
5. Start Numerator
6. Check *Number of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety*:
   a. If *Number of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety* equals Yes, include in *Data Completeness Met and Performance Met*.
      - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in the Sample Calculation.
   b. If *Number of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety* equals No, proceed to check *Number of patients not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety*.
7. Check *Number of patients not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety*:
   a. If *Number of patients not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety* equals Yes, include in *Data Completeness Met and Performance Not Met*.
      - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.
   b. If *Number of patients not screened for food insecurity, housing instability, transportation needs, utility difficulties,*

and interpersonal safety equals No, proceed to check *Data Completeness Not Met*.

8. Check *Data Completeness Not Met*:
    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population / Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #493 (NQF 3620): Adult Immunization Status

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients 19 years of age and older who are up-to-date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap); zoster; and pneumococcal.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for all patients 19 years of age and older on the date of the encounter. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure for patients age 19 years of age and older based on the services provided and the measure-specific denominator coding.

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

This measure will be calculated with 4 performance rates:

1) Percentage of patients (19 years of age and older on the date of the encounter) who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period
2) Percentage of patients (19 years of age and older on the date of the encounter) who received at least 1 tetanus and diphtheria (Td) vaccine or 1 tetanus, diphtheria, and pertussis (Tdap) vaccine between 9 years prior to the encounter and the end of the measurement period
3) Percentage of patients (50 years of age and older on the date of the encounter) who received at least 1 dose of the herpes zoster live vaccine or 2 doses of the herpes zoster recombinant vaccine anytime on or after the patients' 50th birthday
4) Percentage of patients (66 years of age or older on the date of the encounter) who were administered any pneumococcal conjugate vaccine or polysaccharide vaccine, on or after their 60th birthday and before the end of the measurement period

NOTE: *Submission of the 4 performance rates is required for this measure. A weighted average, which is the sum of the performance numerator values divided by the sum of performance denominator values, will be used for performance.*

Measure 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 (SUBMISSION CRITERIA 1):
Patients 19 years of age and older on the date of the encounter with a visit during the measurement period.

DENOMINATOR NOTE: **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.*

Denominator Criteria (Eligible Cases 1):
Patients age 19 and older on the date of the encounter
AND
Patient encounter during the performance period (CPT): 90945, 90947, 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, 99512*, G0438, G0439
AND NOT
DENOMINATOR EXCLUSIONS:
Active chemotherapy during the measurement period:

- Chemotherapy Encounter (ICD-10-CM): Z51.0, Z51.11, Z51.12
- Chemotherapy Procedure (CPT or HCPCS): 96401, 96402, 96405, 96406, 96409, 96413, 96416, 96420, 96422, 96425, 96440, 96450, 96521, 96522, 96523, 96542, 96549

OR
Bone marrow transplant during the measurement period (ICD-10-PCS): 30233AZ, 30233G0, 30233G2, 30233G3, 30233G4, 30233X0, 30233X2, 30233X3, 30233X4, 30233Y0, 30233Y2, 30233Y3, 30233Y4, 30243AZ, 30243G0, 30243G2, 30243G3, 30243G4, 30243X0, 30243X2, 30243X3, 30243X4, 30243Y0, 30243Y2, 30243Y3, 30243Y4
OR
History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period:

- Anatomic or Functional Asplenia (ICD-10-CM): Q89.01
- Cerebrospinal Fluid Leak (ICD-10-CM): G96.0, G96.00, G96.01, G96.02, G96.08, G96.09, G97.0
- Cochlear Implant (CPT): 69930
- Cochlear Implant Device (HCPCS): L8614, L8619, L8627, L8628
- Cochlear Implant Diagnosis (ICD-10-CM): Z96.20, Z96.21
- Immunocompromising Conditions (ICD-10-CM): B20, B59, B97.35, C80.2, C88.8, C94.40, C94.41, C94.42, C94.6, D46.22, D47.1, D47.9, D47.Z1, D47.Z9, D61.09, D61.810, D61.811, D61.818, D70.0, D70.1, D70.2, D70.4, D70.8, D70.9, D71, D72.0, D72.810, D72.818, D72.819, D73.81, D75.81, D76.1, D76.2, D76.3, D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D80.9, D81.0, D81.1, D81.2, D81.4, D81.6, D81.7, D81.89, D81.9, D82.0, D82.1, D82.2, D82.3, D82.4, D82.8, D82.9, D83.0, D83.1, D83.2, D83.8, D83.9, D84.0, D84.1, D84.8, D84.81, D84.821, D84.822, D84.89, D84.9, D89.3, D89.810, D89.811, D89.812, D89.813, D89.82, D89.89, D89.9, E40, E41, E42, E43, I12.0, I13.11, I13.2, K91.2, M35.9, N18.5, N18.6, T86.00, T86.01, T86.02, T86.03, T86.09, T86.10, T86.11, T86.12, T86.13, T86.19, T86.20, T86.21, T86.22, T86.23, T86.290, T86.298, T86.30, T86.31, T86.32, T86.33, T86.39, T86.40, T86.41, T86.42, T86.43, T86.49, T86.5, T86.810, T86.811, T86.812, T86.818, T86.819, T86.830, T86.831, T86.832, T86.838, T86.839, T86.850, T86.851, T86.852, T86.858, T86.859, T86.890, T86.891, T86.892, T86.898, T86.899, T86.90, T86.91, T86.92, T86.93, T86.99, Z21, Z48.21, Z48.22, Z48.23, Z48.24, Z48.280, Z48.290, Z48.298, Z49.01, Z49.02, Z49.31, Z94.0, Z94.1, Z94.2, Z94.3, Z94.4, Z94.81, Z94.82, Z94.83, Z94.84, Z94.89, Z99.2
- Sickle Cell Anemia and HB-S Disease (ICD-10-CM): D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, D57.819

OR
In hospice or using hospice services during the measurement period (HCPCS): M1167

NUMERATOR (SUBMISSION CRITERIA 1):
Patients in Denominator 1 who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period.

NUMERATOR NOTE: *Patient reported vaccine receipt, when recorded in the medical record, is acceptable for meeting the numerator.*

Numerator Options:

Performance Met:	Patient received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period **(M1168)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not administering influenza vaccine (e.g., prior anaphylaxis due to the influenza vaccine) **(M1169)**
OR	
Performance Not Met:	Patient did not receive an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period **(M1170)**

DENOMINATOR (SUBMISSION CRITERIA 2):
Patients 19 years of age and older on the date of the encounter with a visit during the measurement period.

***DENOMINATOR NOTE*:** *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.

Denominator Criteria (Eligible Cases 2):
Patients age 19 and older on the date of the encounter
AND
Patient encounter during the performance period (CPT): 90945, 90947, 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, 99512*, G0438, G0439
AND NOT
DENOMINATOR EXCLUSIONS:
Active chemotherapy during the measurement period:

- Chemotherapy Encounter (ICD-10-CM): Z51.0, Z51.11, Z51.12
- Chemotherapy Procedure (CPT or HCPCS): 96401, 96402, 96405, 96406, 96409, 96413, 96416, 96420, 96422, 96425, 96440, 96450, 96521, 96522, 96523, 96542, 96549

OR
Bone marrow transplant during the measurement period (ICD-10-PCS): 30233AZ, 30233G0, 30233G2, 30233G3, 30233G4, 30233X0, 30233X2, 30233X3, 30233X4, 30233Y0, 30233Y2, 30233Y3, 30233Y4, 30243AZ, 30243G0, 30243G2, 30243G3, 30243G4, 30243X0, 30243X2, 30243X3, 30243X4, 30243Y0, 30243Y2, 30243Y3, 30243Y4
OR
History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle

cell anemia & HB-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period:

- Anatomic or Functional Asplenia (ICD-10-CM): Q89.01
- Cerebrospinal Fluid Leak (ICD-10-CM): G96.0, G96.00, G96.01, G96.02, G96.08, G96.09, G97.0
- Cochlear Implant (CPT): 69930
- Cochlear Implant Device (HCPCS): L8614, L8619, L8627, L8628
- Cochlear Implant Diagnosis (ICD-10-CM): Z96.20, Z96.21
- Immunocompromising Conditions (ICD-10-CM): B20, B59, B97.35, C80.2, C88.8, C94.40, C94.41, C94.42, C94.6, D46.22, D47.1, D47.9, D47.Z1, D47.Z9, D61.09, D61.810, D61.811, D61.818, D70.0, D70.1, D70.2, D70.4, D70.8, D70.9, D71, D72.0, D72.810, D72.818, D72.819, D73.81, D75.81, D76.1, D76.2, D76.3, D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D80.9, D81.0, D81.1, D81.2, D81.4, D81.6, D81.7, D81.89, D81.9, D82.0, D82.1, D82.2, D82.3, D82.4, D82.8, D82.9, D83.0, D83.1, D83.2, D83.8, D83.9, D84.0, D84.1, D84.8, D84.81, D84.821, D84.822, D84.89, D84.9, D89.3, D89.810, D89.811, D89.812, D89.813, D89.82, D89.89, D89.9, E40, E41, E42, E43, I12.0, I13.11, I13.2, K91.2, M35.9, N18.5, N18.6, T86.00, T86.01, T86.02, T86.03, T86.09, T86.10, T86.11, T86.12, T86.13, T86.19, T86.20, T86.21, T86.22, T86.23, T86.290, T86.298, T86.30, T86.31, T86.32, T86.33, T86.39, T86.40, T86.41, T86.42, T86.43, T86.49, T86.5, T86.810, T86.811, T86.812, T86.818, T86.819, T86.830, T86.831, T86.832, T86.838, T86.839, T86.850, T86.851, T86.852, T86.858, T86.859, T86.890, T86.891, T86.892, T86.898, T86.899, T86.90, T86.91, T86.92, T86.93, T86.99, Z21, Z48.21, Z48.22, Z48.23, Z48.24, Z48.280, Z48.290, Z48.298, Z49.01, Z49.02, Z49.31, Z94.0, Z94.1, Z94.2, Z94.3, Z94.4, Z94.81, Z94.82, Z94.83, Z94.84, Z94.89, Z99.2
- Sickle Cell Anemia and HB-S Disease (ICD-10-CM): D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, D57.819

OR

In hospice or using hospice services during the measurement period (HCPCS): M1167

NUMERATOR (SUBMISSION CRITERIA 2):

Patients in Denominator 2 who received at least 1 Td vaccine or 1 Tdap vaccine between 9 years prior to the encounter and the end of the measurement period.

NUMERATOR NOTE: *Patient reported vaccine receipt, when recorded in the medical record, is acceptable for meeting the numerator.*

Numerator Options:

Performance Met:	Patient received at least one Td vaccine or one Tdap vaccine between nine years prior to the encounter and the end of the measurement period **(M1171)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not administering Td or Tdap vaccine (e.g., prior anaphylaxis due to the Td or Tdap vaccine or history of encephalopathy within seven days after a previous dose of a Td-containing vaccine) **(M1172)**
OR	
Performance Not Met:	Patient did not receive at least one Td vaccine or one Tdap vaccine between nine years prior to the encounter and the end of the measurement period

(M1173):

DENOMINATOR (SUBMISSION CRITERIA 3):
Patients 50 years of age and older on the date of the encounter with a visit during the measurement period.

***DENOMINATOR NOTE*:** *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.

Denominator Criteria (Eligible Cases 3):
Patients age 50 and older on the date of the encounter.
AND
Patient encounter during the performance period (CPT): 90945, 90947, 90960, 90961, 90962, 90966, 90970, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99386*, 99387*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, 99512*, G0438, G0439
AND NOT
DENOMINATOR EXCLUSIONS:
Active chemotherapy during the measurement period:
- Chemotherapy Encounter (ICD-10-CM): Z51.0, Z51.11, Z51.12
- Chemotherapy Procedure (CPT or HCPCS): 96401, 96402, 96405, 96406, 96409, 96413, 96416, 96420, 96422, 96425, 96440, 96450, 96521, 96522, 96523, 96542, 96549

OR
Bone marrow transplant during the measurement period (ICD-10-PCS): 30233AZ, 30233G0, 30233G2, 30233G3, 30233G4, 30233X0, 30233X2, 30233X3, 30233X4, 30233Y0, 30233Y2, 30233Y3, 30233Y4, 30243AZ, 30243G0, 30243G2, 30243G3, 30243G4, 30243X0, 30243X2, 30243X3, 30243X4, 30243Y0, 30243Y2, 30243Y3, 30243Y4
OR
History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & HB-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period:
- Anatomic or Functional Asplenia (ICD-10-CM): Q89.01
- Cerebrospinal Fluid Leak (ICD-10-CM): G96.0, G96.00, G96.01, G96.02, G96.08, G96.09, G97.0
- Cochlear Implant (CPT): 69930
- Cochlear Implant Device (HCPCS): L8614, L8619, L8627, L8628
- Cochlear Implant Diagnosis (ICD-10-CM): Z96.20, Z96.21
- Immunocompromising Conditions (ICD-10-CM): B20, B59, B97.35, C80.2, C88.8, C94.40, C94.41, C94.42, C94.6, D46.22, D47.1, D47.9, D47.Z1, D47.Z9, D61.09, D61.810, D61.811, D61.818, D70.0, D70.1, D70.2, D70.4, D70.8, D70.9, D71, D72.0, D72.810, D72.818, D72.819, D73.81, D75.81, D76.1, D76.2, D76.3, D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D80.9, D81.0, D81.1, D81.2, D81.4, D81.6, D81.7, D81.89, D81.9, D82.0, D82.1, D82.2, D82.3, D82.4, D82.8, D82.9, D83.0, D83.1, D83.2, D83.8, D83.9, D84.0, D84.1, D84.8, D84.81, D84.821, D84.822, D84.89, D84.9, D89.3, D89.810, D89.811, D89.812, D89.813, D89.82, D89.89, D89.9, E40, E41, E42, E43, I12.0, I13.11, I13.2, K91.2, M35.9, N18.5, N18.6, T86.00, T86.01, T86.02, T86.03, T86.09, T86.10, T86.11, T86.12, T86.13, T86.19, T86.20, T86.21, T86.22, T86.23, T86.290, T86.298, T86.30, T86.31, T86.32, T86.33, T86.39, T86.40, T86.41, T86.42, T86.43, T86.49, T86.5, T86.810, T86.811, T86.812, T86.818, T86.819, T86.830, T86.831, T86.832, T86.838, T86.839, T86.850, T86.851, T86.852, T86.858, T86.859, T86.890, T86.891, T86.892, T86.898, T86.899, T86.90, T86.91, T86.92, T86.93, T86.99, Z21, Z48.21, Z48.22, Z48.23, Z48.24, Z48.280, Z48.290, Z48.298, Z49.01, Z49.02, Z49.31, Z94.0, Z94.1, Z94.2, Z94.3, Z94.4, Z94.81, Z94.82, Z94.83, Z94.84, Z94.89, Z99.2

- Sickle Cell Anemia and HB-S Disease (ICD-10-CM): D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, D57.819

OR

In hospice or using hospice services during the measurement period (**HCPCS)**: M1167

NUMERATOR (SUBMISSION CRITERIA 3):

Patients in Denominator 3 who received at least 1 dose of the herpes zoster live vaccine or 2 doses of the herpes zoster recombinant vaccine anytime on or after the patients' 50th birthday

NUMERATOR NOTE: *Patient reported vaccine receipt, when recorded in the medical record, is acceptable for meeting the numerator.*

Numerator Options:

Performance Met:	Patient received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period **(M1174).**

OR

Denominator Exception:	Documentation of medical reason(s) for not administering zoster vaccine (e.g., prior anaphylaxis due to the zoster vaccine) **(M1175)**

OR

Performance Not Met:	Patient did not receive at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period **(M1176)**.

DENOMINATOR (SUBMISSION CRITERIA 4):

Patients 66 years of age or older on the date of the encounter with a visit during the measurement period.

DENOMINATOR NOTE: *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.

Denominator Criteria (Eligible Cases 4):

Patients age 66 and older on the date of the encounter

AND

Patient encounter during the performance period (CPT): 90945, 90947, 90960, 90961, 90962, 90966, 90970, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99387*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, 99512*, G0438, G0439

AND NOT

DENOMINATOR EXCLUSIONS:

Active chemotherapy during the measurement period:

- Chemotherapy Encounter (ICD-10-CM): Z51.0, Z51.11, Z51.12
- Chemotherapy Procedure (CPT or HCPCS): 96401, 96402, 96405, 96406, 96409, 96413, 96416, 96420, 96422, 96425, 96440, 96450, 96521, 96522, 96523, 96542, 96549

OR

Bone marrow transplant during the measurement period (ICD-10-PCS): 30233AZ, 30233G0, 30233G2, 30233G3, 30233G4, 30233X0, 30233X2, 30233X3, 30233X4, 30233Y0, 30233Y2, 30233Y3, 30233Y4, 30243AZ, 30243G0, 30243G2, 30243G3, 30243G4, 30243X0, 30243X2, 30243X3, 30243X4, 30243Y0, 30243Y2, 30243Y3, 30243Y4

OR

History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & HB-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period:

- Anatomic or Functional Asplenia (ICD-10-CM): Q89.01
- Cerebrospinal Fluid Leak (ICD-10-CM): G96.0, G96.00, G96.01, G96.02, G96.08, G96.09, G97.0
- Cochlear Implant (CPT): 69930
- Cochlear Implant Device (HCPCS): L8614, L8619, L8627, L8628
- Cochlear Implant Diagnosis (ICD-10-CM): Z96.20, Z96.21
- Immunocompromising Conditions (ICD-10-CM): B20, B59, B97.35, C80.2, C88.8, C94.40, C94.41, C94.42, C94.6, D46.22, D47.1, D47.9, D47.Z1, D47.Z9, D61.09, D61.810, D61.811, D61.818, D70.0, D70.1, D70.2, D70.4, D70.8, D70.9, D71, D72.0, D72.810, D72.818, D72.819, D73.81, D75.81, D76.1, D76.2, D76.3, D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D80.9, D81.0, D81.1, D81.2, D81.4, D81.6, D81.7, D81.89, D81.9, D82.0, D82.1, D82.2, D82.3, D82.4, D82.8, D82.9, D83.0, D83.1, D83.2, D83.8, D83.9, D84.0, D84.1, D84.8, D84.81, D84.821, D84.822, D84.89, D84.9, D89.3, D89.810, D89.811, D89.812, D89.813, D89.82, D89.89, D89.9, E40, E41, E42, E43, I12.0, I13.11, I13.2, K91.2, M35.9, N18.5, N18.6, T86.00, T86.01, T86.02, T86.03, T86.09, T86.10, T86.11, T86.12, T86.13, T86.19, T86.20, T86.21, T86.22, T86.23, T86.290, T86.298, T86.30, T86.31, T86.32, T86.33, T86.39, T86.40, T86.41, T86.42, T86.43, T86.49, T86.5, T86.810, T86.811, T86.812, T86.818, T86.819, T86.830, T86.831, T86.832, T86.838, T86.839, T86.850, T86.851, T86.852, T86.858, T86.859, T86.890, T86.891, T86.892, T86.898, T86.899, T86.90, T86.91, T86.92, T86.93, T86.99, Z21, Z48.21, Z48.22, Z48.23, Z48.24, Z48.280, Z48.290, Z48.298, Z49.01, Z49.02, Z49.31, Z94.0, Z94.1, Z94.2, Z94.3, Z94.4, Z94.81, Z94.82, Z94.83, Z94.84, Z94.89, Z99.2
- Sickle Cell Anemia and HB-S Disease (ICD-10-CM): D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, D57.819

OR

In hospice or using hospice services during the measurement period (**HCPCS)**: M1167

NUMERATOR (SUBMISSION CRITERIA 4):

Patients in Denominator 4 who were administered any pneumococcal conjugate vaccine or polysaccharide vaccine, on or after their 60th birthday and before the end of the measurement period

NUMERATOR NOTE: *The measure provides credit for adults 66 years of age and older who have received any pneumococcal vaccine on or after the patient's 60th birthday.*

Patient reported vaccine receipt, when recorded in the medical record, is acceptable for meeting the numerator.

Numerator Options:

Performance Met:	Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 60th birthday and before the end of the

	measurement period **(M1177)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not administering pneumococcal vaccine (e.g., prior anaphylaxis due to the pneumococcal vaccine) **(M1178)**
OR	
Performance Not Met:	Patient did not receive any pneumococcal conjugate or polysaccharide vaccine, on or after their 60th birthday and before or during measurement period **(M1179)**

RATIONALE:

For adults, the Advisory Committee on Immunization Practices (ACIP) recommends routine vaccination against influenza, tetanus, diphtheria and pertussis for all adults, while vaccines for zoster and pneumococcal disease are recommended for older adults (Kim, et al. 2017). These vaccines are recommended to prevent serious diseases. Healthy People 2020, which provides science-based, 10-year national objectives for improving the health of all Americans, recommends increasing the percentage of adults who are vaccinated against influenza, zoster and pneumococcal disease (U.S. Department of Health and Human Services [HHS], 2017)

Estimates of national vaccination coverage are available through the National Health Interview Survey (NHIS), in which a sample of adults self-report receipt of vaccines. In 2015, 45 percent of adults 19 and older reported that they received the influenza vaccine during the 2014–2015 flu season, well below the Healthy People 2020 target of 70 percent (Williams et al. 2017). 64 percent of adults 65 and older reported having ever received any pneumococcal vaccine, which is below the Healthy People 2020 target of 90 percent (HHS, 2017). In 2015, 31 percent of adults ages 60 and older reported ever receiving the zoster vaccine (HHS, 2017). Although zoster vaccination coverage meets the Healthy People 2020 target of 30 percent coverage, 70 percent of adults are not receiving this recommended vaccination. Although there is no corresponding Healthy People 2020 goal for routine Td or Tdap vaccination among adults, only 62 percent reported receiving any tetanus toxoid-containing vaccination during the past 10 years (HHS, 2017).

There are evidence-based practices for improving adult vaccination coverage. Health care providers can routinely assess patients' vaccination history, implement reminder-recall systems, use standing-order programs and analyze practice- or provider-specific vaccination rates (HHS, 2017). In addition, providing easy access and convenience for adult vaccination (such as walk-in visits or extended hours) within and outside of the health care setting is important for increasing adult vaccine uptake (Ventola, 2016). Leveraging health information technology to share immunization data among patients, providers, pharmacies, retail clinics and public health agencies and registries is also a key strategy for tracking patients' immunization history and keeping them up to date on vaccines (America's Health Insurance Plans, 2015).

References:

Kim, D.K., L.E. Riley, K.H. Harriman, P. Hunter, C.B. Bridges. 2017. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older—United States, 2017." MMWR Morb Mortal Wkly Rep. 66:136–8. DOI: http://dx.doi.org/10.15585/mmwr.mm6605e2

U.S. Department of Health and Human Services. 2017. HealthyPeople.gov 2020 Topics & Objectives: Immunization and Infectious Diseases. (September 25) https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases

Williams W.W., P. Lu, A. O'Halloran, et al. 2017. "Surveillance of Vaccination Coverage among Adult Populations—United States, 2015." MMWR Surveill Summ. 66(No. SS-11):1–28. DOI: http://dx.doi.org/10.15585/mmwr.ss6611a1.

Ventola, C.L. 2016. "Immunization in the United States: Recommendations, Barriers, and Measures to Improve

Compliance: Part 2: Adult Vaccinations." Pharmacy and Therapeutics. 41(8), 492–506.

America's Health Insurance Plans. 2015. "Stakeholder Roundtable: Improving Adult Immunization Rates." Retrieved from https://www.ahip.org/wp-content/uploads/2016/04/Vaccine_Report_8.26.15-1.pdf

CLINICAL RECOMMENDATION STATEMENTS:

The Advisory Committee on Immunization Practices recommends annual influenza vaccination; and tetanus, diphtheria and acellular pertussis (Tdap) and/or tetanus and diphtheria (Td) vaccine; herpes zoster vaccine; and pneumococcal vaccine for adults at various ages.

Murthy N, Wodi AP, Bernstein H, McNally V, Cineas S, Ault K. Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older — United States, 2022. MMWR Morb Mortal Wkly Rep 2022;71:229–233. DOI: http://dx.doi.org/10.15585/mmwr.mm7107a1.

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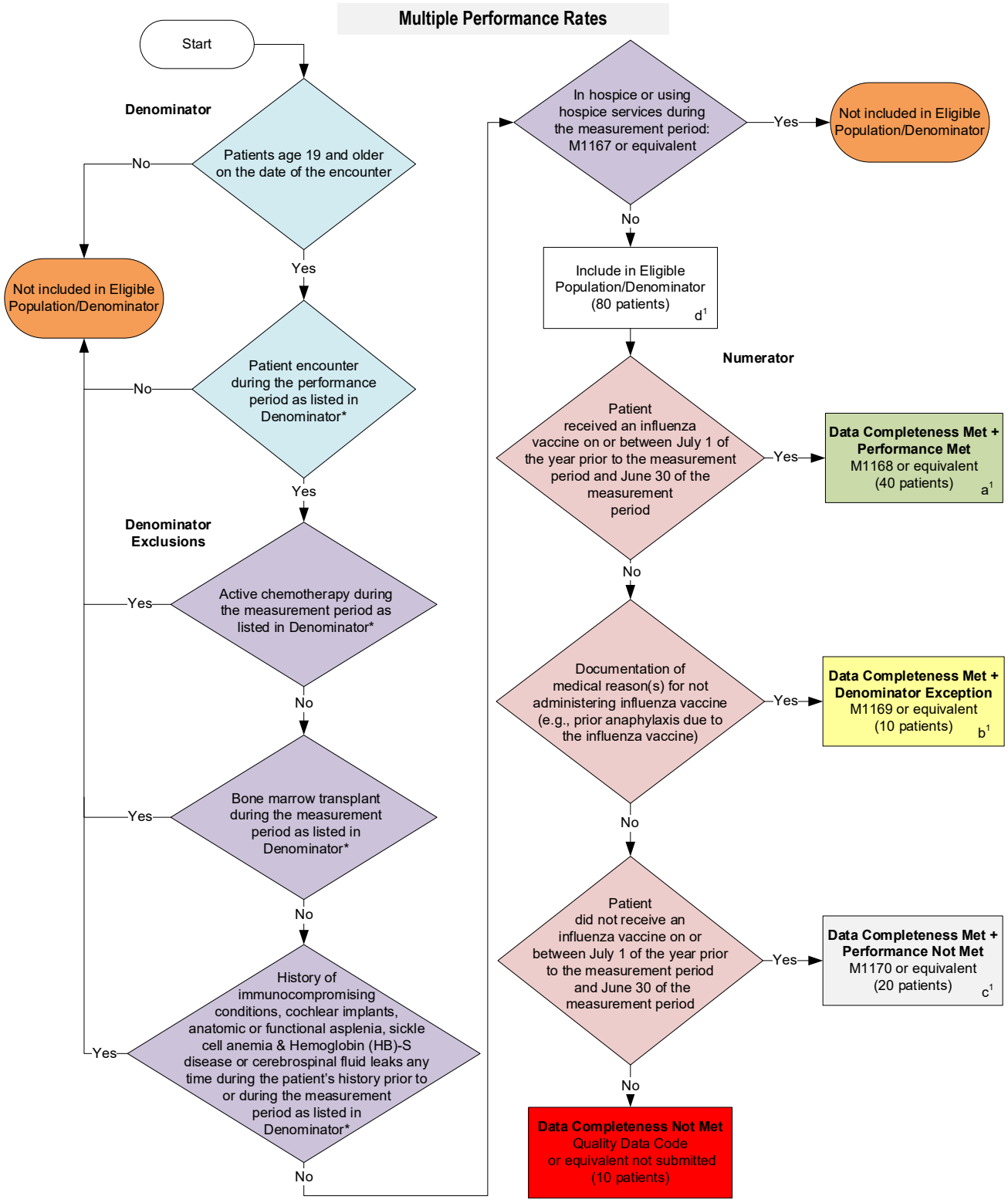
2023 Clinical Quality Measure Flow for Quality ID #493 (NQF 3620):
Adult Immunization Status
Submission Criteria One

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=

Performance Met (a^1=40 patients) + Denominator Exception (b^1=10 patients) + Performance Not Met (c^1=20 patients) = 70 patients = **87.50%**

Eligible Population/Denominator (d^1=80 patients) = 80 patients

Performance Rate=

Performance Met (a^1=40 patients) = 40 patients = **66.67%**

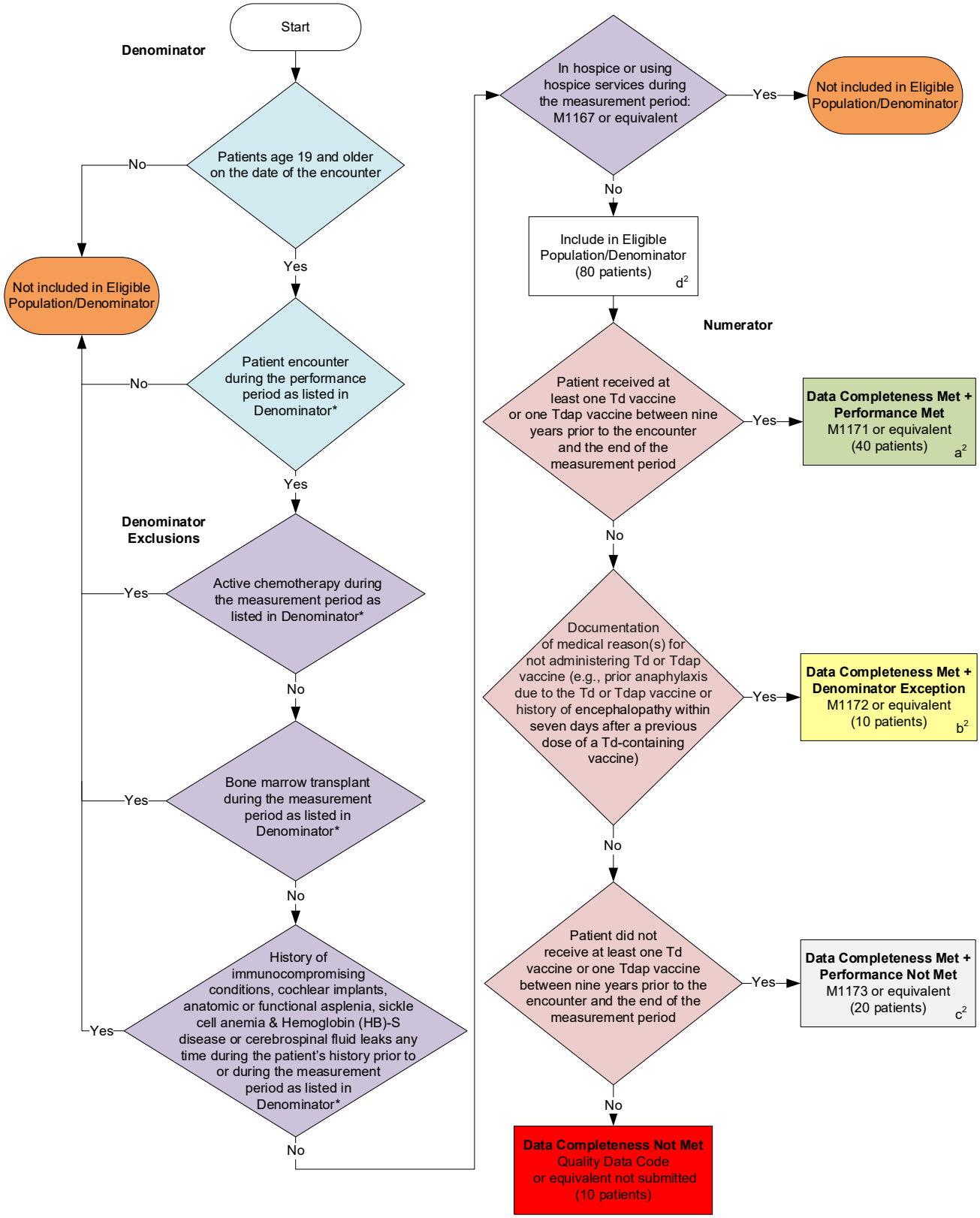
Data Completeness Numerator (70 patients) – Denominator Exception (b^1=10 patients) = 60 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Periodic

v7

Submission Criteria Two



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness=

Performance Met (a^2=40 patients) + Denominator Exception (b^2=10 patients) + Performance Not Met (c^2=20 patients) = 70 patients = **87.50%**

Eligible Population/Denominator (d^2=80 patients) = 80 patients

Performance Rate=

Performance Met (a^2=40 patients) = 40 patients = **66.67%**

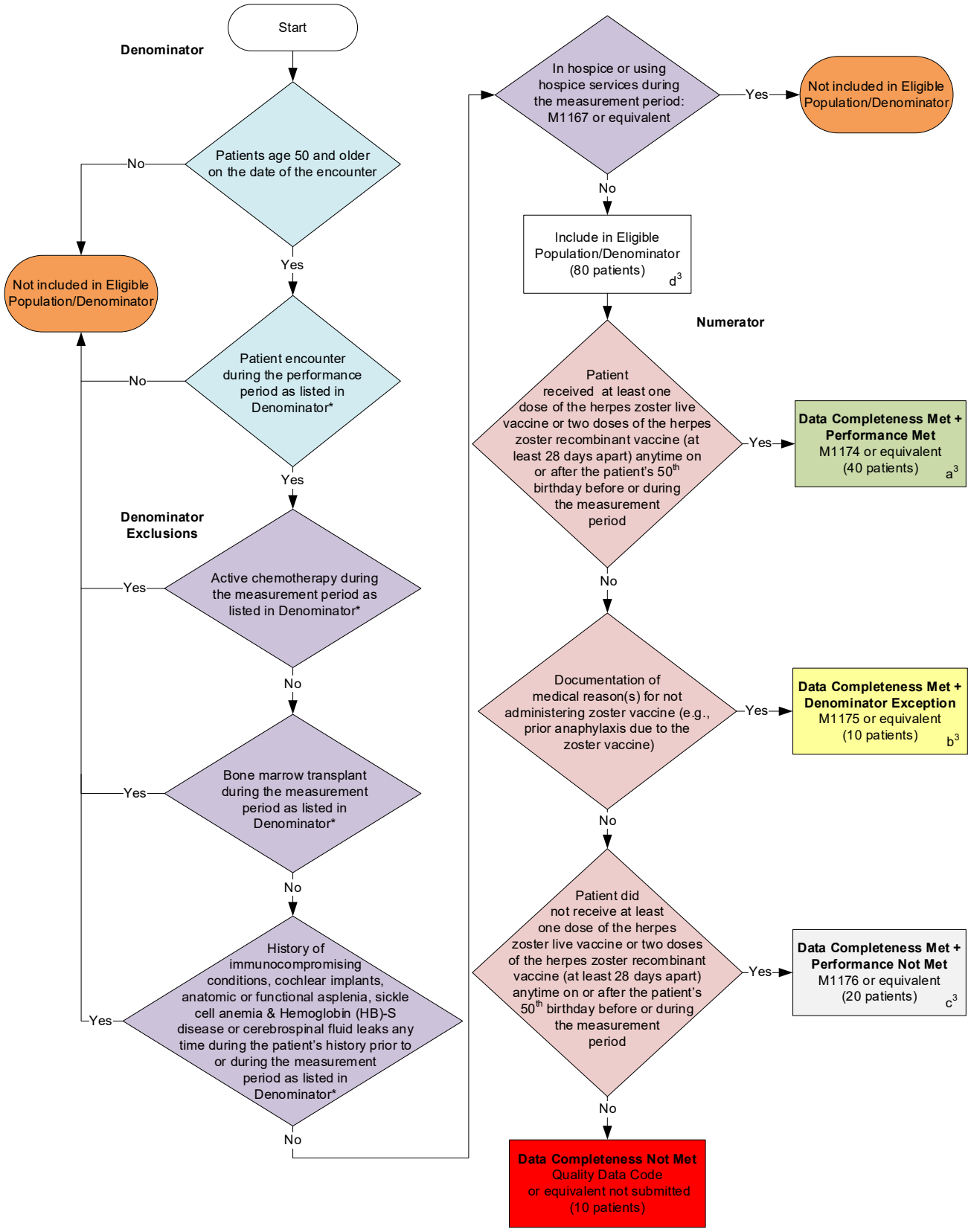
Data Completeness Numerator (70 patients) – Denominator Exception (b^2=10 patients) = 60 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Periodic

v7

Submission Criteria Three



SAMPLE CALCULATIONS: SUBMISSION CRITERIA THREE

Data Completeness=

Performance Met (a^3=40 patients) + Denominator Exception (b^3=10 patients) + Performance Not Met (c^3=20 patients) = 70 patients = **87.50%**

Eligible Population/Denominator (d^3=80 patients) = 80 patients

Performance Rate=

Performance Met (a^3=40 patients) = 40 patients = **66.67%**

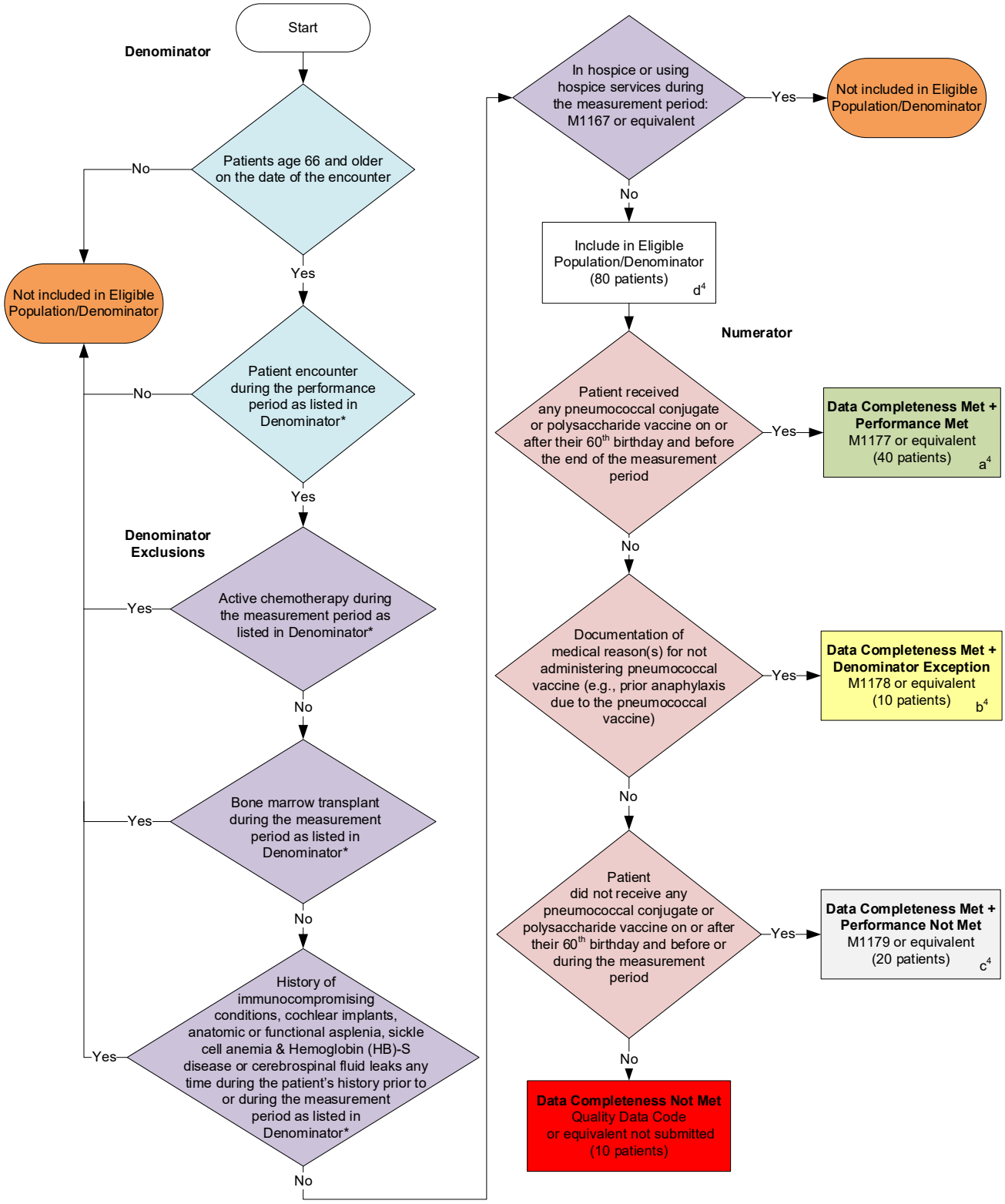
Data Completeness Numerator (70 patients) – Denominator Exception (b^3=10 patients) = 60 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Periodic

v7

Submission Criteria Four



SAMPLE CALCULATIONS: SUBMISSION CRITERIA FOUR

Data Completeness=

Performance Met (a^4=40 patients) + Denominator Exception (b^4=10 patients) + Performance Not Met (c^4=20 patients) = 70 patients = **87.50%**

Eligible Population/Denominator (d^4=80 patients) = 80 patients

Performance Rate=

Performance Met (a^4=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (70 patients) – Denominator Exception (b^4=10 patients) = 60 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Periodic

v7

2023 Clinical Quality Measure Flow Narrative for Quality ID #493 (NQF 3620): Adult Immunization Status

Multiple Performance Rates

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

Submission Criteria One:

1. Start with Denominator
2. Check *Patients age 19 and older on the date of the encounter*:
    a. If *Patients age 19 and older on the date of the encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient age 19 and older on the date of the encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Active chemotherapy during the measurement period as listed in Denominator**.
4. Check *Active chemotherapy during the measurement period as listed in Denominator**:
    a. If *Active chemotherapy during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Active chemotherapy during the measurement period as listed in Denominator** equals No, proceed to check *Bone marrow transplant during the measurement period as listed in Denominator**.
5. Check *Bone marrow transplant during the measurement period as listed in Denominator**:
    a. If *Bone marrow transplant during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Bone marrow transplant during the measurement period as listed in Denominator** equals No, proceed to check *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator**.
6. Check *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator**:
    a. If *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

b. If *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator** equals No, proceed to check *In hospice or using hospice services during the measurement period*.

7. Check *In hospice or using hospice services during the measurement period*:

   a. If *In hospice or using hospice services during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *In hospice or using hospice services during the measurement period* equals No, include in *Eligible Population/Denominator*.

8. Denominator Population:

   - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^1 equals 80 patients in the Sample Calculation.

9. Start Numerator

10. Check *Patient received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period*:

    a. If *Patient received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period* equals Yes, include in *Data Completeness Met and Performance Met.*

       - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 40 patients in Sample Calculation

    b. If *Patient received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period* equals No, proceed to check *Documentation of medical reason(s) for not administering influenza vaccine (e.g., prior anaphylaxis due to the influenza vaccine).*

11. Check *Documentation of medical reason(s) for not administering influenza vaccine (e.g., prior anaphylaxis due to the influenza vaccine)*:

    a. If *Documentation of medical reason(s) for not administering influenza vaccine (e.g., prior anaphylaxis due to the influenza vaccine)* equals Yes, include in *Data Completeness Met and Denominator Exception*.

       - *Data Completeness Met and Denominator Exception is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b1 equals 10 patients in the Sample Calculation.*

    b. If *Documentation of medical reason(s) for not administering influenza vaccine (e.g., prior anaphylaxis due to the influenza vaccine)* equals No, proceed to check *Patient did not receive an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period*.

12. Check *Patient did not receive an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period*:

a. If *Patient did not receive an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period* equals Yes, include in *Data Completeness Met and Performance Not Met*.

- *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 20 patients in the Sample Calculation.

b. If *Patient did not receive an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period* equals No, proceed to check *Data Completeness Not Met*.

13. Check *Data Completeness Not Met*:

- If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria One

Data Completeness equals Performance Met (a^1 equals 40 patients) plus Denominator Exception (b^1 equals 10 patients) plus Performance Not Met (c^1 equals 20 patients) divided by Eligible Population/Denominator (d^1 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b^1 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

Note: Submission Frequency: Patient-Periodic

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Two:

1. Start with Denominator
2. Check *Patients age 19 and older on the date of the encounter*:

   a. If *Patients age 19 and older on the date of the encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Patients age 19 and older on the date of the encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.

3. Check *Patient encounter during the performance period as listed in Denominator**:

   a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Active chemotherapy during the measurement period as listed in*

*Denominator**.

4. Check *Active chemotherapy during the measurement period as listed in Denominator**:

    a. If *Active chemotherapy during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Active chemotherapy during the measurement period as listed in Denominator** equals No, proceed to check *Bone marrow transplant during the measurement period as listed in Denominator**.

5. Check *Bone marrow transplant during the measurement period as listed in Denominator**:

    a. If *Bone marrow transplant during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Bone marrow transplant during the measurement period as listed in Denominator** equals No, proceed to check *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator**.

6. Check *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator**:

    a. If *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator** equals No, proceed to check *In hospice or using hospice services during the measurement period*.

7. Check *In hospice or using hospice services during the measurement period*:

    a. If *In hospice or using hospice services during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *In hospice or using hospice services during the measurement period* equals No, include in *Eligible Population/Denominator*.

8. Denominator Population:

    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 80 patients in the Sample Calculation.

9. Start Numerator

10. Check *Patient received at least one Td vaccine or one Tdap vaccine between nine years prior to the encounter and the end of the measurement period*:

    a. If *Patient received at least one Td vaccine or one Tdap vaccine between nine years prior to the*

encounter and the end of the measurement period equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 40 patients in Sample Calculation.

b. If *Patient received at least one Td vaccine or one Tdap vaccine between nine years prior to the encounter and the end of the measurement period* equals No, proceed to check *Documentation of medical reason(s) for not administering Td or Tdap vaccine (e.g., prior anaphylaxis due to the Td or Tdap vaccine or history of encephalopathy within seven days after a previous dose of a Td-containing vaccine)*.

11. Check *Documentation of medical reason(s) for not administering Td or Tdap vaccine (e.g., prior anaphylaxis due to the Td or Tdap vaccine or history of encephalopathy within seven days after a previous dose of a Td-containing vaccine):*

    a. If *Documentation of medical reason(s) for not administering Td or Tdap vaccine (e.g., prior anaphylaxis due to the Td or Tdap vaccine or history of encephalopathy within seven days after a previous dose of a Td-containing vaccine)* equals Yes, include in *Data Completeness Met and Denominator Exception*.

    - *Data Completeness Met and Denominator Exception* is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not administering Td or Tdap vaccine (e.g., prior anaphylaxis due to the Td or Tdap vaccine or history of encephalopathy within seven days after a previous dose of a Td-containing vaccine)* equals No, proceed to check *Patient did not receive at least one Td vaccine or one Tdap vaccine between nine years prior to the encounter and the end of the measurement period*.

12. Check *Patient did not receive at least one Td vaccine or one Tdap vaccine between nine years prior to the encounter and the end of the measurement period*:

    a. If *Patient did not receive at least one Td vaccine or one Tdap vaccine between nine years prior to the encounter and the end of the measurement period* equals Yes, include in *Data Completeness Met and Performance Not Met*.

    - *Data Completeness Met and Performance Not Met* is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 20 patients in the Sample Calculation.

    b. If *Patient did not receive at least one Td vaccine or one Tdap vaccine between nine years prior to the encounter and the end of the measurement period* equals No, proceed to check *Data Completeness Not Met*.

13. Check *Data Completeness Not Met*:

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Two

Data Completeness equals Performance Met (a^2 equals 40 patients) plus Denominator Exception (b^2 equals 10 patients)

plus Performance Not Met (c^2 equals 20 patients) divided by Eligible Population/Denominator (d^2 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b^2 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

Note: Submission Frequency: Patient-Periodic

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Three:

1. Start with Denominator
2. Check *Patients 50 years of age and older on the date of the encounter*:
    a. If *Patients 50 years of age and older on the date of the encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients 50 years of age and older on the date of the encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Active chemotherapy during the measurement period as listed in Denominator**.
4. Check *Active chemotherapy during the measurement period as listed in Denominator**:
    a. If *Active chemotherapy during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Active chemotherapy during the measurement period as listed in Denominator** period equals No, proceed to check *Bone marrow transplant during the measurement period as listed in Denominator**.
5. Check *Bone marrow transplant during the measurement period as listed in Denominator**:
    a. If *Bone marrow transplant during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Bone marrow transplant during the measurement period as listed in Denominator** equals No, proceed to check *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator**.
6. Check *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator**:

a. If *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

b. If *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator** equals No, proceed to check *In hospice or using hospice services during the measurement period*.

7. Check *In hospice or using hospice services during the measurement period*:

   a. If *In hospice or using hospice services during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *In hospice or using hospice services during the measurement period* equals No, include in *Eligible Population/Denominator*.

8. Denominator Population:

   a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^3 equals 80 patients in the Sample Calculation.

9. Start Numerator

10. Check *Patient received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the Patient's 50th birthday before or during the measurement period*:

    a. If *Patient received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the Patient's 50th birthday before or during the measurement period* equals Yes, include in *Data Completeness Met and Performance Met*.

       - *Data Completeness Met and Performance Met* is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^3 equals 40 patients in Sample Calculation.

    b. If *Patient received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the Patient's 50th birthday before or during the measurement period* equals No, proceed to check *Documentation of medical reason(s) for not administering zoster vaccine (e.g., prior anaphylaxis due to the zoster vaccine)*.

11. Check *Documentation of medical reason(s) for not administering zoster vaccine (e.g., prior anaphylaxis due to the zoster vaccine)*:

    a. If *Documentation of medical reason(s) for not administering zoster vaccine (e.g., prior anaphylaxis due to the zoster vaccine)* equals Yes, include in *Data Completeness Met and Denominator Exception*.

       - *Data Completeness Met and Denominator Exception* is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^3 equals 10 patients in the Sample Calculation.

b. If *Documentation of medical reason(s) for not administering zoster vaccine (e.g., prior anaphylaxis due to the zoster vaccine)* equals No, proceed to check *Patient did not receive at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period*.

12. Check *Patient did not receive at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period*:

    a. If *Patient did not receive at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^3 equals 20 patients in the Sample Calculation.

    b. If *Patient did not receive at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period* equals No, proceed to check *Data Completeness Not Met*.

13. Check *Data Completeness Not Met*:

        - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Three

Data Completeness equals Performance Met (a^3 equals 40 patients) plus Denominator Exception (b^3 equals 10 patients) plus Performance Not Met (c^3 equals 20 patients) divided by Eligible Population/Denominator (d^3 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^3 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b^3 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

Note: Submission Frequency: Patient-Periodic

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Four:

1. Start with Denominator

2. Check *Patients 66 years of age and older on the date of the encounter*:

    a. If *Patients 66 years of age and older on the date of the encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

b. If *Patients 66 years of age and older on the date of the encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.

3. Check *Patient encounter during the performance period as listed in Denominator**:

   a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Active chemotherapy during the measurement period as listed in Denominator**.

4. Check *Active chemotherapy during the measurement period as listed in Denominator**:

   a. If *Active chemotherapy during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Active chemotherapy during the measurement period as listed in Denominator** equals No, proceed to check *Bone marrow transplant during the measurement period as listed in Denominator**.

5. Check *Bone marrow transplant during the measurement period as listed in Denominator**:

   a. If *Bone marrow transplant during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Bone marrow transplant during the measurement period as listed in Denominator** equals No, proceed to check *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator**.

6. Check *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator**:

   a. If *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & Hemoglobin (HB)-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period as listed in Denominator** equals No, proceed to check *In hospice or using hospice services during the measurement period*.

7. Check *In hospice or using hospice services during the measurement period*:

   a. If *In hospice or using hospice services during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *In hospice or using hospice services during the measurement period* equals No, include in *Eligible Population/Denominator*.

8. Denominator Population:

- Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^4 equals 80 patients in the Sample Calculation.

9. Start Numerator

10. Check *Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 60th birthday and before the end of the measurement period*:

    a. If *Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 60th birthday and before the end of the measurement period* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^4 equals 40 patients in Sample Calculation.

    b. If *Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 60th birthday and before the end of the measurement period* equals No, proceed to check *Documentation of medical reason(s) for not administering pneumococcal vaccine (e.g., prior anaphylaxis due to the pneumococcal vaccine)*.

11. Check *Documentation of medical reason(s) for not administering pneumococcal vaccine (e.g., prior anaphylaxis due to the pneumococcal vaccine)*:

    a. If *Documentation of medical reason(s) for not administering pneumococcal vaccine (e.g., prior anaphylaxis due to the pneumococcal vaccine)* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^4 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not administering pneumococcal vaccine (e.g., prior anaphylaxis due to the pneumococcal vaccine)* equals No, proceed to check *Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 60th birthday and before or during measurement period*.

12. Check *Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 60th birthday and before or during measurement period*:

    a. If *Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 60th birthday and before or during measurement period* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^4 equals 20 patients in the Sample Calculation.

    b. If *Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 60th birthday and before or during measurement period* equals No, proceed to check *Data Completeness Not Met*.

13. Check *Data Completeness Not Met*:

- If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Four

Data Completeness equals Performance Met (a^4 equals 40 patients) plus Denominator Exception (b^4 equals 10 patients) plus Performance Not Met (c^4 equals 20 patients) divided by Eligible Population/Denominator (d^4 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^4 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b^4 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

Note: Submission Frequency: Patient-Periodic

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

IRIS1: Endothelial Keratoplasty - Post-operative improvement in best corrected visual acuity to 20/40 or greater (better)

Updated December 2022.

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of endothelial keratoplasty patients with a best corrected visual acuity of 20/40 or better at 90 days after surgery

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Patients aged 18 years or older who underwent a corneal graft procedure.

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator

ICD-10 Diagnosis Codes

- Bullous keratopathy (ICD-10: H18.11, H18.12, H18.13)
- Idiopathic corneal edema (ICD-10: H18.221, H18.222, H18.223)
- Secondary corneal edema (ICD-10: H18.231, H18.232, H18. 233)
- Endothelial corneal dystrophy (ICD-10: H18.511, H18.512, H18.513)

- Other hereditary corneal dystrophies (ICD-10: H18.591, H18.592, H18.593)

CPT Codes

Corneal graft procedure (CPT: 65756 with modifier RT, LT)

How to Report the Measure

Numerator: Patients with a best corrected visual acuity of 20/40 or better within 90 days of surgery.

Denominator Exclusions:

- Acute and subacute iridocyclitis: H20.00, H20.011, H20.012, H20.013, H20.021, H20.022, H20.023, H20.031, H20.032, H20.033, H20.041, H20.042, H20.043, H20.051, H20.052, H20.053
- Adhesions and disruptions of iris and ciliary body: H21.40, H21.41, H21.42, H21.43, H21.501, H21.502, H21.503, H21.511, H21.512, H21.513, H21.521, H21.522, H21.523, H21.531, H21.532, H21.533, H21.541, H21.542, H21.543, H21.551, H21.552, H21.553, H21.561, H21.562, H21.563, H21.81, H21.82, H21.89
- Anterior chamber IOL (identified by mapping IRIS for “AC IOL,” “anterior chamber IOL,” “AC lens” or “anterior chamber lens” and matching laterality)
- Aphakia: H27.01, H27.02, H27.03– match laterality with reported CPT laterality
- Blindness and low vision: H54.0X33, H54.0X34, H54.0X35, H54.0X43, H54.0X44, H54.0X45, H54.0X53, H54.0X54, H54.0X55, H54.1131, H54.1132, H54.1141, H54.1142, H54.1151, H54.1152, , H54.1213, H54.1214, H54.1215, H54.1223, H54.1224, H54.1225, H54.2X11, H54.2X12,H54.2X21, H54.2X22
- Cataract secondary to ocular disorders: H26.211, H26.212, H26.213, H26.221, H26.222, H26.223,
- Cataract, congenital: Q12.0
- Cataract, mature or hypermature: H25.89
- Cataract, posterior polar: Q12.0
- **C**ataract, traumatic: H26.101, H26.102, H26.103, H26.111, H26.112, H26.113, H26.121, H26.122, H26.123, H26.131, H26.132, H26.133
- Central corneal ulcer: H16.011, H16.012, H16.013
- Choroidal hemorrhage and rupture: H31.301, H31.302, H31.303, H31.311, H31.312, H31.313, H31.321, H31.322, H31.323
- Chronic iridocyclitis: A18.54, H20.11, H20.12, H20.13
- Cystoid macular degeneration: H35.351, H35.352, H35.353
- Degeneration of macula and posterior pole: H35.3110, H35.3111, H35.3112, H35.3113, H35.3114, H35.3120, H35.3121, H35.3122, H35.3123, H35.3124, H35.3130, H35.3131, H35.3132, H35.3133, H35.3134, H35.3210, H35.3211, H35.3212, H35.3213, H35.3220, H35.3221, H35.3222, H35.3223, H35.3224, H35.3230, H35.3231, H35.3232, H35.3233, H35.3234
- Degenerative disorders of globe: H44.21, H44.22, H44.23, H44.311, H44.312, H44.313, H44.321, H44.322, H44.323, H44.391, H44.392, H44.393
- Diabetic Macular Edema: E08.311, E08.3211, E08.3212, E08.3213, E08.3311, E08.3312, E08.3313, E08.3411, E08.3412, E08.3413, E08.3511, E08.3512, E08.3513, E09.311, E09.3211, E09.3212, E09.3213, E09.3311, E09.3312,

E09.3313, E09.3411, E09.3412, E09.3413, E09.3511, E09.3512, E09.3513, E10.311, E10.3211, E10.3212, E10.3213, E10.3311, E10.3312, E10.3313, E10.3411, E10.3412, E10.3413, E10.3511, E10.3512, E10.3513, E11.311, E11.3211, E11.3212, E11.3213, E11.3311, E11.3312, E11.3313, E11.3411, E11.3412, E11.3413, E11.3511, E11.3512, E11.3513, E13.311, E13.3211, E13.3212, E13.3213, E13.3311, E13.3312, E13.3313, E13.3411, E13.3412, E13.3413, E13.3511, E13.3512, E13.3513

- Diabetic Retinopathy with Macular Edema: E08.319, E08.3291, E08.3292, E08.3293, E08.3391, E08.3392, E08.3393, E08.3491, E08.3492, E08.3493, E08.3521, E08.3522, E08.3523, E08.3529, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.37X1, E08.37X2, E08.37X3, E08.37X9, E09.311, E09.319, E09.3291, E09.3292, E09.3293, E09.3299,E09.3391, E09.3392, E09.3393, E09.3399, E09.3491, E09.3492, E09.3493, E09.3499, E09.3521, E09.3522, E09.3523, E09.3529, E09.3531, E09.3532, E09.3533, E09.3539, E09.3541, E09.3542, E09.3543, E09.3549, E09.3551, E09.3552, E09.3553, E09.3559, E09.3591, E09.3592, E09.3593, E10.3291, E10.3292, E10.3293, E10.3391, E10.3392, E10.3393, E10.3491, E10.3492, E10.3493, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E10.319;E11.319, E11.3291, E11.3292, E11.3293, E11.3391, E11.3392, E11.3393, E11.3491, E11.3492, E11.3493, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.319, E13.3291, E13,3292, E13.3293, E13.3391, E13.3392, E13.3393, E13.3491, E13.3492, E13.3493, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593
- Dislocation of lens: H27.10, H27.111, H27.112, H27.113, H27.121, H27.122, H27.123, H27.131, H27.132, H27.133
- Disorders of optic chiasm: H47.41, H47.42, H47.43
- Disorders of visual cortex: H47.611, H47.612
- Disseminated chorioretinitis and disseminated retinochoroiditis: A18.53, H30.101, H30.102, H30.103, H30.111, H30.112, H30.113, H30.121, H30.122, H30.123, H30.131, H30.132, H30.133, H30.141, H30.142, H30.143
- Drusen (degenerative) of macula: H35.361, H35.362, H35.363
- Hereditary choroidal dystrophies: H31.20, H31.21, H31.22, H31.23
- Hereditary retinal dystrophies: H35.50, H35.51, H35.52, H35.53, H35.54, H36
- High hyperopia: H52.00, H52.01, H52.02, H52.03
- Hypotony of eye: H44.40, H44.411, H44.412, H44.413, H44.421, H44.422, H44.423, H44.431, H44.432, H44.433, H44.441, H44.442, H44.443
- Injury to optic nerve and pathways: S04.011A, S04.012A, S04.02XA, S04.031A, S04.032A, S04.041A, S04.042A
- Macular cyst, hole or pseudohole: H35.341, H35.342, H35.343
- Nystagmus and other irregular eye movements: H55.01
- Open wound of eyeball: S05.11XA, S05.12XA, S05.21XA, S05.22XA, S05.31XA, S05.32XA, S05.51XA, S05.52XA, S05.61XA, S05.62XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A, S05.8X9A, S05.91XA. S05.92X
- Optic atrophy: H47.20, H47.211, H47.212, H47.213, H47.22, H47.231, H47.232, H47.233, H47.291, H47.292, H47.293

- Other endophthalmitis: H16.241, H16.242, H16.243, H21.331, H21.332, H21.333, H33.121, H33.122, H33.123, H44.111, H44.112, H44.113, H44.121, H44.122, H44.123, H44.131, H44.132, H44.133, H44.19
- Other proliferative retinopathy: H35.101, H35.102, 103, H35.111, H35.112, H35.113, H35.121, H35.122, H35.123, H35.131, H35.132, H35.133, H35.141, H35.142, H35.143, H35.151, H35.152, H35.153, H35.161, H35.162, H35.163, H35.171, H35.172, H35.173
- Pathologic myopia: H44.20, H44.21, H44.22, H44.23, H44.2A1, H44.2A2, H44.2A3, H44.2B1, H44.2B2, H44.2B3, H44.2C1, H44.2C2, H44.2C3, H44.2D1, H44.2D2, H44.2D3, H44.2E1, H44.2E2, H44.2E3, H44.30
- Posterior lenticonus: Q12.2, Q12.4, Q12.8
- Prior glaucoma filtering surgery: CPT 66170, 66172, 66179, 66180, 66183, 66184, 66185 – match laterality
- Prior pars plana vitrectomy: CPT 67036, 67039, 67040, 67041, 67042, 67043 (patient with history of this procedure or IRIS mapping to a past surgical history of vitrectomy)
- Prior penetrating keratoplasty: CPT 65730, 65750, 65755 – match laterality)
- Puckering of macula: H35.371, H35.372, H35.373
- Purulent endophthalmitis: H44.001, H44.002, H44.003, H44.011, H44.012, H44.013, H44.021, H44.022, H44.023
- Retinal vascular occlusion: H34.10, H34.11, H34.12, H34.13, H34.231, H34.232, H34.233, H34.811, H34.812, H34.813, H34.831, H34.832, H34.833
- Retrolental fibroplasias: H35.171, H35.172, H35.173
- Scleritis and episcleritis: A18.51, H15.021, H15.022, H15.023, H15.031, H15.032, H15.033
- Toxic maculopathy: H35.381, H35.382, H35.383
- Use of systemic sympathetic alpha-1a antagonist medication for treatment of prostatic hypertrophy patient taking tamsulosin hydrochloride: G9503
- Uveitis: H44.111, H44.112, H44.113, H44.131, H44.132, H44.133
- Vascular disorders of iris and ciliary body: H21.1X1, H21.1X2, H21.1X3

How CMS Scores Your Performance

- If you successfully report a measure for *less than* 70% of your patients, you will earn points based on your practice size:
    - Small practices (≤ 15 clinicians) will receive 3 points,
    - Larger practices (> 15 clinicians) will receive 0 points.
- If you successfully report a measure for *at least* 70% of your patients, but do not report at least 20 cases, you will receive 3 points.
- If you report this measure for *at least* 70% of applicable patients and on *at least* 20 patients during a performance period, you will earn points based on the decile that corresponds to your performance rate. Not all measures offer points for every decile.

Benchmarks

See QPP resource library for benchmarks.

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IRIS2: Glaucoma – Intraocular Pressure Reduction

Updated December 2022.

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of glaucoma patient visits where their IOP was below a threshold level based on the severity of their diagnosis.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Total number of visits for patients aged between 40 and 85 years, with a minimum of 4 office visits during the prior 2 years, with a glaucoma diagnosis and documentation of the severity of their glaucoma:

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator.

Diagnosis Codes

Diagnosis of glaucoma with documentation of severity

- Open-angle glaucoma, unspecified (ICD-10: H40.10X1, H40.10X2, H40.10X3)
- Pigmentary glaucoma (ICD-10: H40.1311, H40.1312, H40.1313, H40.1321, H40.1322, H40.1323, H40.1331, H40.1332, H40.1333, H40.1391, H40.1392, H40.1393)

- Primary open angle glaucoma (ICD-10: H40.11X1, H40.11X2, H40.11X3)
- Pseudoexfoliation glaucoma (ICD-10: H40.1411, H40.1412, H40.1413, H40.1421, H40.1422, H40.1423, H40.1431, H40.1432, H40.1433, H40.1491, H40.1492, H40.1493)
- Chronic angle-closure glaucoma (ICD-10: 2211, H40.2212, H40.2213, H40.2221, H40.2222, H40.2223, H40.2231, H40.2232, H40.2233, H40.2311, H40.2312, H40.2313, H40.2321, H40.2322, H40.2323, H40.2331, H40.2332, H40.2333, H40.2411, H40.2412, H40.2413, H40.2421, H40.2422, H40.2423, H40.2431, H40.2432, H40.2433)

CPT Codes

- Patient had ≥ 4 encounters during prior 2 years (CPT: 92012, 92014, 99212, 99213, 99214, 99215)

How to Report the Measure

Numerator: Visits where the eye(s) IOP was below a specified threshold based on the severity of their glaucoma

- Mild Stage: IOP ≤ 22mm HG
- Moderate Stage: IOP ≤ 18 mm HG
- Severe Stage: IOP ≤ 15 mm HG

Denominator Exclusions

- Patients with a diagnosis of low tension glaucoma (ICD-10: H40.12)
- Eyes with a documented severity of indeterminate stage (ICD-10: H40.11X4, H40.1314, H40.1324, H40.1334, H40.1394, H40.1414, H40.1424, H40.1434, H40.1494)
- Eyes with absolute glaucoma blindness (ICD-10: H44.511, H44.512, H44.513, H44.519)
- Eyes with a glaucoma incisional surgery performed within the last 90 days (CPT: 66170, 66172, 66174, 66175, 66179, 66180, 66183, 66184, 66185, 66250, 65820, 65850, 66711, 66989, 66991, 0449T)
- Visual acuity findings: Count fingers (CF or FC), hand motion (HM), light perception (LP), no light perception (NLP)

How CMS Scores Your Performance

- If you successfully report a measure for *less than* 70% of your patients, you will earn points based on your practice size:
    - Small practices (≤ 15 clinicians) will receive 3 points,
    - Larger practices (> 15 clinicians) will receive 0 points.
- If you successfully report a measure for *at least* 70% of your patients, but do not report at least 20 cases, you will receive 3 points.

- If you report this measure for *at least* 70% of applicable patients and on *at least* 20 patients during a performance period, you will earn points based on the decile that corresponds to your performance rate. Not all measures offer points for every decile.

Benchmarks

See QPP resource library for benchmarks.

Copyright

IRIS6: Acquired Involutional Entropion: Normalized lid position after surgical repair

Updated December 2022.

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of chronic Conditions

Description: Percentage of surgical entropion patients with normalized lid position within 90 days postoperatively.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged 18 years or older with a diagnosis of involutional entropion who underwent a surgical procedure for the condition.

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

Diagnosis Codes

- Senile entropion (ICD-10: H02.031, H02.032, H02.033, H02.034, H02.035, H02.036, H02.039)

CPT Codes

Entropion surgical procedure

- Lateral canthoplasty (CPT: 67950)
- Lateral tarsal strip (CPT: 67917)
- Entropion repair (CPT: 67924)
- Excision and repair of eyelid (CPT: 67961)
- Excision and repair of eyelid (CPT: 67966)

How to Report the Measure

Numerator: Patients with normalized lid position within 90 days postoperatively

EHR-IRIS Registry Integration

We have had difficulty identifying pre and post op lid position descriptions. To improve capture of this measures, it would be helpful if you could document these in your electronic health record notes:

1. "Normal or normalized lid position" in your assessment and notes within 90 days of surgery OR
2. "Abnormal or not normalized lid position" in your assessment and notes within 90 days of surgery

How CMS Scores Your Performance

See QPP resource library for benchmarks.

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IRIS13: Diabetic Macular Edema: Loss of Visual Acuity

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Promote Effective Prevention & Treatment of Chronic Disease

Description: Percentage of patients with a diagnosis of diabetic macular edema with a loss of less than 3 Snellen lines (which is equivalent to less than 0.3 logMar) of visual acuity within the past 12 months.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged 18 years or older with a diagnosis of diabetic macular edema including documentation of the laterality (OD, OS, OU) who have received anti-VEGF injections, intravitreal injections or laser photocoagulation therapy with *2 visual acuity values with at least one on or after date of treatment.*

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator.

Diagnosis Codes

- Diagnosis of diabetic macular edema (ICD-10: E08.311, E08.3211, E08.3212, E08.3213, E08.3311, E08.3312, E08.3313, E08.3411, E08.3412,

E08.3413, E08.3511, E08.3512, E08.3513, E09.311,
E09.3211, E09.3212, E09.3213, E09.3311, E09.3312, E09.3313, E09.3411,
E09.3412, E09.3413, E09.3511, E09.3512, E09.3513, E10.311, E10.3211,
E10.3212, E10.3213, E10.3311, E10.3312, E10.3313,
E10.3411, E10.3412, E10.3413, E10.3511, E10.3512, E10.3513, E11.311,
E11.3211, E11.3212, E11.3213, E11.3311, E11.3312, E11.3313,
E11.3411, E11.3412, E11.3413, E11.3511, E11.3512, E11.3513,
E13.311, E13.3211, E13.3212, E13.3213, E13.3311, E13.3312, E13.3313,
E13.3411, E13.3412, E13.3413, E13.3511, E13.3512, E13.3513)

AND

2 visual acuity values with at least one on or after date of treatment

CPT Codes

Treatment with Anti-VEGF agents *OR* intravitreal steroids *OR* laser photocoagulation

- Bevacizumab (Avastin®) injections (CPT: 67028 and HCPCS: J9035; CPT: 67028 and HCPCS: J3490; CPT: 67028 and HCPCS: J3590; CPT: 67028 and HCPCS: C9257; CPT: 67028 & HCPCS: J7999; CPT: 67028 & HCPCS: Q5107; CPT: 67028 & HCPCS: Q9977)
- Ranibizumab (Lucentis®) injections (CPT: 67028 and HCPCS: J2778)
- Aflibercept (EYLEA®) injections (CPT: 67028 and HCPCS: J0178)
  Brolucizumab (Beovu(R)) injections (CPT: 67028 and HCPCS: J0179
  Farcimab (Vabysmo(R)) injections (CPT: 67028 and HCPCS: J2777)
  Ranibizumab-eqrn (Cimerli) injections (CPT: 67028 and HCPCS J3490, J3590, C9399, or Q5128)

OR

- Fluocinolone acetonide (Iluvien (R)) injections (CPT: 67028 and HCPCS: J7313)
- Dexamethasone (Ozurdex(R)) injections (CPT: 67028 and HCPCS: J7312)
- Triamcinalone (Kenalog(R)) injections (CPT: 67028 and HCPCS: J3301)
- Triamcinolone acetonide (Triesence(R)) injections (CPT: 67028 and HCPCS: J3300)

OR

- Laser photocoagulation (CPT: 67210, 67228)

How to Report the Measure

Numerator: Patients with two or more recorded visual acuity values within the past 12 months; at least one visual acuity value recorded prior to treatment, at least one visual acuity value recorded after treatment; loss of visual acuity less than 3 Snellen lines (which is equivalent to less than 0.3 logMar).

Denominator Exclusions: Patients with ophthalmic complications of diabetic retinopathy including neovascular glaucoma, traction retinal detachment, vitreous hemorrhage, history of vitreous surgery, history of retinal surgery, development of retinopathy in fellow eye.

Ophthalmic complications of diabetic retinopathy (ICD-10-CM): H40.89, H33.41, H33.42, H33.43, H43.11, H43.12, H43.13

Notes: Loss of less than three Snellen lines would be calculated as follows:

From 20/20 to 20/25 or 20/32 would be considered less than 3 Snellen lines of loss, from 20/20 to 20/40 or greater would be considered 3 Snellen lines of loss
From 20/40 to 20/50 or 20/63 would be considered less than 3 Snellen lines of loss, from 20/40 to 20/80 or greater would be considered 3 Snellen lines of loss
From 20/50 to 20/63 or 20/80 would be considered less than 3 Snellen lines of loss, from 20/50 to 20/100 or greater would be considered 3 Snellen lines of loss
From 20/80 to 20/100 or 20/125 would be considered less than 3 Snellen lines of loss, from 20/80 to 20/160 or great would be considered 3 Snellen lines of loss

The chart shows the conversion of logMAR and Snellen visual acuity (formerly the measure was < 0.3 logMar which is equivalent to less than 3 Snellen Lines)

Visual Acuity Conversion Table

Feet	LogMar
20/200	1.00
20/160	0.90
20/125	0.80
20/100	0.70
20/80	0.60
20/63	0.50
20/50	0.40
20/40	0.30
20/32	0.20
20/25	0.10
20/20	0.00
20/16	-0.10
20/12.5	-0.20
20/10	-0.30

How CMS Scores Your Performance

- If you successfully report a measure for *less than* 70% of your patients, you will earn points based on your practice size:
- Small practices (≤ 15 clinicians) will receive 3 points,
- Larger practices (> 15 clinicians) will receive 0 points.
- If you successfully report a measure for *at least* 70% of your patients, but do not report at least 20 cases, you will receive 3 points.

- If you report this measure for *at least* 70% of applicable patients and on *at least* 20 patients during a performance period, you will earn points based on the decile that corresponds to your performance rate. Not all measures offer points for every decile.

Benchmarks

See QPP resource library for benchmarks.

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IRIS17: Acute Anterior Uveitis: Post-treatment Grade 0 anterior chamber cells

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients with acute anterior uveitis post-treatment with Grade 0 anterior chamber cells

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Patients aged 18 years or older who underwent treatment for acute anterior uveitis

There are two criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”

Diagnosis Codes

Diagnosis of acute uveitis

- Primary iridocyclitis (ICD-10: H20.011, H20.012, H20.013, H20.019)
- Recurrent acute iridocyclitis (ICD-10: H20.021, H20.022, H20.023, H20.029)
- Unspecified acute and subacute iridocyclitis (ICD-10: H20.00)

How To Report the Measure

Numerator: Patients with Grade 0 anterior chamber cells after treatment within 30 days after onset of treatment and not on topical corticosteroids at 60 days after treatment

How CMS Scores Your Performance

- If you successfully report a measure for *less than* 70% of your patients, you will earn points based on your practice size:
- Small practices (≤ 15 clinicians) will receive 3 points,
- Larger practices (> 15 clinicians) will receive 0 points.
- If you successfully report a measure for *at least* 70%of your patients, but do not report at least 20 cases, you will receive 3 points.
- If you report this measure for *at least* 70%of applicable patients and on *at least* 20 patients during a performance period, you will earn points based on the decile that corresponds to your performance rate. Not all measures offer points for every decile.

Benchmarks

See QPP resource library for benchmarks.

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IRIS23: Refractive Surgery: Patients with a postoperative uncorrected visual acuity (UCVA) of 20/20 or better within 30 days

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry for EHR Integration: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients with an uncorrected visual acuity of 20/20 or better within 30 days

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged 18 years or greater and diagnosis of myopia who underwent refractive surgery

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

Diagnosis Codes

- Diagnosis of myopia (H52.11 (right eye), H52.12 (left eye), H52.13 (bilateral))

CPT Codes

- Refractive surgery treatment (CPT: S0810 (PRK), S0800 (LASIK)

How to Report the Measure

Numerator: Patients receiving refractive surgery with a postoperative uncorrected visual acuity of 20/20 or better within 30 days (could be earlier at last postoperative visit).

How CMS Scores Your Performance

- If you successfully report a measure for *less than* 70% of your patients, you will earn points based on your practice size:
    - Small practices (≤ 15 clinicians) will receive 3 points,
    - Larger practices (> 15 clinicians) will receive 0 points.
- If you successfully report a measure for *at least* 70% of your patients, but do not report at least 20 cases, you will receive 3 points.
- If you report this measure for *at least* 70% of applicable patients and on *at least* 20 patients during a performance period, you will earn points based on the decile that corresponds to your performance rate. Not all measures offer points for every decile.

Benchmarks

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IRIS24: Refractive Surgery: Patients with a postoperative correction within ± 0.5 Diopter (D) of the intended correction

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry for EHR Integration: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients with an actual spherical equivalent (SE) within + or -0.5D of the intended correction or SE

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged 18 years or greater with a diagnosis of myopia who underwent refractive surgery

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

Diagnosis Codes

- Diagnosis of myopia (ICD-10: H52.11 (right eye), H52.12 (left eye), H52.13 (bilateral))

CPT Codes

- Refractive surgery treatment (CPT: S0810 (PRK), S0800 (LASIK))

How to Report the Measure

Numerator: Patients receiving refractive surgery with an actual postoperative correction within ± 0.5D of the intended correction within 30 days (could be earlier at last postoperative visit)

How CMS Scores Your Performance

See the QPP resource library for benchmarks.

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IRIS35: Improvement of Macular Edema in Patients with Uveitis

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients with uveitis and macular edema with a reduction of 20% or greater in the central subfield thickness on OCT within 90 days after treatment.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Patients aged 18 years or older with uveitis who underwent treatment for macular edema.

There are two criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”

Diagnosis Codes

Diagnosis of Uveitis:

- Anterior uveitis
    - Primary iridocyclitis (H20.011, H20.012, H20.013)
    - Recurrent acute iridocyclitis (H20.021, H20.022, H20.023)
- Intermediate uveitis (H30.21, H30.22, H30.23)
- Panuveitis (H44.111, H44.112, H44.113)

- Posterior uveitis
    - Exudative retinopathy (H35.021, H35.022, H35.023)
    - Retinal vasculitis (H35.061, H35.062, H35.063)
    - Unspecified focal chorioretinal inflammation (H30.001, H30.002, H30.003)
    - Focal chorioretinal inflammation, juxtapapillary (H30.011, H30.012, H30.013)
    - Focal chorioretinal inflammation of posterior pole (H30.021, H30.022, H30.023)
    - Focal chorioretinal inflammation, peripheral (H30.031, H30.032, H30.033)
    - Focal chorioretinal inflammation, macular or paramacular (H30.041, H30.042, H30.043)
      Unspecified disseminated chorioretinal inflammation (H30.101, H30.102, H30.103)
    - Disseminated chorioretinal inflammation posterior pole (H30.111, H30.112, H30.113)
    - Disseminated chorioretinal inflammation, peripheral (H30.121, H30.122, H30.123)
    - Disseminated chorioretinal inflammation, generalized (H30.131, H30.132, H30.133)
      Unspecified chorioretinal inflammation (H30.91, H30.92, H30.93)
    - Other chorioretinal inflammations (H30.891, H30.892, H30.893)
    - Harada's disease (H30.811, H30.812, H30.813)
      Vogt-Koyanagi Syndrome (H20.821, H20.822, H20.823)

AND

Diagnosis of Macular Edema

- Cystoid macular degeneration (H35.351, H35.352, H35.353)
- Retinal edema (H35.81)

How to Report the Measure

Numerator: Patients with a 20% reduction or greater of central subfield thickness within 90 days of treatment initiation

How CMS Scores Your Performance

See the QPP resource library for benchmarks.

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IRIS38: Endothelial Keratoplasty - Dislocation Requiring Surgical Intervention

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of endothelial keratoplasty patients with a rebubbling or revision or repair procedure within 90 days after surgery

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: Yes
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Patients aged 18 years or older who underwent an endothelial keratoplasty surgery.

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator

CPT Codes

Corneal graft procedure (CPT: 65756 with modifier RT, LT)

How To Report the Measure

Numerator: Patients with a surgical intervention within 90 days of endothelial keratoplasty surgery.

Surgical intervention – rebubbling, revision or repair (CPT: 66020, 66250)

Denominator Exclusions:

- Adherent leukoma: H17.01, H17.02, H17.03
- Pupillary membranes: H21.41, H21.42, H21.43
- Adhesions and disruptions of iris and ciliary body: H21.501, H21.502, H21.503
- Anterior synechiae (iris): H21.511, H21.512, H21.513
- Goniosynechiae: H21.521, H21.522, H21.523
- Iridodialysis: H21.531, H21.532, H21.533,
- Posterior synechiae (iris): H21.541, H21.542, H21.543,
- Recession of chamber angle: H21.551, H21.552, H21.553,
- Pupillary abnormalities: H21.561, H21.562, H21.563
- Other disorders of iris and ciliary body: H21.81, H21.82, H21.89,
- Anterior chamber IOL
- Aphakia: H27.01, H27.02, H27.03
- Dislocation of lens: H27.10, H27.111, H27.112, H27.113, H27.121, H27.122, H27.123, H27.131, H27.132, H27.133
- Hypotony of eye: H44.40, H44.411, H44.412, H44.413, H44.421, H44.422, H44.423, H44.431, H44.432, H44.433, H44.441, H44.442, H44.443
- Open wound of eyeball: S05.11XA, S05.12XA, S05.21XA, S05.22XA, S05.31XA, S05.32XA, S05.41XA, S05.42XA, S05.51XA, S05.52XA, S05.61XA, S05.62XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A, S05.91XA, S05.92XA
- Prior glaucoma filtering surgery: CPT 66170, 66172, 66179, 66180, 66183, 66184, 66185
- Prior pars plana vitrectomy: CPT 67036, 67039, 67040, 67041, 67042, 67043
- Prior penetrating keratoplasty: CPT 65730, 65750, 65755

How CMS Scores Your Performance

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IRIS39: Glaucoma – Intraocular Pressure Reduction Following Trabeculectomy or an Aqueous Shunt Procedure

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients who underwent trabeculectomy or aqueous shunt procedures who had IOP reduced by 20% or more from their pretreatment between 3 and 4 months of treatment or a reduction in overall number of glaucoma medications.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Patients aged between 40 and 85 years with a diagnosis of open-angle glaucoma, pigmentary glaucoma, primary open-angle glaucoma, pseudoexfoliation glaucoma or chronic angle glaucoma and who underwent a trabeculectomy or an aqueous shunt procedure.

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator.

Diagnosis Codes

Diagnosis of glaucoma with documentation of severity

- Open-angle glaucoma, unspecified (ICD-10: H40.10X1, H40.10X2, H40.10X3)
- Low-tension glaucoma (ICD-10: H40.1211, H40.1212, H40.1213, H40.1221, H40.1222, H40.1223, H40.1231, H40.1232, H40.1233)
- Pigmentary glaucoma (ICD-10: H40.1311, H40.1312, H40.1313, H40.1321, H40.1322, H40.1323, H40.1331, H40.1332, H40.1333, H40.1391, H40.1392, H40.1393)
- Primary open angle glaucoma (ICD-10: H40.1111, H40.1112, H40.1113, H40.1121, H40.1122, H40.1123, H40.1131, H40.1132, H40.1133)
- Pseudoexfoliation glaucoma (ICD-10: H40.1411, H40.1412, H40.1413, H40.1421, H40.1422, H40.1423, H40.1431, H40.1432, H40.1433, H40.1491, H40.1492, H40.1493)
- Chronic angle glaucoma (ICD-10: H40.2211, H40.2212, H40.2213, H40.2221, H40.2222, H40.2223, H40.2231, H40.2232, H40.2233, H40.2311, H40.2312, H40.2313, H40.2321, H40.2322, H40.2323, H40.2331, H40.2332, H40.2333, H40.2411, H40.2412, H40.2413, H40.2421, H40.2422, H40.2423, H40.2431, H40.2432, H40.2433)

CPT Codes

- Trabeculectomy procedure (CPT: 66170, 66172 with modifier RT, LT, -50)

OR

- Aqueous shunt procedure (CPT: 66179, 66180, 66183, 0449T with modifier RT, LT, -50, 0450T with modifier RT, LT, -50)

How to Report the Measure

Numerator: Patients with a reduction in IOP ≥ 20% from the pretreatment level or a reduction in the overall number of glaucoma medications. The procedure must be performed during the performance year.

Numerator Calculation

% change between pretreatment IOP (Do not include IOP values taken on the day of procedure) and the lowest IOP measures between 3 and 4 months postoperatively OR a reduction in the overall number of glaucoma medications

Calculation is based on the IOP of the eye that underwent the procedure. Medications are by patient, if it cannot be identified by eye level

Denominator Exclusions

- Eyes with absolute glaucoma blindness (ICD-10: H44.511, H44.512, H44.513)
- Visual acuity findings: Count fingers (CF or FC), Hand motion (HM), Light perception (LP), No light perception (NLP)

How CMS Scores Your Performance

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IRIS41: Improved visual acuity after epiretinal membrane treatment within 120 days

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients with a 20% improvement in visual acuity within 120 days following epiretinal membrane treatment

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged18 years or older with a diagnosis of epiretinal membrane and had a procedure to treat epiretinal membrane.

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with epiretinal membrane will submit this measure.

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator.

Diagnosis Codes

- Diagnosis of epiretinal membrane (ICD-10: H35.373, H35.379, H35.371, H35.372)

CPT Codes

- Had procedure to treat epiretinal membrane (CPT: 67041, 67042)

How To Report the Measure

Numerator: Patients with a 20% improvement in visual acuity within 120 days following epiretinal membrane treatment

Denominator Exclusions:

- Cystoid macular edema (ICD-10: H59.031, H59.032, H59.033, H59.039, H35.351, H35.352, H35.353, H35.359)
- Uveitis (ICD-10: H20.00, H20.011, H20.012, H20.013, H20.019, H20.021, H20.022, H20.023, H20.029, H20.11, H20.12, H20.13)

Notes: 20% improvement is defined as an improvement compared to the preoperative logMAR (-log(Snellen fraction)). The following table shows the 20% visual acuity improvement threshold.

logMAR	Preop Snellen	20% improve logMAR	20% improve Postop Snellen
0.1	20/25	0.08	20/25 +1
0.176	20/30	0.1408	20/25 -2
0.2	20/32	0.16	20/32 +2
0.3	20/40	0.24	20/32 -2
0.4	20/50	0.32	20/40 -1
0.477	20/60	0.3816	20/50 +1
0.5	20/63	0.4	20/50
0.544	20/70	0.4352	20/50 -2
0.6	20/80	0.48	20/63 +1
0.7	20/100	0.56	20/80 +2
0.8	20/125	0.64	20/80 -2
0.9	20/160	0.72	20/100 -1
1	20/200	0.8	20/125
1.1	20/250	0.88	20/160 +1
1.18	20/300	0.944	2/160 -2

1.2	20/320	0.96	20/200 +2
1.3	20/400	1.04	20/200 -2
1.5	20/640	1.2	20/320
1.6	20/800	1.28	20/400 +1

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IRIS43: Glaucoma – Intraocular Pressure Reduction Following Laser Trabeculoplasty

Updated December 2022.

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry
- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients who underwent laser trabeculoplasty who had IOP reduced by 20% or more from their pretreatment IOP or had a reduction in overall number of glaucoma medications.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Patients aged between 40 and 85 years who underwent laser trabeculoplasty.

There are two criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator.

CPT Codes

- Laser trabeculoplasty procedure (CPT: 65855 with modifier RT, LT, -50)

How to Report the Measure

Numerator: Patients with a reduction in IOP ≥ 20% from the pretreatment level or had a reduction in overall number of glaucoma medications. (If two eyes of patient meet denominator criteria, select one eye with the smaller percentage decrease in IOP or no reduction in overall number of glaucoma medications).

Numerator calculation:

- Percent change between pretreatment IOP (do not include IOP values taken on the day of procedure) and the lowest IOP measures between 2 and 4 months postoperatively.
- Calculation is based on the IOP of the eye that underwent the procedure.
- Number of glaucoma medication is compared prior to laser trabeculoplasty and after laser trabeculoplasty between 2 and 4 months postoperatively.

Denominator Exclusions

- Eyes with absolute glaucoma blindness (ICD-10: H44.511, H44.512, H44.513)
- Visual acuity findings: Count fingers (CF or FC), hand motion (HM), light perception (LP), no light perception (NLP)

How CMS Scores Your Performance

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IRIS44: Glaucoma – Visual Field Progression in Glaucoma

Updated December 2022.

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients with a diagnosis of glaucoma, with a mean deviation loss of 3dB or more from their baseline value.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: Yes
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Patients aged between 40 and 85 years, with a minimum of 2 visual field tests during the prior 3 years, with a glaucoma diagnosis.

There are two criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator.

Diagnosis Codes

Diagnosis of glaucoma

- Low-tension glaucoma (ICD-10: H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294)

- Open-angle glaucoma, unspecified (ICD-10: H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4)
- Pigmentary glaucoma (ICD-10: H40.1310, H40.1311, H40.1312, H40.1313, H40.1314, H40.1320, H40.1321, H40.1322, H40.1323, H40.1324, H40.1330, H40.1331, H40.1332, H40.1333, H40.1334, H40.1390, H40.1391, H40.1392, H40.1393, H40.1394)
- Primary open angle glaucoma (ICD-10: H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4)
- Pseudoexfoliation glaucoma (ICD-10: H40.1410, H40.1411, H40.1412, H40.1413, H40.1414, H40.1420, H40.1421, H40.1422, H40.1423, H40.1424, H40.1430, H40.1431, H40.1432, H40.1433, H40.1434, H40.1490, H40.1491, H40.1492, H40.1493, H40.1494)

CPT Codes

- Patient had ≥ 2 visual field tests during prior 3 years (CPT: 92083)

How To Report the Measure

Numerator: Patients with a mean deviation loss of 3dB or more from 'baseline' visual field tests to the most recent test. (If two eyes of patient meet denominator criteria, select 1 eye with a mean deviation loss of 3dB or more).

Denominator Exclusions

- Eyes with absolute glaucoma blindness (ICD-10: H44.511, H44.512, H44.513, H44.519)
- Eyes with a glaucoma incisional surgery performed within the last 90 days (CPT: 66170, 66172, 66174, 66175, 66179, 66180, 66183, 66184, 66185, 66250, 65850, 65820, 66711, 66989, 66991, 0449T, 0671T)
- Conditions that may result in visual field worsening independent of glaucoma (ICD-10: H34.8110, H34.8111, H34.8112, H34.8120, H34.8121, H34.8122, H34.8130, H34.8131, H34.8132, H34.821, H34.822, H34.823, H34.8310, H34.8311, H34.8312, H34.8320, H34.8321, H34.8322, H34.8330, H34.8331, H34.8332, H35.3210, H35.3211, H35.3212, H35.3213, H35.3220, H35.3221, H35.3222, H35.3223, H35.3230, H35.3231, H35.3232, H35.3233, H47.011, H47.012, H47.013)
- Visual acuity findings: Count fingers (CF or FC), hand motion (HM), light perception (LP), no light perception (NLP)

How CMS Scores Your Performance

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IRIS46: Evidence of anatomic closure of macular hole within 90 days after surgery as documented by OCT

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients with a macular hole who have evidence of anatomic closure documented by OCT within 90 days after surgical treatment.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged 18 years or older with a diagnosis of macular hole and a surgical treatment for macular hole.

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator.

Diagnosis Codes

- Diagnosis of macular hole (ICD-10: H35.341, H35.342, H35.343)

CPT Codes

- Had a surgical procedure to treat or close macular hole (CPT: 67036, 67039, 67041, 67042)

Instructions: This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with macular hole will submit this measure.

How to Report the Measure

Numerator: All patients with a macular hole who received surgical treatment and had anatomic closure within 90 days. This could consist of documentation based on OCT that the macular hole is closed or resolved.

Numerator Options

- **Performance met:** Evidence of anatomic closure within 90 days of surgical treatment (e.g., macular hole is closed or resolved based on OCT)
- **Performance not met:** No evidence of anatomic closure within 90 days of surgical treatment (e.g., macular hole is open or not closed or not resolved based on OCT)

Denominator Exclusions

- Associated retinal detachment before the date of the surgical treatment (ICD-10: H33.001, H33.002, H33.003, H33.011, H33.012, H33.013, H33.021, H33.022, H33.023, H33.031, H33.032, H33.033, H33.041, H33.042, H33.043, H33.051, H33.052, H33.053, H33.8)

How CMS Scores Your Performance

No scoring benchmark currently exists for this measure.

- If you successfully report a measure for *less than 70%* of your patients, you will earn points based on your practice size:
    - Small practices (≤ 15 clinicians) will receive 3 points,
    - Larger practices (> 15 clinicians) will receive 0 points.
- If you successfully report a measure for *at least 70%* of your patients, but do not report at least 20 cases, you will receive 3 points.

If at least 20 physicians report the measure on at least 70% of qualifying patients and at least 20 patients, CMS will develop a scoring benchmark using data collected during the 2020 reporting year.

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IRIS48: Adult Surgical Esotropia: Postoperative alignment

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry QCDR for EHR Integration: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Promote Effective Prevention & Treatment of Chronic Disease

Description: Percentage of adult esotropia patients receiving surgical treatment with a posttreatment alignment of 12 prism diopters (PD) or less.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged 19 years or more who underwent a surgical procedure for esotropia.

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator.

Diagnosis Codes

- Esotropia (ICD-10: H50.00, H50.011, H50.012, H50.021, H50.022, H50.031, H50.032, H50.041, H40.042, H50.05, H50.06, H50.07, H50.08)
- Intermittent esotropia (ICD-10: H50.30, H50.311, H50.312, H50.32)
- Partially accommodative esotropia (ICD-10: H50.43)

- Divergence insufficiency (ICD-10: H51.8)
- Sixth nerve palsy (ICD-10: H49.21, H49.22, H49.23)

CPT Codes

- Surgical intervention for esotropia (CPT: 67311, 67312)

How to Report the Measure

Numerator: Postoperative alignment of 12 PD or less recorded between 4 and 12 weeks after surgery.

Note: If there are multiple prism diopter measurements, the lowest measurement (likely to be the Simultaneous Prism and Cover Test) is to be used

Denominator Exclusions

- Duane syndrome (ICD-10: H50.811, H50.812)
- Scarring of extraocular muscles (CPT: 67322)

Notes:

- Must have alignment within 12 PD for at least one testing condition

How CMS Scores Your Performance

See the QPP resource library for benchmarks.

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IRIS49: Surgical Pediatric Esotropia: Postoperative alignment

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry QCDR manual data entry: groups and individuals
- IRIS Registry QCDR for EHR: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of surgical esotropia patients with a postoperative alignment of 12 prism diopters or less without a reoperation.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged 18 years or less who underwent a surgical procedure for esotropia.

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

Diagnosis Codes

- Esotropia (ICD-10: H50.00, H50.011, H50.012, H50.021, H50.022, H50.031, H50.032, H50.041, H40.042, H50.05, H50.06, H50.07, H50.08)
- Intermittent esotropia (ICD-10: H50.30, H50.311, H50.312, H50.32)
- Partially accommodative esotropia (ICD-10: H50.43)

CPT Codes

- Surgical intervention for esotropia (CPT: 67311, 67312)

How to Report the Measure

Numerator: Postoperative alignment of 12 PD or less recorded between 4 and 12 weeks after surgery.

Note: If there are multiple prism diopter measurements, the lowest measurement (likely to be the Simultaneous Prism and Cover Test) is to be used.

Denominator Exclusions

- Patients with a history of diplopia (ICD-10: H53.2), CN 6 palsy (ICD-10: H49.20, H49.21, H49.22, H49.23) or Duane syndrome (ICD-10: H50.811, H50.812)

Notes:

- Must not have re-operation in the same reporting period
- Must have alignment within 12 PD for at least one testing condition

How CMS Scores Your Performance

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IRIS50: Amblyopia: Interocular visual acuity

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of newly diagnosed amblyopic patients with one or more of the following:

1. a corrected interocular (or if not reported, the uncorrected) visual acuity difference less than 0.23 logMAR 3-12 months after first diagnosis of amblyopia OR
2. an improvement in the corrected visual acuity of the amblyopic eye of 3 or more Snellen lines (> or = 0.30 logMAR) 3-12 months after first diagnosis of amblyopia OR
3. a final visual acuity in the amblyopic eye equal to 20/30 or better (less than or equal to 0.18 logMAR) 3-12 months after first diagnosis of amblyopia

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged between 3 to 7 years at diagnosis of amblyopia with recognized visual acuity difference of greater than 0.29 logMAR between right and left eye (IOD criterion is to exclude bilateral ametropic amblyopia).

There are two criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”

The quality measure also has exclusions for the denominator.

Diagnosis Codes

- Amblyopia (ICD-10: H53.001, H53.002, H53.003, H53.021, H53.022, H53.023, H53.031, H53.032, H53.033)

How to Report the Measure

Numerator: Patients with interocular visual acuity difference of < 0.23 logMAR* or an improvement of three or more Snellen lines (> or = 0.30 logMAR)** in the amblyopic eye or a final visual acuity in the amblyopic eye of 20/30 or better (< or = 0.18 logMAR)*** recorded between 3 and 12 months after first use of amblyopia diagnosis code

*Difference in visual acuity values between right and left eye (inter-eye)

**Difference between baseline and visual acuity at 3-12 months in the amblyopic eye (intra-eye)

***Absolute visual acuity, not a difference

Denominator Exclusions: Patients with diagnosis of deprivation amblyopia (ICD 10: H53.01), cataract (ICD –10: H26.0), aphakia (ICD-10: H27.00, H27.01, H27.02, H27.03), or pseudophakia (ICD-10: Z96.1)

How CMS Scores Your Performance

See the QPP resource library for benchmarks.

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IRIS51: Acute Anterior Uveitis: Post-treatment visual acuity

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

Meaningful Measure Area: Management of Chronic Conditions

NQS Domain: Effective Clinical Care

Description: Percentage of acute anterior uveitis patients with a post-treatment best corrected visual acuity of 20/20 or better *or* patients whose visual acuity had returned to their baseline value prior to onset of uveitis.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Patients aged 18 years or older who underwent treatment for acute anterior uveitis.

There are two criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”

Diagnosis Codes

Diagnosis of acute uveitis

- Primary iridocyclitis (ICD-10: H20.011, H20.012, H20.013)
- Recurrent acute iridocyclitis (ICD-10: H20.021, H20.022, H20.023)
- Unspecified acute and subacute iridocyclitis (ICD-10: H20.00)

How to Report the Measure

Numerator:

Patients with a best corrected visual acuity of 20/20 or better within 90 days of treatment initiation

OR

Patients whose visual acuity had returned to their baseline value prior to onset of acute uveitis within 90 days of treatment initiation

How CMS Scores Your Performance

See the QPP resource library for benchmarks.

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IRIS53: Chronic Anterior Uveitis - Post-treatment visual acuity

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of chronic anterior uveitis patients with a post-treatment best corrected visual acuity of 20/30 or better *or* patients whose visual acuity had returned to their baseline value prior to onset of uveitis.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged 18 years or greater who underwent treatment for chronic anterior uveitis.

There are two criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”

Diagnosis Codes

- Chronic iridocyclitis (ICD-10: H20.10, H20.11, H20.12, H20.13)

How to Report the Measure

Numerator: Patients with a best corrected visual acuity of 20/30 or better within 90 days of treatment initiation

OR

Patients whose visual acuity had returned to their baseline value prior to onset of acute uveitis within 90 days of treatment initiation

How CMS Scores Your Performance

See the QPP resource library for benchmarks.

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IRIS54: Complications After Cataract Surgery

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Option:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measures Area: Management of Chronic Conditions

Description: Percentage of eyes of patients aged 18 years and older with a diagnosis of cataract who had cataract surgery and had the following complications within 90 days after cataract surgery: prolonged inflammation, incision complications, iris complications, retinal detachment, cystoid macular edema, corneal complications or return to OR.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: Yes
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Eyes of patients aged 18 years and older with a diagnosis of cataract who had cataract surgery.

- This measure is to be calculated *each time* a procedure for uncomplicated cataracts is performed during the reporting period. This measure is intended to reflect the quality of services provided for the patients receiving cataract surgery.
- Include only procedures performed through Sept. 30 of the reporting period. This will allow the postoperative period to occur within the reporting year.
- Clinicians who indicate modifier 55, postoperative management only OR modifier - 56, preoperative management only, *will not* qualify for this measure

There are two criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above)
2. **Procedure codes (CPT):** Codes located in “CPT Codes”

CPT Codes

66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984, 66987, 66988

How To Report the Measure

Numerator: Eyes of patients aged 18 years and older with a diagnosis of cataract who had cataract surgery and had the following complications within 90 days after cataract surgery: prolonged inflammation, incision complications, iris complications, retinal detachment, cystoid macular edema, corneal complications or return to the operating room.

Lower rate indicates better performance.

ICD-10 Codes

T85.79XA, T81.31XA, H20.051, H20.052, H20.053, H21.531, H21.532, H21.533, H21.561, H21.562, H21.563, H33.012, H33.013, H33.021, H33.022, H33.023, H33.031, H33.032, H33.033, H33.041, H33.042, H33.043, H33.051, H33.052, H33.05, H59.031, H59.032, H59.033, H18.11, H18.12, H18.13, H18.231, H18.232, H18.233

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IRIS55: Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery

Updated December 2022.

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of eyes of patients aged 18 years and older with a diagnosis of cataract who had cataract surgery and minimally invasive glaucoma surgery and achieved 20/30 best-corrected distance visual acuity or better OR an improvement in best-corrected distance visual acuity within 4 months following the cataract surgery. Weighted average of performance rates reported.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Eyes of patients aged 18 years and older who underwent a cataract surgery procedure and minimally invasive glaucoma surgery on the same date.

There are two criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Procedure codes (CPT):** Codes located in “CPT Codes.”

CPT Codes

- Cataract Surgery
  CPT Codes: 66989, 66991

WITHOUT

Modifier -55 (Postoperative management only) OR Modifier -56 (Preoperative management only)

How to Report This Measure

Numerator: 20/30 best-corrected distance visual acuity OR an improvement in best-corrected distance visual acuity achieved within 4 months following the cataract surgery:

Eyes with mild to moderate stage glaucoma and a 20/30 or better post-operative best-corrected distance visual acuity

AND

Eyes with severe stage glaucoma or a pre-operative best-corrected visual acuity of 20/200 and a 2 lines or better improvement in the post-operative best-corrected distance visual acuity from preoperative visual acuity

AND

Eyes with a pre-operative best-corrected visual acuity of 20/400 and a 1 line or better improvement in the post-operative best-corrected distance visual acuity from pre-operative visual acuity

Denominator Exclusions:

- Eyes with absolute glaucoma blindness (ICD-10: H44.511, H44.512, H44.513)
- Eyes with these visual acuity findings: Count fingers (CF or FC), Hand motion (HM), Light perception (LP), No light perception (NLP)

Instructions:
This measure is to be calculated each time a procedure for cataracts and a procedure for MIGS is performed during the reporting period. This measure is intended to reflect the quality of services provided for the eyes receiving cataract surgery and MIGS on the same day.

- Include only procedures performed through August 31 of the reporting period. This will allow the postoperative period to occur within the reporting year.

Clinicians who indicate modifier 55, postoperative management only OR modifier -56, preoperative management only, will not qualify for this measure

How CMS Scores Your Performance

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IRIS56: Adult Diplopia: Improvement of ocular deviation or absence of diplopia or functional improvement

Updated December 2022.

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients with a diagnosis of double vision (diplopia) who had an improvement of ocular deviation as determined by reduction of strabismus in primary gaze to less than 10 prism diopters horizontal or less than 2 prism diopters vertical deviation OR were absent of diplopia in primary gaze OR had functional improvement in ptosis within 6 months of initiating treatment.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged 18 years or older diagnosed with diplopia between January 1 and June 30 of the reporting period AND received treatment for the condition.

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

Diagnosis Codes

Diagnosis of diplopia (ICD-10: H53.2)

AND

Additional diagnostic codes indicating likely cause of diplopia

- Third nerve palsy (ICD-10: H49.0x), Fourth nerve palsy (ICD-10: H49.1x), Sixth nerve palsy (ICD-10: H49.2x)
- Mechanical strabismus (ICD-10: H50.6x), restrictive strabismus (ICD-10: H50.89, H50.9)
- Hypertropia or hypotropia (ICD-10: H50.21, H50.22)
- Esotropia (ICD-10: H50.0x), intermittent esotropia (ICD-10: H50.30, H50.31x, H50.32)
- Exotropia (ICD-10: H50.1x), intermittent exotropia (ICD-10: H50.33, H50.34, H50.33x)
- Ocular myasthenia gravis (ICD-10: G70.0x)
- Thyroid eye disease (ICD-10: E05.00)
- Skew deviation (ICD-10: H51.8)
- Convergence insufficiency (ICD-10: H51.11) or excess (ICD-10: H51.12)
- Internuclear ophthalmoplegia (ICD-10: H51.2x)

AND

Treatment initiated

- Patient prescribed one of the following medications for conditions associated with diplopia - pyridostigmine, prednisone, mycophenolate mofetil, azathioprine, cyclosporine, rituximab.
- Strabismus surgery (CPT: 67311, 67312, 67314, 67316, 67318)
- Extraocular muscle procedure (CPT: 67345)
- Press-on prism (HCPCS: V2718)
- Occluder lens (HCPCS: V2770)

CPT Codes

Two or more encounters within the last 6 months (CPT: 99024, 99201, 99202, 99203, 99204, 99205, 99244, 99245, 92002, 92004, 92012, 92014, 99212, 99213, 99214, 99215)

How to Report the Measure

Numerator: Patients with improvement in ocular deviation (<10 PD horizontal and/or <2PD vertical) within 6 months after initial treatment OR absence of diplopia in primary gaze within 6 months after initial treatment OR functional improvement of ptosis within 6 months after initiating treatment.

Performance Not Met: Patient did not meet any of the performance criteria (improvement of ocular deviation or absence of diplopia in primary gaze or functional improvement in ptosis).

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IRIS57: Idiopathic Intracranial Hypertension: Improvement of mean deviation or stability of mean deviation

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients with improvement in mean deviation or stability of mean deviation (+1db) within 6 months of initiating therapy.

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged 18 years or older who were newly diagnosed with idiopathic intracranial hypertension between January 1 and June 30 of the reporting period with two or more encounters during the last six months and who received treatment.

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator.

Diagnosis Codes

- **Diagnosis of idiopathic intracranial hypertension**

- Benign intracranial hypertension (ICD-10: G93.2)

CPT Codes

Two or more encounters within the last 6 months (CPT: 99201, 99202, 99203, 99204, 99205, 99244, 99245, 92002, 92004, 92012, 92014, 99212, 99213, 99214, 99215)

AND

Formal visual field testing (CPT: 92081, 92082, 92083)

AND

Treatment initiated

- Lumbar puncture (CPT: 62270, 62272)
- Obesity screening and treatment (HCPCS: G0447)
- Patient prescribed one of the following medications – acetazolamide, topiramate, furosemide

How to Report the Measure

Numerator: Patients with improvement of mean deviation or stability of mean deviation within 6 months of initiating therapy.

- **Performance met** (patient included in numerator *and* denominator)**:**
  - Patients whose mean deviation was stable (+ 1dB), 6 months after intiating therapy.
    Or
  - Patients with improvement of mean deviation within 6 months after initiating therapy.

- **Performance not met** (patient *not* included in numerator, but included in denominator)**:** Patients whose mean deviation worsened by (> 1dB) within 6 months after intiating therapy.

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IRIS58: Improved Visual Acuity after Vitrectomy for Complications of Diabetic Retinopathy within 120 Days

Updated December 2022

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of patients with a 20% or greater improvement in visual acuity within 120 days following vitrectomy for complications of diabetic retinopathy

Risk Adjusted: No
Performance Rate: 1
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: All patients aged 18 years or older with a diagnosis of diabetic retinopathy and had a vitrectomy procedure

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

Diagnosis Codes

- Diagnosis of diabetic retinopathy (ICD-10: E08.311, E08.319, E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413,E08.3491, E08.3492, E08.3493, E08.3511, E08.3512,

E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E09.311, E09.319, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492, E10.3493, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3291, E13.3292, E13.3293, E13.3311, E13.3312, E13.3313, E13.3391, E13.3392, E13.3393, E13.3411, E13.3412, E13.3413, E13.3491, E13.3492, E13.3493, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593)

CPT Codes

- Had a vitrectomy procedure to treat complications of diabetic retinopathy (CPT: 67036, 67039, 67040, 67041, 67042)

How to Report the Measure

Numerator: Patients with a 20% or greater improvement in visual acuity within 120 days following vitrectomy

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IRIS59: Regaining Vision After Cataract Surgery

Updated December 2022.

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Management of Chronic Conditions

Meaningful Measure Area: Promote Effective Prevention & Treatment of Chronic Disease

Description: Percentage of eyes of patients aged 18 years and older with a diagnosis of cataract who had cataract surgery and had 20/20 best-corrected distance visual acuity or better OR an improvement in best-corrected distance visual acuity achieved within 30 days following the cataract surgery. Weighted average of performance rates reported,

Risk Adjusted: No
Performance Rate: 3, and a weighted average
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

Instructions:
This measure is intended to reflect the quality of services provided for the patients receiving cataract surgery.

- Include only procedures performed through November 30 of the reporting period. This will allow the postoperative period to occur within the reporting year.
- Clinicians who indicate modifier 55, postoperative management only OR modifier -56, preoperative management only, will not qualify for this measure

To Which Patients Does the Measure Apply?

Denominator: Eyes of patients aged 18 years and older with a diagnosis of cataract who had cataract surgery (with the criteria for preoperative comorbidities and visual acuity as noted in the next section for the 3 categories).

There are two criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator.

CPT Codes

66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984

How to Report the Measure

Numerator: Eyes of patients aged 18 years and older who had cataract surgery and had a best-corrected distance visual acuity of 20/20 or better OR an improvement in best-corrected distance visual acuity achieved within 30 days following the cataract surgery:

Eyes of patients with no comorbidities or additional procedures on the same date as the cataract surgery and a 20/20 or better post-operative best corrected distance visual acuity

AND

Eyes of patients with comorbidities with a pre-operative visual acuity of 20/200 or better and a

2 lines or better improvement in the post-operative best-corrected distance visual acuity from preoperative visual acuity

AND

Eyes of patients with comorbidities with a pre-operative visual acuity of 20/400 or worse and a

1 line or better improvement in the post-operative best-corrected distance visual acuity from pre-operative visual acuity

Denominator Exclusions:

- Eyes of patients with high risk combined cataract surgery and glaucoma surgery procedures: 66987, 66988, 66989, 66991

Table 1: Comorbidities

Comorbidity	Corresponding ICD-10-CM Codes
Acute and Subacute Iridocyclitis	H20.00, H20.011, H20.012, H20.013, H20.021, H20.022, H20.023, H20.031, H20.032, H20.033, H20.041, H20.042, H20.043, H20.051, H20.052, H20.053,
Amblyopia	H53.011, H53.012, H53.013, H53.021, H53.022, H53.023, H53.031, H53.032, H53.033, H53.041, H53.042, H53.043
Burn Confined to Eye and Adnexa	T26.01XA, T26.02XA, T26.11XA, T26.12XA,T26.21XA, T26.22XA, T26.31XA, T26.32XA, , T26.41XA, T26.42XA,T26.51XA, T26.52XA, T26.61XA, T26.62XA, T26.71XA, T26.72XA, T26.81XA, T26.82XA,T26.91XA, T26.92XA
Cataract Secondary to Ocular Disorders	H26.211, H26.212, H26.213, H26.221, H26.222, H26.223

Central Corneal Ulcer	H16.011, H16.012, H16.013
Certain Types of Iridocyclitis	H20.21, H20.22, H20.23, H20.811, H20.812, H20.813, H20.821, H20.822, H20.823, H20.9,
Chorioretinal Scars	H31.011, H31.012, H31.013, H31.021, H31.022, H31.023,
Choroidal Degenerations	H35.33
Choroidal Detachment	H31.411, H31.412, H31.413
Choroidal Hemorrhage and Rupture	H31.301, H31.302, H31.303, H31.311, H31.312, H31.313, , H31.321, H31.322, H31.323
Chronic Iridocyclitis	A18.54, H20.10, H20.11, H20.12, H20.13
Cloudy Cornea	H17.01, H17.02, H17.03, H17.11, H17.12, H17.13,
Corneal Edema	H18.11, H18.12, H18.13, H18.221, H18.222, H18.223, ,H18.231, H18.232, H18.233, H18.421, H18.422, H18.423,
Corneal Opacity and Other Disorders of Cornea	H17.01, H17.02, H17.03, H17.11, H17.12, H17.13, H17.89, H17.9
Degeneration of Macula and Posterior Pole	H35.30, H35.3110, H35.3111, H35.3112, H35.3113, H35.3114, H35.3120, H35.3121, H35.3122, H35.3123, H35.3124, H35.3130, H35.3131, H35.3132, H35.3133, H35.3134, , H35.3210, H35.3211, H35.3212, H35.3213, H35.3220, H35.3221, H35.3222, H35.3223, H35.3230, H35.3231, H35.3232, H35.3233, H35.341, H35.342, H35.343, H35.351, H35.352, H35.353, , H35.361, H35.362, H35.363, , H35.371, H35.372, H35.373, , H35.381, H35.382, H35.383,
Degenerative Disorders of Globe	H44.2A1, H44.2A2, H44.2A3, H44.2B1, H44.2B2, H44.2B3, H44.2C1, H44.2C2, H44.2C3, H44.2D1, H44.2D2, H44.2D3, H44.2E1, H44.2E2, H44.2E3 H44.21, H44.22, H44.23, H44.311, H44.312, H44.313, H44.321, H44.322, H44.323, H44.391, H44.392, H44.393
Diabetic Macular Edema	E08.311, E08.3211, E08.3212, E08.3213, E08.3311, E08.3312, E08.3313, , E08.3411, E08.3412, E08.3413, E08.3511, E08.3512, E08.3513, , E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, , E08.37X1, E08.37X2, E08.37X3, E09.311, E09.3211, E09.3212, E09.3213, E09.3311, E09.3312, E09.3313, , E09.3411, E09.3412, E09.3413, E09.3511, E09.3512, E09.3513, , E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.37X1, E09.37X2, E09.37X3, , E10.311, E10.3211, E10.3212, E10.3213, , E10.3311, E10.3312, E10.3313, E10.3411, E10.3412, E10.3413, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.37X1, E10.37X2, E10.37X3, , E11.311, E11.3211, E11.3212, E11.3213, , E11.3311, E11.3312, E11.3313,

Diabetic Retinopathy without Macular Edema	E11.3411, E11.3412, E11.3413, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.37X1, E11.37X2, E11.37X3, , E13.311, E13.3211, E13.3212, E13.3213, E13.3311, E13.3312, E13.3313, , E13.3411, E13.3412, E13.3413, , E13.3511, E13.3512, E13.3513, , E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.37X1, E13.37X2, E13.37X3, E08.319, E08.3291, E08.3292, E08.3293, E08.3391, E08.3392, E08.3393, E08.3491, E08.3492, E08.3493, E08.3521, E08.3522, E08.3523, , E08.3531, E08.3532, E08.3533, , E08.3541, E08.3542, E08.3543, , E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, , E09.319, E09.3291, E09.3292, E09.3293, E09.3391, E09.3392, E09.3393, E09.3491, E09.3492, E09.3493, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, , E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, , E09.3591, E09.3592, E09.3593, E10.319, E10.3291, E10.3292, E10.3293, E10.3391, E10.3392, E10.3393, E10.3491, E10.3492, E10.3493, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, , E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E11.319, E11.3291, E11.3292, E11.3293, E11.3391, E11.3392, E11.3393, E11.3491, E11.3492, E11.3493, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.319, , E13.3291, E13.3292, E13.3293, E13.3391, E13.3392, E13.3393, E13.3491, E13.3492, E13.3493, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, , E13.3591, E13.3592, E13.3593,
Disorders of Optic Chiasm	H47.41, H47.42, H47.43,
Disorders of Visual Cortex	H47.611, H47.612, H47.621, H47.622, H47.631, H47.632, H47.641, H47.642
Disseminated Chorioretinitis and Disseminated Retinochoroiditis	A18.53, H30.101, H30.102, H30.103, H30.111, H30.112, H30.113, H30.121, H30.122, H30.123, , H30.131, H30.132, H30.133, H30.141, H30.142, H30.143,
Focal Chorioretinitis and Focal Retinochoroiditis	H30.001, H30.002, H30.003, H30.011, H30.012, H30.013, , H30.021, H30.022, H30.023, H30.031, H30.032, H30.033, H30.041, H30.042, H30.043
Glaucoma	H40.10X3, H40.10X4, H40.1113, H40.1114, H40.1123, H40.1124, H40.1133, H40.1134, H40.1213, H40.1214, H40.1223, H40.1224, H40.1233, H40.1234, H40.1313, H40.1314, , H40.1323, H40.1324, H40.1333, H40.1334, H40.1413, H40.1414, H40.1423, H40.1424, H40.1433, H40.1434, H40.20X0, H40.20X1, H40.20X2, H40.20X3, H40.20X4, H40.211, H40.212, H40.213, H40.2213, H40.2214, H40.2223, H40.2224, H40.2233, H40.2234, H40.31X3, H40.31X4, H40.32X3, H40.32X4, H40.33X3, H40.33X4, H40.41X3, H40.41X4, H40.42X3, H40.42X4, H40.43X3, H40.43X4, H40.51X3, H40.51X4, H40.52X3, H40.52X4, H40.53X3, H40.53X4, H40.61X3, H40.61X4, H40.62X3, H40.62X4, H40.63X3, H40.63X4, H40.821, H40.822, H40.823, H40.831, H40.832, H40.833, H40.9, Q15.0

Hereditary Choroidal Dystrophies	H31.20, H31.21, H31.22, H31.23
Hereditary Corneal Dystrophies	H18.501, H18.502, H18.503, H18.511, H18.512, H18.513, H18.521, H18.522, H18.523, H18.531, H18.532, H18.533, H18.541, H18.542, H18.543, H18.551, H18.552, H18.553, H18.591, H18.592, H18.593
Hereditary Retinal Dystrophies	H18.501, H18.502, H18.503, H18.511, H18.512, H18.513, H18.521, H18.522, H18.523, H18.531, H18.532, H18.533, H18.541, H18.542, H18.543, H18.551, H18.552, H18.553
Injury to Optic Nerve and Pathways	S04.011A, S04.012A, S04.02XA, S04.031A, S04.032A, S04.041A, S04.042A
Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	H54.1131, H54.1132, H54.1141, H54.1142, H54.1151, H54.1152, H54.1213, H54.1214, H54.1215, H54.1223, H54.1224, H54.1225
Nystagmus and Other Irregular Eye Movements	H55.01, H55.02, H55.03, H55.04, H55.09, H55.81, H55.82, H55.89
Open Wound of Eyeball	S05.11XA, S05.12XA, S05.21XA, S05.22XA, , S05.31XA, S05.32XA, S05.41XA, S05.42XA, , S05.51XA, S05.52XA, S05.61XA, S05.62XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A, S05.91XA, S05.92XA
Optic Atrophy	H47.20, H47.211, H47.212, H47.213, H47.22, H47.231, H47.232, H47.233, H47.291, H47.292, H47.293
Optic Neuritis	H46.01, H46.02, H46.03, H46.11, H46.12, H46.13, H46.2, H46.3, H46.8, H46.9
Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis	H30.21, H30.22, H30.23, H30.811, H30.812, H30.813, H30.891, H30.892, H30.893, H30.91
Other Background Retinopathy and Retinal Vascular Changes	H35.021, H35.022, H35.023,
Other Corneal Deformities	H18.711, H18.712, H18.713, H18.721, H18.722, H18.723, , H18.731, H18.732, H18.733
Other Disorders of Optic Nerve	H47.011, H47.012, H47.013
Other Disorders of Sclera	H15.831, H15.832, H15.833, H15.841, H15.842, H15.843
Other Endophthalmitis and other entities	H16.241, H16.242, H16.243, H21.331, H21.332, H21.333, , H33.121, H33.122, H33.123, H44.111, H44.112, H44.113, H44.121, H44.122, H44.123, , H44.131, H44.132, H44.133, , H44.19
Other Proliferative Retinopathy	H35.101, H35.102, H35.103, H35.111, H35.112, H35.113, , H35.121, H35.122, H35.123, , H35.131, H35.132, H35.133, H35.141, H35.142, H35.143, , H35.151, H35.152, H35.153, H35.161, H35.162, H35.163, , H35.171, H35.172, H35.173

Keratoconus	H18.601, H18.602, H18.603, H18.611, H18.612, H18.613, H18.621, H18.622, H18.623
Profound Impairment, Both Eyes	H54.0X33, H54.0X34, H54.0X35, H54.0X43, H54.0X44, H54.0X45, H54.0X53, H54.0X54, H54.0X55
Purulent Endophthalmitis	H44.001, H44.002, H44.003, H44.011, H44.012, H44.013, H44.021, H44.022, H44.023
Retinal Detachment with Retinal Defect	H33.001, H33.002, H33.003, H33.011, H33.012, H33.013, H33.021, H33.022, H33.023, H33.031, H33.032, H33.033, , H33.041, H33.042, H33.043, H33.051, H33.052, H33.053, H33.8
Retinal Vascular Occlusion	H34.11, H34.12, H34.13, H34.231, H34.232, H34.233, H34.8110, H34.8111, H34.8112, H34.8120, H34.8121, H34.8122, H34.8130, H34.8131, H34.8132, H34.8310, H34.8311, H34.8312, H34.8320, H34.8321, H34.8322, H34.8330, H34.8331, H34.8332
Scleritis	H15.021, H15.022, H15.023, H15.031, H15.032, H15.033, H15.041, H15.042, H15.043, H15.051, H15.052, H15.053, H15.091, H15.092, H15.093
Separation of Retinal Layers	H35.711, H35.712, H35.713, H35.721, H35.722, H35.723H35.731, H35.732, H35.733
Visual Field Defects	H53.411, H53.412, H53.413, H53.421, H53.422, H53.423, H53.431, H53.432, H53.433, H53.451, H53.452, H53.453, H53.461, H53.462, H53.47, H53.481, H53.482, H53.483

How CMS Scores Your Performance

Benchmarks

See QPP resource library for benchmarks.

If at least 20 physicians report the measure on at least 70% of qualifying patients and at least 20 patients, CMS will develop a scoring benchmark using data collected during the 2020 reporting year.

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IRIS60: Glaucoma – Visual Acuity Improvement Following Cataract Surgery Combined with a Trabeculectomy or an Aqueous Shunt Procedure

Updated December 2022.

Care Setting: Ambulatory Care: Clinician Office/Clinic

Reporting Options:

- IRIS Registry QCDR for EHR: groups and individuals
- IRIS Registry QCDR manual data entry: groups and individuals

Measure Type: Outcome

NQS Domain: Effective Clinical Care

Meaningful Measure Area: Management of Chronic Conditions

Description: Percentage of eyes of patients who underwent cataract surgery combined with a trabeculectomy or an aqueous shunt procedure who had their visual acuity improve 1 or 2 more Snellen lines from their preoperative visual acuity between 3 and 6 months post-operatively. Weighted average of performance rates reported.

Risk Adjusted: No
Performance Rate: 3, weighted average of performance rates reported
High Priority Measure: Yes
Inverse Measure: No
Proportional Measure

To Which Patients Does the Measure Apply?

Denominator: Eyes of patients aged between 40 and 85 years with a diagnosis of open-angle glaucoma, pigmentary glaucoma, primary open-angle glaucoma, pseudoexfoliation glaucoma or chronic angle glaucoma and who underwent cataract surgery combined with a trabeculectomy or an aqueous shunt procedure.

There are three criteria for inclusion of a patient into the denominator.

1. **Patient characteristics**: Description located in “Denominator” (see above).
2. **Diagnosis codes (ICD-10-CM):** Codes located in “Diagnosis Codes.”
3. **Procedure codes (CPT):** Codes located in “CPT Codes.”

The quality measure also has exclusions for the denominator.

Diagnosis Codes

Diagnosis of glaucoma with documentation of disease staging

- Open-angle glaucoma, unspecified (ICD-10: H40.10X1, H40.10X2, H40.10X3)
- Low-tension glaucoma (ICD-10: H40.1211, H40.1212, H40.1213, H40.1221, H40.1222, H40.1223, H40.1231, H40.1232, H40.1233)
- Pigmentary glaucoma (ICD-10: H40.1311, H40.1312, H40.1313, H40.1321, H40.1322, H40.1323, H40.1331, H40.1332, H40.1333)
- Primary open angle glaucoma (ICD-10: H40.1111, H40.1112, H40.1113, H40.1121, H40.1122, H40.1123, H40.1131, H40.1132, H40.1133)
- Pseudoexfoliation glaucoma (ICD-10: H40.1411, H40.1412, H40.1413, H40.1421, H40.1422, H40.1423, H40.1431, H40.1432, H40.1433)
- Chronic angle glaucoma (ICD-10: H40.2211, H40.2212, H40.2213, H40.2221, H40.2222, H40.2223, H40.2231, H40.2232, H40.2233, H40.2311, H40.2312, H40.2313, H40.2321, H40.2322, H40.2323, H40.2331, H40.2332, H40.2333, H40.2411, H40.2412, H40.2413, H40.2421, H40.2422, H40.2423, H40.2431, H40.2432, H40.2433)

CPT Codes

- Cataract surgery (CPT: 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984, 66987, 66988)

WITHOUT Modifier -55 (Postoperative management only) OR Modifier -56 (Preoperative management only)

AND

- Trabeculectomy procedure (CPT: 66170, 66172 with modifier RT, LT, -50)

OR, AND

- Aqueous shunt procedure (CPT: 66179, 66180, 66183, 0449T, with modifier RT, LT, -50, 0450 T, with modifier RT, LT,-50)

How to Report the Measure

Numerator: Eyes of patients with a preoperative visual acuity better than 20/200 and 2 or more lines from their preoperative visual acuity and between 3 and 6 months postoperatively.

AND

Eyes of patients with a preoperative visual acuity of 20/200, and an improvement of 2 or more lines from their preoperative visual acuity between 3 and 6 months postoperatively

AND

Eyes of patients with a preoperative visual acuity of 20/400, and an improvement of 1 or more lines from their preoperative visual acuity between 3 and 6 months postoperatively

Numerator Calculation

Percent change between preoperative visual acuity and the visual acuity measured between 3 and 6 months postoperatively.

Calculation is based on the visual acuity of the eye that underwent the combined procedure.

Denominator Exclusions

- Eyes with absolute glaucoma blindness (ICD-10: H44.511, H44.512, H44.513)
- Visual acuity findings: Count fingers (CF or FC), Hand motion (HM), Light perception (LP), No light perception (NLP)

How CMS Scores Your Performance

See the QPP resource library for benchmarks.

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