

AMERICAN ACADEMY
OF OPHTHALMOLOGY®

2026 IRIS® Registry **Preparation Kit**

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AMERICAN ACADEMY
OF OPHTHALMOLOGY®

2026 IRIS® Registry (Intelligent Research in Sight) Preparation Kit

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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, life member, life fellow) membership category
- Optometrists can use the IRIS Registry only if they are employed by an ophthalmologist or an ophthalmic practice

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

Membership

To use the IRIS Registry, all ophthalmologists in the practice must be Academy members in good standing (e.g., have paid their current year’s member dues for the MIPS reporting year that they are reporting).

- If any ophthalmologist in the practice (including part-time) is not a current Academy member, the practice cannot use the IRIS Registry. Exceptions include neuro-ophthalmologists and neurologists practicing as neuro-ophthalmologists.
- An active Academy member who works at multiple practices may only be able to use the IRIS Registry if the given practice has registered to use the IRIS Registry.
- You can check your Academy membership status by emailing Member Services at member_services@aao.org, or calling +1 866.561.8558.
- Ophthalmologists can log into their accounts at aao.org/renew to see if there is an outstanding balance. Note that ophthalmologists whose membership has lapsed by more than one year may not show a current dues bill when you log in.
- Third parties can contact Member Services with the name of all ophthalmologists who work for the practice, both full and part time, and their member ID numbers, if available.

Introduction

Origins. More than a decade ago, the Board of Trustees and Dr. David W. Parke, 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 ability for 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 enthusiasm for participation by the Academy membership was quite rapid, with 3,000 practices signing up in the first year. As of March 2026, there are over 14,000 ophthalmologists and their eligible clinicians in practice with them participating in the IRIS Registry.

Driving your MIPS success. An important objective of the IRIS Registry is to help practices with their quality reporting to the Centers for Medicare & Medicaid Services (CMS) with the Merit-Based Incentive Payment System (MIPS). The IRIS Registry is the best tool ophthalmology practices have to comply with MIPS requirements and maximize their score. Compiling a full year of electronic health record data can be challenging for individual ophthalmologists. 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 developed by the Academy. Ophthalmologists participating in the IRIS Registry have saved billions in avoided penalties. In addition, a majority of ophthalmologists participating in the IRIS Registry have earned bonuses each year.

Pioneering research. Another benefit of the IRIS Registry are the scientific advancements afforded by the accumulation of de-identified data. As of March 2026, over 160 articles have been published based on data from the IRIS Registry database, and over 200 presentations, either in paper or poster format, have been provided 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 and risk factors for disease progression, which will improve patient outcomes in everyday practice. As of March 2026, there are an aggregate of 86 million patients in the IRIS Registry database.

Why you need this Preparation Kit. 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 do during 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 process improvements, and seeing these improvements in subsequent performance rates and in enhanced team communications and/or documentation.

IRIS Registry and Deadlines for the 2026 MIPS Performance Year

May 31, 2026	Deadline to pay Academy dues for eligible physicians participating in the IRIS Registry.
July 1, 2026	Last day to register for EHR Integration with IRIS Registry.
July 5, 2026	Last day to start 180-day reporting period for promoting interoperability measures.
July 31, 2026	Deadline to make your preferred measures selection and submit mapping requests.
Aug. 1, 2026	Last day to notify Verana Health about changes to your EHR or data system affecting the 2026 Performance Year (ex. upgrades, moving to the cloud, etc.).
Aug. 31, 2026	Deadline to Earn MOC Part IV MIPS Credit with Improvement Project.
Sep. 30, 2026	Last day to complete EHR or data system changes (ex. upgrades, moving to the cloud, etc.) to ensure integration the 2026 Performance Year for your IRIS dashboard.
Oct. 3, 2026	Last day to start 90-day reporting period for improvement activities.
Oct. 31, 2026	Deadline for new practices to register for manual reporting with IRIS Registry.
Nov. 30, 2026	Last Day to register for MVP Reporting via https://qpp.cms.gov/mips/mvps/learn-about-mvp-registration
Dec. 31, 2026	Last day to add new physicians/locations for reporting via IRIS Registry-EHR integration or submit a hardship exception application for the 2026 Performance Year.
Jan. 31, 2027	All practices reporting for the 2026 Performance Year should sign their Data Release Consent Form. Practices should 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 soon afterwards.
Mar. 15, 2027	Deadline to submit data through CMS portal.



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.

For the 2026 Performance Year, the threshold to avoid a penalty on 2028 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, an ophthalmology practice that does not perform cataract surgery or melanoma resections is unlikely to be subject to the cost performance category. Additionally, small practices (15 or fewer eligible clinicians) are automatically exempt from reporting in the PI category.



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

Your MIPS final score (0-100 points) is based on up to four performance category scores, which are weighted as shown in the table above (e.g., if quality is weighted at 30%, it contributes up to 30 points to your MIPS final score).

CMS may reweight how performance categories contribute to your MIPS final score if it determines that you shouldn't be scored on one or more categories (e.g., if extreme and uncontrollable circumstances apply, if a promoting interoperability exception applies, or if you don't meet the case minimum for any cost measures).



2026 Solo and Small-Practice Roadmap for MIPS

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

Verify your status by using the QPP Participation Status Tool (<https://qpp.cms.gov/participation-lookup>).

- CMS released the initial eligibility status December 2025 and will release the final eligibility status December 2026.

Clinicians qualify for an automatic exemption from MIPS if they meet one or more of the following criteria:

- New to Medicare for 2026 and hasn't previously submitted claims under Medicare
- Less than or equal to \$90,000 in Medicare Part B service allowed charges
- Provides covered professional services to 200 or fewer Medicare Part B patients
- Provides 200 or fewer covered professional services to Part B patients. When you treat more than 200 patients you are, by definition, performing at least 200 services
- 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:

- October 1, 2024 – September 30, 2025, and/or
- October 1, 2025 - September 30, 2026

Please note that if the clinician is reporting as a part of a group, the low-volume threshold is evaluated at the group level.



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.

(<https://qpp.cms.gov/participation-lookup>).

- If you are a large practice, please refer to the Large Practice Roadmap on page 22.

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 2028 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 2028 Medicare Part B services reimbursements	75 points
Small bonus	Qualifies you for a small bonus on your 2028 Medicare Part B services reimbursements	Above 75 points

Step 4. How to Achieve Your Goal for the 2026 Performance Year

The MIPS final score is the weighted sum of performance category scores. For example, if a category is weighted at 30%, it contributes up to 30 MIPS final score points to the total score of up to 100 points.

MIPS Performance Category	2026 Score Default Weight
Quality	30%
Promoting interoperability	25%
Improvement activities	15%
Cost	30%



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 (for example, they are cataract surgeons, or you are in a multispecialty practice and a non-ophthalmology cost measure applies).

For those eligible for the cost performance category, do all the following to avoid a penalty (requires a MIPS final score of 75 points).

Quality performance category:

- IRIS Registry participants can choose to report via traditional MIPS, the Complete Ophthalmologic Care MIPS Value Pathway (MVP), or both. If submitting through both, CMS will apply the higher scoring submission.
- If you are reporting via traditional MIPS, you are required to 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 practices reporting through the Complete Ophthalmologic Care MVP, you are required to report on 4 quality measures. However, you must select your quality measures from a more limited subset of measures. The subset of measures can be found on [the Complete Ophthalmologic Care MVP webpage](#).
- This category must be performed for the full calendar year on at least 75% of denominator-eligible patients to meet the data completeness threshold AND at least 20 patients in the denominator for each measure AND a performance rate >0% (or <100% if an inverse measure).
- CMS emphasizes that 100% of eligible patients is desired for MIPS reporting. If you are NOT submitting 100% of all eligible patients, you must provide your total eligible population to verify that you meet the data completeness threshold.
- Review the benchmark summaries on page 46 to make sure your choices maximize your point potential.
- All small practices that report on at least one quality measure will receive 6 bonus points for the quality category.
- For small practices *without* EHR:
 - Fully report on at least 75% of denominator-eligible patients to meet the data completeness threshold and provide the total eligible patient populations for the reporting period AND with at least 20 patients in the denominator for all quality measures.



- You must achieve a quality category score of at least 88 out of 100 (with the automatic PI hardship for small practices assuming the cost category contributes 10 points out of 30 points to your MIPS final score).
- For small practices with EHR (and not taking the automatic PI hardship exception):
 - Fully report on at least 75% of denominator-eligible patients to meet the data completeness threshold AND with at least 20 patients in the denominator for all quality measures.
 - If not on the EHR 100% the entire year, provide the total eligible patient populations (CMS requires reporting on at least 75% of denominator-eligible patients to meet the data completeness threshold AND with at least 20 patients in the denominator) for all quality measures.
 - The score you need will depend on how well you do in the EHR-based PI category

Improvement activities performance category:

- Complete 1 improvement activity for 90+ consecutive days. The full list of all improvement activities available for reporting in 2026 can be found on [the QPP webpage](#).
- If group reporting, at least 50% of eligible clinicians in your group must complete the same activity in any continuous 90-day period. The clinicians do not need to share the same 90-day period.

Promoting interoperability performance category:

- All small practices will receive an automatic PI exemption and have the category reweighted.
- If you accept the automatic PI exemption, the points associated with the PI performance category will be reallocated to the quality and improvement activities performance categories (see reweighting table on page 9). Take into account how this will impact your MIPS final score when deciding whether to accept or decline the automatic PI exemption for small practices
- For practices that plan to submit data for the PI performance category and have certified electronic health record technology (CEHRT) that meets certification criteria defined by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health Information Technology (ONC), complete the PI required measures and try to maximize your performance where possible.



For those not eligible for the cost performance category (the category is reweighted), do all the following to avoid a penalty (requires a MIPS final score of 75 points).

Quality performance 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.

- IRIS Registry participants can choose to report via traditional MIPS, the Complete Ophthalmologic Care MIPS Value Pathway (MVP), or both. If submitting through both, CMS will apply the higher scoring submission.
- If you are reporting via traditional MIPS, you are required to 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 practices reporting through the Complete Ophthalmologic Care MVP, you are required to report on 4 quality measures. However, you must select your quality measures from a more limited subset of measures. The subset of measures can be found on [the Complete Ophthalmologic Care MVP webpage](#).
- This category must be performed for the full calendar year on at least 75% of denominator-eligible patients to meet the data completeness threshold AND at least 20 patients in the denominator for each measure AND a performance rate >0% (or <100% if an inverse measure).
- CMS emphasizes that 100% of eligible patients is desired for MIPS reporting. If you are NOT submitting 100% of all eligible patients, you must provide your total eligible population to verify that you meet the data completeness threshold.
- Review the benchmark summaries on page 46 to make sure your choices maximize your point potential.
- All small practices that report on at least one quality measure will receive 6 bonus points within the quality category.
- For small practices *without* EHR:
 - Fully report (on at least 75% of denominator-eligible patients and providing the total eligible patient populations for the reporting period AND with at least 20 patients in the denominator) for all quality measures.
 - You must achieve a quality category score of at least 50 out of 100 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 75% 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) for all quality measures.
- The score you need will depend on how well you do in the EHR-based PI category.

Improvement activities performance category:

- Complete 1 improvement activity for 90+ consecutive days. The full list of all improvement activities available for reporting in 2026 can be found on [the QPP webpage](#).
- If group reporting, at least 50% of eligible clinicians in your group must complete the same activity or activities in any continuous 90-day period. The clinicians do not need to share the same 90-day period.

Promoting interoperability performance category:

- All small practices will receive an automatic PI exemption and have the category reweighted.
- If you accept the automatic PI exemption, the points associated with the PI performance category will be reallocated to the quality and improvement activities performance categories (see reweighting table on page 9). Take into account how this will impact your MIPS final score when deciding whether to accept or decline the automatic PI exemption for small practices
- For practices that plan to submit data for the PI performance category and have certified electronic health record technology (CEHRT) that meets certification criteria defined by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health IT (ONC), complete the PI required measures and try to maximize your performance where possible.

Step 5: Choose your measures and/or activities.

Each MIPS performance 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.

Quality performance 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 (or 4 if reporting through the ophthalmology MVP).



- General Quality Performance Category Information:
- This category must be performed for the full calendar year on 75% 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). CMS emphasizes that 100% of eligible patients is desired for MIPS reporting.
 - Report on at least 6 quality measures (or 4 if reporting through the ophthalmology MVP), 1 of which must be an outcome measure or, if no outcome measure is available, another type of high priority measure
 - Review the benchmark summaries on page 46 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.

Improvement activities performance category:

- To fulfill the entire improvement activities category score: complete 1 improvement activity for 90+ consecutive days.
- 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.
- CMS can audit each activity you report, so it is recommended that you submit only the required number of activities.
- The following are improvement activities that many clinicians/practices already do routinely. Read the activity specifications available on the [QPP webpage](#).
- IA_BE_4: Engagement of patients through implementation of new patient portal
 - Implement and provide access to a new patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange
 - Examples include, but are not limited to: brief patient reevaluation by messaging, communication about test results and follow up, and management for any relevant acute or chronic disease management
- IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings
 - Collect and follow up on patient experience and satisfaction data
 - This activity also requires follow-up on findings of assessments, including the development and implementation of improvement plans.



- IA_EPA_8: Provide Education Opportunities for New Clinicians
 - Act as a preceptor for clinicians-in-training (such as medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved, or rural areas.
- IA_BE_25: Drug Cost Transparency
 - Provide counseling to patients and/or their caregivers regarding: costs of medications using a real time benefit tool (RTBT)
- IA_BMH_12: Promoting Clinician Well-Being
 - Develop and implement programs to support clinician well-being and resilience through relationship-building opportunities, leadership development plans, or creation of a team within a practice to address clinician well-being
- IA_CC_8: Implementation of documentation improvements for practice/process improvements
 - Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure)
- IA_CC_9: Implementation of Practices/Processes for Developing Regular Individual Care Plans
 - Implementation of practices/processes, including a discussion on care, to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s).
- IA_EPA_6: Create and Implement a Language Access Plan
 - Create and implement a language access plan to address communication barriers for individuals with limited English proficiency.

Promoting interoperability performance category:

- Performance period: 180+ consecutive days
- This requires the use of certified electronic health record technology (CEHRT) that meets certification criteria defined by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health IT (ONC),
 - Note: You can only report data that is captured by CEHRT for this category. If you report as a group, you will not be downgraded if not all your clinicians use CEHRT.
- How CMS Scores the Category:
 - Four PI objectives are required



- 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
- Critical attestations. To score more than 0%, you must submit “Yes” for:
 - The Security Risk Analysis attestations
 - 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 or, where available, claim an exclusion to get any PI credit
 - For each performance rate-based measure, you must have at least one patient in the numerator
 - Exclusion for e-Prescribing
 - Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.
 - 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 in accordance with applicable law OR does not electronically prescribe any Schedule II opioids and Schedule III and IV drugs during the 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 as of 6 months prior to the start of the performance period.
- 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 as of 6 months prior to the start of the performance period.



Promoting Interoperability Performance Category Objectives and Measures

Objective	Measures	Reporting requirement	Maximum points
e-Prescribing	e-Prescribing**	Numerator/denominator	10 points
	Query of Prescription Drug Monitoring Program**	Yes/No	10 points
Health-information exchange	Support electronic referral loops by sending health information**	Numerator/denominator	15 points
	Support electronic referral loops by receiving and reconciling health information**	Numerator/denominator	15 points
	OR	OR	OR
	HIE Bi-Directional Exchange	Yes/No	30 points
	OR	OR	OR
	Enabling Exchange under TEFCA	Yes/No	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** and Electronic Case Reporting**	Yes/No	25 points
	Optional measures: Clinical Data Registry reporting,* OR Public Health Registry Reporting, OR Syndromic Surveillance Reporting, OR Public Health Registry Reporting OR Public Health Reporting Using TEFCA		5 bonus points maximum

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

**Exclusions are available. Check the measure specifications to see if you qualify.

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.



STEP 6: Submission

The submission function on the Verana Quality Measures (VQM) Dashboard MIPS Submission tab is activated the January after the end of the performance year. You must review measures, attest, and click the submit button for your information to go to CMS. The Academy and Verana Health will provide reminders of submission deadlines.

Academy and Verana Health Resources:

The Eye on Advocacy 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.

Eye on Advocacy	www.aao.org/advocacy/eye-on-advocacy
Academy MIPS Webpages	https://www.aao.org/medicare/mips
EyeNet's MIPS 2026 Resources	https://www.aao.org/eyenet/mips
Email IRIS Registry questions to:	irisdatalink@veranahealth.com for registration, practice-related dashboard, mapping and MIPS submission irisregistry@aao.org for general issues
Email MIPS questions to:	mips@aao.org
AAOE-Talk (for AAOE Members)	https://aao.mobilize.io/users/sign_in/



2026 Large Practice Roadmap for MIPS

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

Verify your status by using the QPP Participation Status Tool (<https://qpp.cms.gov/participation-lookup>).

- CMS released the initial eligibility status December 2025 and will release the final eligibility status December 2026.

Clinicians qualify for an automatic exemption from MIPS if they meet one or more of the following criteria:

- New to Medicare for 2026 and hasn't previously submitted claims under Medicare
- Less than or equal to \$90,000 in Medicare Part B service allowed charges
- Provides covered professional services to 200 or fewer Medicare Part B patients
- Provides 200 or fewer covered professional services to Part B patients. When you treat more than 200 patients you are, by definition, performing at least 200 services
- 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:

- October 1, 2024 – September 30, 2025, and/or
- October 1, 2025 - September 30, 2026

Please note that if the clinician is reporting as a part of a group, the low-volume threshold is evaluated at the group level



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 on page 10.

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 2028 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 2028 Medicare Part B services reimbursements	75 points
Small bonus	Qualifies you for a small bonus on your 2028 Medicare Part B services reimbursements	Above 75 points

Step 4. How to Achieve Your Goal for the 2026 Performance Year

The MIPS final score is the weighted sum of performance category scores. For example, if a category is weighted at 30%, it contributes up to 30 MIPS final score points to the total score of up to 100 points.

MIPS Performance Category	2026 Score Default Weight
Quality	30%
Promoting interoperability	25%
Improvement activities	15%
Cost	30%



To Avoid a Penalty (requires a MIPS final score of 75 points), do the following:

Quality performance category:

- IRIS Registry participants can choose to report via traditional MIPS, the Complete Ophthalmologic Care MIPS Value Pathway (MVP), or both. If submitting through both, CMS will apply the higher scoring submission.
- If you are reporting via traditional MIPS, you are required to 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 practices reporting through the Complete Ophthalmologic Care MVP, you are required to report on 4 quality measures. However, you must select your quality measures from a more limited subset of measures. The subset of measures can be found on [the Complete Ophthalmologic Care MVP webpage](#).
- This category must be performed for the full calendar year on at least 75% of denominator-eligible patients to meet the data completeness threshold AND at least 20 patients in the denominator for each measure AND a performance rate >0% (or <100% if an inverse measure).
- CMS emphasizes that 100% of eligible patients is desired for MIPS reporting. If you are NOT submitting 100% of all eligible patients, you must provide your total eligible population to verify that you meet the data completeness threshold.
- Review the benchmark summaries on page 46 to make sure your choices maximize your point potential.

Improvement activities performance category:

- Complete 1 improvement activity for 90+ consecutive days. The full list of all improvement activities available for reporting in 2026 can be found on [the QPP webpage](#).
- If group reporting, at least 50% of eligible clinicians in your group must complete the same activity or activities in any continuous 90-day period. The clinicians do not need to share the same 90-day period.

Promoting interoperability performance category:

- With certified electronic health record technology (CEHRT) that meets certification criteria defined by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health Information Technology (ONC), complete the PI required measures and try to maximize your performance where possible.



Step 5: Choose your measures and/or activities.

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.

Quality performance 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 (or 4 if reporting through the ophthalmology MVP).
- General Quality Performance Category Information:
- This category must be performed for the full calendar year on 75% 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). CMS emphasizes that 100% of eligible patients is desired for MIPS reporting.
 - Report on at least 6 quality measures (or 4 if reporting through the ophthalmology MVP), 1 of which must be an outcome measure or, if no outcome measure is available, another type of high priority measure
 - Review the benchmark summaries on page 46 to make sure your choices maximize your point potential.

Improvement activities performance category:

- To fulfill the entire improvement activities category score: complete 2 improvement activities for 90+ consecutive days.
- 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.
- CMS can audit each activity you report, so it is recommended that you submit only the required number of activities.
- The following are improvement activities that many clinicians/practices already do routinely. Read the activity specifications available on the [QPP webpage](#).
- To fulfill the entire improvement activities category score: complete 1 improvement activity for 90+ consecutive days.



- 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.
- CMS can audit each activity you report, so it is recommended that you submit only the required number of activities.
- The following are improvement activities that many clinicians/practices already do routinely. Read the activity specifications available on the [QPP webpage](#).
- IA_BE_4: Engagement of patients through implementation of new patient portal
 - Implement and provide access to a new patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange
 - Examples include, but are not limited to: brief patient reevaluation by messaging, communication about test results and follow up, and management for any relevant acute or chronic disease management
- IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings
 - Collect and follow up on patient experience and satisfaction data
 - This activity also requires follow-up on findings of assessments, including the development and implementation of improvement plans.
- IA_EPA_8: Provide Education Opportunities for New Clinicians
 - Act as a preceptor for clinicians-in-training (such as medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved, or rural areas.
- IA_BE_25: Drug Cost Transparency
 - Provide counseling to patients and/or their caregivers regarding: costs of medications using a real time benefit tool (RTBT)
- IA_BMH_12: Promoting Clinician Well-Being
 - Develop and implement programs to support clinician well-being and resilience through relationship-building opportunities, leadership development plans, or creation of a team within a practice to address clinician well-being
- IA_CC_8: Implementation of documentation improvements for practice/process improvements
 - Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure)
- IA_CC_9: Implementation of Practices/Processes for Developing Regular Individual Care Plans



- Implementation of practices/processes, including a discussion on care, to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s).
- IA_EPA_6: Create and Implement a Language Access Plan
 - Create and implement a language access plan to address communication barriers for individuals with limited English proficiency.

Promoting interoperability performance category:

- Performance period: 180+ consecutive days
- This requires the use of certified electronic health record technology (CEHRT) that meets certification criteria defined by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health IT (ONC),
 - Note: You can only report data that is captured by CEHRT for this category. If you report as a group, you will not be downgraded if not all your clinicians use CEHRT.
- How CMS Scores the Category:
 - Four PI objectives are required
 - 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
 - Critical attestations. To score more than 0%, you must submit "Yes" for:
 - The Security Risk Analysis attestations
 - 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 or, where available, claim an exclusion to get any PI credit
 - For each performance rate-based measure, you must have at least one patient in the numerator
 - Exclusion for e-Prescribing



- Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.
- 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 in accordance with applicable law OR does not electronically prescribe any Schedule II opioids and Schedule III and IV drugs during the 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 as of 6 months prior to the start of the performance period.
- 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 as of 6 months prior to the start of the performance period.



Promoting Interoperability Performance Category Objectives and Measures

Objective	Measures	Reporting requirement	Maximum points
e-Prescribing	e-Prescribing**	Numerator/denominator	10 points
	Query of Prescription Drug Monitoring Program**	Yes/No	10 points
Health-information exchange	Support electronic referral loops by sending health information**	Numerator/denominator	15 points
	Support electronic referral loops by receiving and reconciling health information**	Numerator/denominator	15 points
	OR	OR	OR
	HIE Bi-Directional Exchange	Yes/No	30 points
	OR	OR	OR
	Enabling Exchange under TEFCA	Yes/No	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** and Electronic Case Reporting**	Yes/No	25 points
	Optional measures: Clinical Data Registry reporting,* OR Public Health Registry Reporting, OR Syndromic Surveillance Reporting, OR Public Health Registry Reporting OR Public Health Reporting Using TEFCA		5 bonus points maximum

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

** Exclusions are available. Check the measure specifications to see if you qualify.

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.



STEP 6: Submission

The submission function on the Verana Quality Measures (VQM) Dashboard MIPS Submission tab is activated the January after the end of the performance year. You must review measures, attest, and click the submit button for your information to go to CMS. The Academy and Verana Health will provide reminders of submission deadlines.

Academy and Verana Health Resources:

The Eye on Advocacy 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.

Eye on Advocacy www.aao.org/advocacy/eye-on-advocacy

Academy MIPS Webpages <https://www.aao.org/medicare/mips>

EyeNet's MIPS 2026 Resources <https://www.aao.org/eyenet/mips>

Email IRIS Registry questions to: irisdatalink@veranahealth.com for registration, practice-related dashboard, mapping and MIPS submission

irisregistry@aao.org for general issues

Email MIPS questions to: mips@aao.org

AAOE-Talk (for AAOE Members) https://aao.mobilize.io/users/sign_in/



Certified Electronic Health Record (EHR) Technology for Integrated Practices: Roles, Responsibilities, and Schedule

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

- It is essential for practices to review the data in the IRIS Registry at least every quarter and compare it with their EHR to ensure accuracy and alignment.
- Discrepancies found during monitoring usually have four possible causes:
 - 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 Health Support to report the discrepancy.
 - 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.
 - 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.
 - Failing to Add New Clinicians: Have you notified Verana Health about any new clinicians joining your practice, either through Zendesk, contacting your practice experience manager, or by emailing irisdatalink@veranahealth.com? If not, then Verana Health will not know to pull data for them. The performance you see would not be representative of the entire practice.
- It is critical to catch problems early. The Academy believes the data should be checked no less than quarterly; a monthly cadence would be more beneficial.
- 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 MIPS submission tab in the Verana Quality Measures (VQM) Dashboard. These consist of:



- Confirming Academy Member ID numbers for each ophthalmologist (Q1-Q4 2026).
- Verifying your Taxpayer ID Number (TIN) with a Medicare Claims Form as mandated by CMS for confirmation (Q4 2026).
- Signing the Data Release Consent Form (DRCF) (January 2027).
- Answering the “Validation” questions (January 2027).
- Submitting your data to CMS after the performance period ends (before 3/31/2027). Reminder: All practices must review, attest and submit the data themselves to CMS through the MIPS submission portal of the VQM dashboard.

Selecting Your Quality Measures

- Mapping is required to use data from your EHR to record your clinicians' quality measure performance in the IRIS Registry, and this process cannot happen without your participation. It is essential to verify the accuracy of the mapping and regularly share performance insights with clinicians to support ongoing improvement throughout the year.
- The first thing to do at the beginning of the performance period is to review the list of quality measures and select the 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:
 - The benchmark summaries in page 46 shows how many measure achievement points are possible for each measure.
- Considerations in making your selection for MIPS submission:
 - You should pick at least 6 quality measures (or 4 if reporting through the ophthalmology MVP) 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 measures should be classified as an outcome measure or, if none are available, another type of high priority measure.
- The Academy encourages you to report on more than the required measures with special emphasis on the IRIS Registry QCDR measures. If you submit more than the required measures, only the measures with the highest scores will be counted towards your quality performance category score.
- 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) while some measures may not have a benchmark.
- On your first pass, pick measures that allow you to earn up to 10.0 achievement points without any gaps (no stalled measures and no capped measures).
- 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 your practice 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.
- If enough practices report on the IRIS Registry QCDR measures that have no historical benchmark, 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 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 for mapping refinements is October 31, 2026.
 - 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 for the reporting period.
- Have there been any reorganizations at your practice? If you're using a different Taxpayer ID Number, you'll need to get that updated and provide a Medicare claim form for appropriate document (required by CMS for TIN confirmation). 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 in the monthly IRIS Registry newsletters.

- 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 deadline to add any new clinicians or locations for mapping is September 1, 2026. You can update this information by using Zendesk or emailing irisdatalink@veranahealth.com.
 - Have there been changes to the administrative staff? If more people need IRIS Registry access, you can take care of that using Zendesk. 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 Health 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.
- 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.
- One way to improve your PI score is to make sure your electronic contact information is recorded with CMS.
- CMS asks you to add your secure electronic contact information, also known as an electronic end point or "Direct address" 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 EHR vendor for this information. Go to the [NPPES website](#) and update your provider profile. You can add your electronic address under the "Health Information Exchange" section.



- 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.
- 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.
- Pick your IAs 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.
- You will need your EHR's Certified IT Product List (CHPL) number. The easiest way to obtain this number is to contact your EHR vendor.
- Run your PI report from your EHR and review the results. The PI reporting period is 180 consecutive days, so you have time to improve your score. Of course, as soon as you get a great score in a 180-day period, then you can consider yourself done with the performance category that much earlier.
 - Plug your measure performance report data into the VQM Dashboard PI screen and you can see what your estimated MIPS score will be for that 180-day period. You're not committing to what you've entered and can key in values for a different 180-day period later.
- 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.



End of Second Quarter:

- Review your VQM Dashboard.
 - Does the measure performance match your expectation?
 - 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, 2026. 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 or new practice locations?
 - Use Zendesk to add clinicians and locations.
 - 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, 2026 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, you have a last chance to take corrective action: the performance period for PI is now 180 days (up from 90 days in 2023).
- Check that the documentation for the selected IAs is adequate for at least half your clinicians (if reporting as a group). If not, implement changes for the third quarter.

End of Third Quarter:

- 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 in the middle of the 180-day period which is the very 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:

- Check your Academy membership status through <https://www.aao.org/membership> to ensure your ophthalmologists' member dues are paid.
- Review your VQM Dashboard
 - 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 your practice experience manager or Verana Health at irisdatalink@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
 - 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 180 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.
- You're ready to submit your data to CMS. You can do so as soon as the VQM Dashboard MIPS submission tab is available. This does not occur without the practice actually reviewing, attesting and submitting the information in the VQM Dashboard MIPS submission tab.



Common Pitfalls:

- Remember you need to review, attest and submit your MIPS data to CMS. (This is the practice's responsibility.)
- 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 data partner for the IRIS Registry.
 - Not monitoring their quality measure performance regularly.
 - Not reviewing and updating their quality measure choices each year, if needed.
 - Not notifying Verana Health through Zendesk or Practice Experience Manager of the following:
 - 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 submitting in the IA category.
 - 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.
- **Finally, remember that MIPS is a year-long process, and please do these throughout the year:**
 - 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.



Manually Reporting: Roles, Responsibilities, and Schedule

- Manually reporting through the IRIS Registry requires substantial time and effort, as quality measure data must be entered at the individual patient level. To avoid a penalty, practices must achieve a minimum Merit-Based Incentive Payment System (MIPS) final score of 75 points, necessitating a significant volume of data entry.
- To streamline this process, practices should consider integrating an electronic health record (EHR) system with the IRIS Registry. EHR integration eliminates the most labor-intensive aspects of MIPS reporting, allowing for a more efficient and strategic approach to compliance.
- 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. 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.
- Lastly, there are housekeeping tasks that must be performed to be able to submit MIPS through Verana Health for the IRIS Registry. Here's what you should do throughout the year.
 - Confirming Academy Member ID numbers for each ophthalmologist (Q1-Q4 2026).
 - Verifying your Taxpayer ID Number (TIN) with a Medicare Claims Form as mandated by CMS for confirmation (Q4 2026).
 - Signing the Data Release Consent Form (DRCF) (January 2027).
 - Answering the "Validation" questions (January 2027).
 - Submitting your data to CMS after the performance period ends (before 3/31/2027). Reminder: All practices must review, attest and submit the data themselves to CMS through the MIPS submission portal of the Verana Quality Measures (VQM) dashboard.
 - The first step, however, is to choose your quality measures.

Selecting Your Quality Measures.

- 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:
 - The benchmark summaries in page 46 shows how many measure achievement points are possible for each measure.
- Considerations in making your selection for MIPS submission:
 - You should pick at least 6 quality measures (or 4 if reporting through the ophthalmology MVP). 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 measures should be classified as an outcome measure or, if none are available, another type of high priority measure.
 - The Academy encourages you to report on more than the required measures with special emphasis on the IRIS Registry QCDR measures. If you submit more than the required measures, only the measures with the highest scores will be counted towards your quality performance category score.
 - 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) while some measures may not have a benchmark.
 - On your first pass, pick measures that allow you to earn up to 10.0 achievement points without any gaps (no stalled measures and no capped measures).
- 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 your practice 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 restriction.
- If enough practices report on the IRIS Registry QCDR measures that have no historical benchmark, 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 core measures.

January 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. Use the spreadsheet provided by Verana Health to enter your data.
 - 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.
- Pick the improvement activities the providers will perform for a 90 consecutive day period. Distribute the improvement activities' measure specifications to the clinicians. Establish workflow that allows you to retain the suggested documentation.
- 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 the practice's clinicians to report through the IRIS Registry.

Monthly:

- Keep up with the quality measure reporting in the spreadsheet provided by Verana Health.
- 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 and provide a Medicare claim form for appropriate document (required by CMS for TIN confirmation). 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 in the monthly IRIS Registry newsletters.

End of First Quarter:

- 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.
- If the quality measure performance data entry is correct, then engage your clinicians to show them their data.
- 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 at least 90 consecutive days – and be able to show documentation in case of an audit.
- If you are participating in the EHR-based promoting interoperability performance category, run your first quarter's promoting interoperability report. See how well you are doing and make changes to maximize your score. 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. (Note: Clinicians in small practices are eligible for an automatic exception to promoting interoperability, provided they—and, if reporting as part of a group, their colleagues—don't do any reporting on the performance category.)

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.
- 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 points in the category to avoid a penalty, you'll be reporting on at least 75% of the denominator-eligible patients, across all payors, seen in the year, for which the measure applies.
- 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.
- If you are reporting the promoting interoperability category, run your second quarter reports. Are you seeing an improvement? The performance period for promoting interoperability is 180 consecutive days.



- 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, you should 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 and taxpayer ID numbers (documented by a Medicare Claims Form), and confirming payment of Academy Member fees.
- 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.
- If you are reporting the promoting interoperability performance category, then run your third quarter report. Compare it against your other two quarters and decide which 180 days you would like to use to report your promoting interoperability. 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

- Submit your spreadsheet to Verana Health and attest to your practice's improvement activities if you have not done so already.
- If you question the number of measure achievement points, check the benchmark summaries for insight. If you think something isn't calculating correctly, enter a ticket via Zendesk right away. (See the Zendesk for Verana Support: Manual Data Entry User Guide.)
- You're ready to submit your data to CMS. You can do so as soon as the VQM Dashboard MIPS submission tab is available. This does not occur without the practice reviewing, attesting and submitting the information on the VQM Dashboard MIPS submission tab.

Common Pitfalls

- Remember it is your responsibility to review, attest and submit your MIPS data to CMS



- 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 submitting in the improvement activities category
 - Assuming that there aren't any improvement activities suited to ophthalmology (there are lots!)
 - Answering the Settings questions incorrectly in the MIPS submission portal (preventing the submission in some performance categories)
 - Not checking all the performance category boxes during the submission process



2026 Quality Measures and Benchmark Summaries

- The tables below list quality measures available for reporting through the IRIS Registry for the 2026 performance year. They summarize which measures have benchmarks and the achievement points you can earn. To view the full list of 2026 benchmarks—including point values tied to performance deciles, visit the [QPP Benchmarks Webpage](#) and download 2026 Benchmark Files.
- There are four types of quality measures, each with its own set of benchmarks:
 - MIPS Clinical Quality Measures (MIPS CQMs)
 - Electronic CQMs (eCQMs)
 - Qualified Clinical Data Registry (QCDR) Measures
 - Claims-based Measures
- Some measures, like Measure 117: Diabetes Eye Exam, exist in multiple forms (e.g., MIPS CQM and eCQM), each of which has its own benchmark.
- If you report enough data for a measure with a benchmark, your performance rate will be scored against it. You can earn achievement points as shown in the tables below based on your performance for that measure.
- For measures without a historical benchmark, CMS will attempt to establish one after the 2026 performance year. If successful, the measure may earn up to 10 points, provided data completeness and case minimum requirements are met.
- If a benchmark cannot be established, small practices can receive 3 points for reporting the measure and large practices will receive 0 points, though there is a caveat for measures that are new measures in their first or second year.
- For measures in their first or second year of MIPS, there is a 7- or 5-point floor, respectively, provided that you meet the data completeness and case minimum criteria. If CMS is able to establish a benchmark for the measure based on 2026 performance year data, you may be able to earn more than the 7- or 5-point floor.
- **Consider reporting IRIS Registry QCDR measures without benchmarks in addition to your core selection. Doing so supports the development of future benchmarks and expands your measure options to better reflect your practice.**



2026 Clinical Quality Measures (CQMs) Benchmarks

QPP Measure ID: Title	Points (Large Practice)	Points (Small Practice)	Notes
1: Diabetes: Glycemic Status Assessment Greater Than 9%	1-10 points	3-10 points	Intermediate outcome measure; flat benchmark
117: Diabetes: Eye Exam	1-4.9 or, with a 100% performance rate, 7 points	3-4.9 or, with a 100% performance rate, 7 points	Topped out; 7-point cap
130: Documentation of Current Medications in the Medical Record	1-4.9 or, with a 100% performance rate, 7 points	3-4.9 or, with a 100% performance rate, 7 points	High-priority measure; topped out; 7-point cap
141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care	1-5.9 or, with a 100% performance rate, 10 points	3-5.9 or, with a 100% performance rate, 10 points	Topped out; Outcome measure
191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	1-3.9 or, with a 100% performance rate, 7 points	3-3.9 or, with a 100% performance rate, 7 points	Outcome measure; topped out; 7-point cap
226: Preventive Care and Screening Tobacco Use: Screening and Cessation Intervention	1-5.9 or, with a 100% performance rate, 7 points	3-5.9 or, with a 100% performance rate, 7 points	Topped out; 7-point cap
236: Controlling High Blood Pressure	1-10 points	3-10 points	Intermediate outcome measure; flat benchmark
238: Use of High-Risk Medications in Older Adults	1-2.9 or, with a 0% performance rate, 7 points	3 or, with a 0% performance rate, 7 points	High-priority measure; topped out; 7-point cap
317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	1-6.9 or, with a 100% performance rate, 10 points	3-6.9, with a 100% performance rate, 10 points	Topped out



374: Closing the Referral Loop: Receipt of Specialist Report	1-4.9 or, with a 100% performance rate, 7 points	3-4.9, with a 100% performance rate, 7 points	High-priority measure; topped out; 7-point cap
384: Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room within 90 Days of Surgery	1-7 points	3-7 points	Outcome measure; topped out; 7-point cap
385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement within 90 Days of Surgery	1-10 points	3-10 points	Outcome measure
389: Cataract Surgery: Difference Between Planned and Final Refraction	No benchmark	No benchmark	Outcome measure
397: Melanoma Reporting	1-10 points	3-10 points	High-priority measure; topped out
440: Skin Cancer: Biopsy Reporting Time - Pathologist to Clinician	1-10 points	3-10 points	High-priority measure; topped out
499: Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy	1-10 points	3-10 points	
500: Acute Posterior Vitreous Detachment Appropriate Examination and Follow-Up	No benchmark	No benchmark	
501: Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up	No benchmark	No benchmark	
509: Melanoma: Tracking and Evaluation of Recurrence	No benchmark	No benchmark	Second year measure (5-point floor)
513: Patient Reported Falls and Plan of Care	No benchmark	No benchmark	First year measure (7-point floor)



2026 Electronic Clinical Quality Measures (eCQMs) Benchmarks

QPP Measure ID: Title	Points (Large Practice)	Points (Small Practice)	Notes
1: Diabetes: Glycemic Status Assessment Greater Than 9%	1-10 points	3-10 points	Intermediate outcome measure
12: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	1-10 points	3-10 points	
19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	1-10 points	3-10 points	High-priority measure
117: Diabetes: Eye Exam	1-8.9 points or, with a 100% performance rate, 10 points	3-8.9 points or, with a 100% performance rate, 10 points	
130: Documentation of Current Medications in the Medical Record	1-7 points	3-7 points	High priority measure; topped out; 7-point cap
191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	1-10 points	3-10 points	Outcome measure
226: Preventive Care and Screening Tobacco Use: Screening and Cessation Intervention	1-10 points	3-10 points	
236: Controlling High Blood Pressure	1-10 points	3-10 points	Intermediate outcome measure
238: Use of High-Risk Medications in the Elderly	1-7 points	3-7 points	High-priority measure; topped out; 7-point cap
318: Falls: Screening for Future Fall Risk	1-10 points	3-10 points	High-priority measure
374: Closing the Referral Loop: Receipt of Specialist Report	1-10 points	3-10 points	High-priority measure



515: Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes	No benchmark	No benchmark	First year measure (7-point floor)



2026 Qualified Clinical Data Registry (QCDR) Benchmarks

Measure ID: Title	Points (Large Practice)	Points (Small Practice)	Notes
IRIS1: Endothelial Keratoplasty- Post-operative improvement in best corrected visual acuity to 20/40 or better	No benchmark	No benchmark	Outcome measure
IRIS2: Glaucoma - Intraocular Pressure Reduction	1-10 points	3-10 points	Intermediate outcome measure
IRIS13: Diabetic Macular Edema - Loss of visual acuity	1-3.9 or, with a 100% performance rate, 7 points	3-3.9 or, with a 100% performance rate, 7 points	Outcome measure; topped out, 7-point cap
IRIS17: Acute Anterior Uveitis: Post-treatment Grade 0 anterior chamber cells	No benchmark	No benchmark	Outcome measure
IRIS23: Refractive Surgery: Patients with a postoperative uncorrected visual acuity (UCVA) of 20/20 or better within 30 days	1-10 points	3-10 points	Outcome measure
IRIS38*: Endothelial Keratoplasty - Dislocation Requiring Surgical Intervention	No benchmark	No benchmark	Outcome measure
IRIS39: Intraocular Pressure Reduction following Trabeculectomy or an Aqueous Shunt Procedure	1-10 points	3-10 points	Outcome measure
IRIS50: Amblyopia: Interocular visual acuity	No benchmark	No benchmark	Outcome measure
IRIS54: Complications after Cataract Surgery	1-6.9 or, with a 0% performance rate, 10 points	3-6.9 or, with a 0% performance rate, 10 points	Outcome measure
IRIS58: Improved Visual Acuity after Vitrectomy for Complications of Diabetic Retinopathy within 120 Days	1-10 points	3-10 points	Outcome measure
IRIS59: Regaining Vision After Cataract Surgery	No benchmark	No benchmark	Outcome measure
IRIS61: Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery	1-10 points	3-10 points	Outcome measure



IRIS63: Exudative Age-Related Macular Degeneration: Gain of Visual Acuity	No benchmark	No benchmark	Outcome measure; second year measure (5-point floor)



Verana Health Practice Community Portal User Guide

2026

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Verana Health Practice Community Portal Introduction



This guide provides step-by-step instructions to help you manage your practice account, contacts, clinicians, and locations directly within the portal.

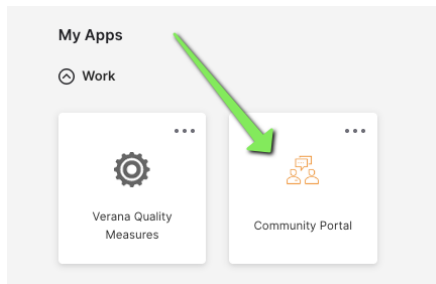
Tips for Success

- Use the **pencil icon** to edit fields throughout the portal.
- Always click **Save** after making changes.
- For assistance or portal access issues, contact support@veranahealth.com.

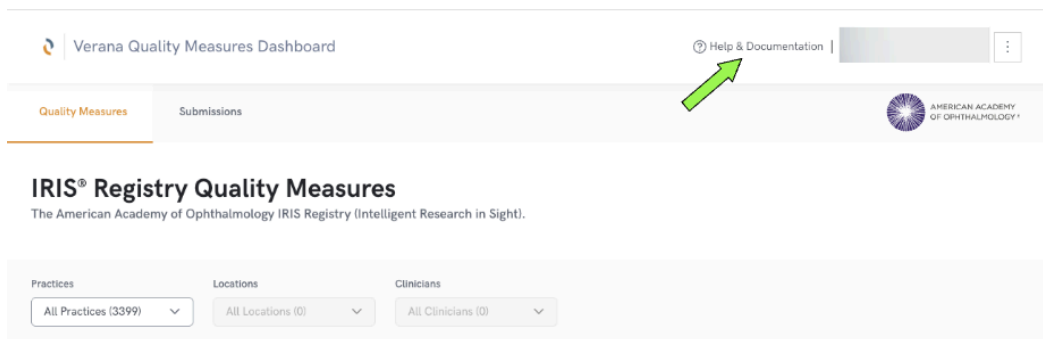
To Access the Community Portal

To access your Community Portal, follow these steps:

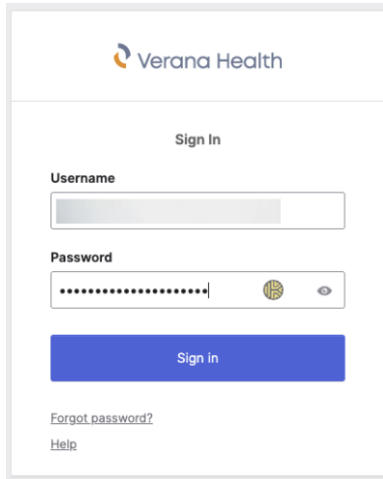
1. Log in to your VQM Dashboard account (<http://veranahealth.okta.com/>), and then click the **Community Portal** icon.



OR To access your Community Portal from within the Verana Quality Measures dashboard, click **Help & Documentation**.

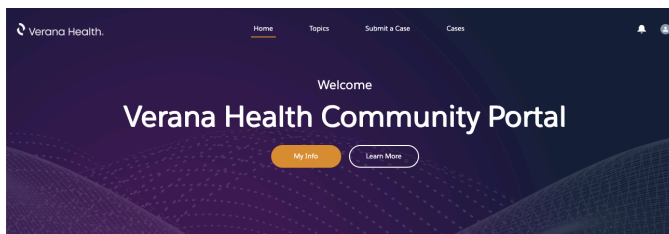


Note: You may be directed to log in again. Enter your password, and then click **Sign In**.

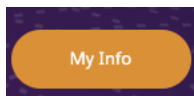


The image shows a 'Sign In' form for Verana Health. At the top is the Verana Health logo. Below it is the title 'Sign In'. There are two input fields: 'Username' and 'Password'. The 'Password' field has a toggle icon (an eye) to the right of the input box. Below the input fields is a blue 'Sign in' button. At the bottom of the form are two links: 'Forgot password?' and 'Help'.

2. The **Community Portal** home page opens.



3. Click the orange icon **My Info**.



4. You can view and update the following practice account details directly in the portal:

- a. [Practice Accounts](#)
- b. [Practice Contacts](#)
- c. [Clinicians](#)
- d. [Locations](#)

Practice Account Information



You can view and update your practice account details directly in the portal outside of the [Registry Renewal](#) workflow.

To Update Practice Account Information

1. Click the **pencil icon** next to the field you wish to edit.
2. Update the desired information:
 - Account Name
 - Legal Name
 - Other Names
 - Website
 - Phone
 - Practice Established Date
 - Organization NPI
 - Tax ID Number(s)
 - Primary EHR Version
 - EHR Date in Service
 - Billing Address
3. Click **Save** when complete.

Practice Contacts



You can add, edit, or manage relationships for practice contacts within the portal. Your practice should have two contacts (primary and backup) and one IT contact. You can designate a third-party contact too if relevant for your practice. Please inactivate any contacts who are no longer with the practice.

To View All Contacts

Under **Related Contacts**, click **View All**.

To Add a New Contact

1. Click **New Contact**.
2. Enter the required information.
3. Click **Save**.

To Edit an Existing Contact

1. Click the **contact name** you wish to update.
2. Click the **pencil icon** to edit any fields.
3. Click **Save**.

Editable fields include:

- Title
- Email
- Mobile Number
- Fax Number
- Status (Active/Inactive)
- Do Not Contact
- Wants Verana Dashboard Access
- Requested VQM User Role

To Add a Relationship to an Existing Contact

1. Click **Add Relationship**.
2. Enter the required information.
3. Click **Save**.

Clinicians



The portal allows you to add new clinicians, edit existing ones, or update clinician status outside of the [Registry Renewal](#) process.

To View All Clinicians

Under **Clinicians**, click **View All**.

To Add a New Clinician

1. Click **Add**.
2. Enter the required clinician information.
3. **Clinician Status:** Please make sure that the **Is Clinician Active?** field is **Yes** for all active clinicians to ensure smooth MIPS submissions.

* Is Clinician Active?

Yes

--None--

✓ Yes

No

Unverified

Never associated with practice

4. Click **Save**.

Note: There is not an option to remove a clinician from the portal.

To Update an Existing Clinician

1. Click the clinician's name.
2. Click the **pencil icon** next to the field you want to edit.
3. **Clinician Status:** please make sure that the **Is Clinician Active** field is **Yes** to ensure smooth MIPS submissions. For all other clinicians, select an alternate appropriate status.
4. Make your updates and click **Save**.

To View a Membership Status

The Clinicians section displays the membership status.

Clinicians (2)		New	
Clinician Name	NPI	Is Clinician Active?	Registry Membership Status
		No	☒
		Yes	☒
			View All

Users do not have an option to update the membership status. Dues can be at: <https://www.aao.org/membership>. The AAO will send us updated information when dues have been paid, though there can be a delay before this appears in the portal.

Locations



You can update location information or modify a location's status.

To View or Edit Locations

Under **Locations**, click **View All**.

To Edit a Location

1. Click the **Verana Location Number** in the first column next to the location name.
2. Click the **pencil icon** in the desired field(s) to make updates.
3. Click **Save**.

To Update Location Status

1. Click the **Verana Location Number** in the first column.
2. Click the **pencil icon** next to the **Status** field.
3. Update as needed (select **active**, **inactive**, or **never associated with practice**), and then click **Save**.

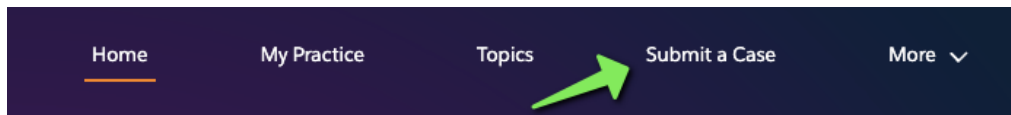
How to Submit Tickets to Support



Data Refinement Support Ticket

View a video tutorial of this process [here](#).

1. At the top of the **Community Portal** home page, click **Submit a Case**.



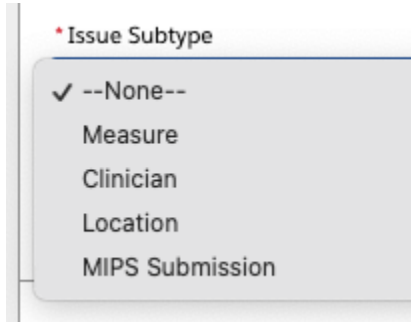
2. To start your new case, ensure that the following fields are complete:
 - a. **Contact**. This field is automatically populated from your user profile.
 - b. **Account Name**. This field is automatically populated from your user profile.
 - c. **Subject**. Manually enter a concise purpose/description for the case.
 - d. **Description**. Manually enter all necessary and relevant details related to the case you are opening.

A screenshot of a web form titled 'Add Case Details Below'. The form contains several input fields. The 'Subject' and 'Description' fields are highlighted with green rounded rectangles. Above them are fields for 'Contact' (with a profile picture icon), 'Account Name', and 'Registry' (with an 'IRIS' label). The 'Subject' field has a small blue asterisk icon to its left, and the 'Description' field has a small red asterisk icon to its left.

3. Click **Issue Type**, and select **Quality Measures Dashboard** from the dropdown menu.

A screenshot of a dropdown menu titled 'Issue Type'. The menu is open, showing a list of options. The first option is '--None--' with a checkmark to its left. Below it are 'User Access', 'Quality Measures Dashboard', 'Data Link', and 'Manual Data Entry'. The 'Quality Measures Dashboard' option is highlighted with a light blue background.

- Click **Issue Subtype**, and select **Measure** from the dropdown menu.

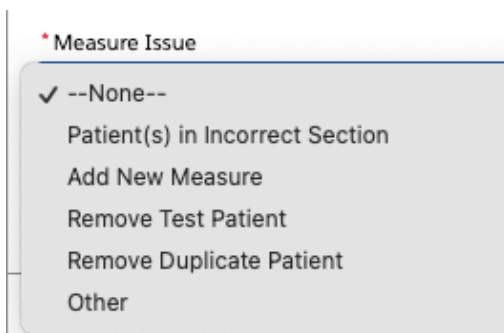


- In the **Measure** field, enter the measure related to your ticket.

Note: You must enter the type of measure in front of the numbers (e.g., eCQM, QPP, QCDR as shown below). Then click on the measure related to the ticket.



- Click **Measure Issue**, and select **Patient(s) in Incorrect Section** from the dropdown menu. If your EHR documentation shows the patient(s) should be listed in a different section on the dashboard for that measure.



- Click **Section Patient(s) are in**, and select the section from the dropdown menu the patient(s) are listed in on the dashboard.

*Section Patient(s) are in

- ✓ --None--
- Numerator
- Numerator Exception
- Numerator Not Met
- Denominator
- Denominator Exclusion
- Denominator Exception
- Not In Denominator
- None

- Click **Section Patient(s) should be in**, and select the section from the dropdown menu the patient(s) should be in based upon the measure specifications and documentation within your EHR.

*Section Patient(s) should be in

- ✓ --None--
- Numerator
- Numerator Exception
- Numerator Not Met
- Denominator
- Denominator Exclusion
- Denominator Exception
- Not In Denominator
- None

- In the **Please add one or more Patient Examples below** section, complete the required fields.

Note: You can add more than one patient example to the ticket if it is related to the same measure and same issue.

Please add one or more Patient Examples below:

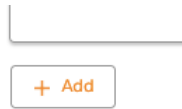
* First Name

* Last Name

* Date of Birth

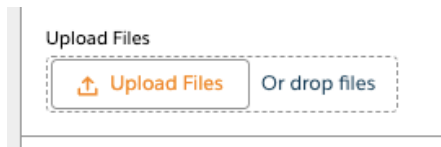
* MRN

10. To add additional patients, click **+Add**. This will give you another patient information section to complete.

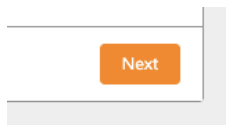


11. Click **Upload Files** to upload the screenshots for the patient examples to attach to the ticket.

IMPORTANT! Without any screenshots we will not be able to troubleshoot your ticket. Please take a FULLscreen screenshot that shows where the documented information is in the patient(s) chart. It is also helpful to upload a screenshot of the patient(s) diagnosis list and CPT codes used for the visit.

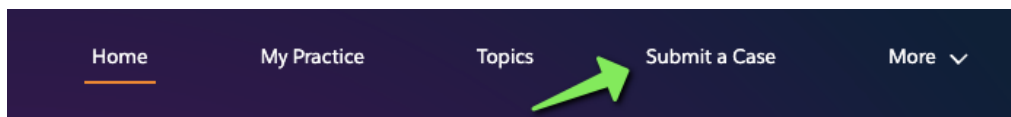


12. To **submit** your case, click **Next**.



Other Quality Measures Support Tickets

1. From the top navigation bar of the **Community Portal** home page, click **Submit a Case**.

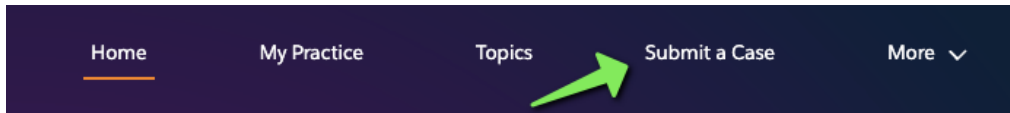


2. Add details about your case to this form.
3. In **Issue Type**, select **Quality Measures Dashboard**.
4. In **Issue Sub-Type**, select the option that best describes your request:
 - a. **Feature request or application issue**. This includes suggestions for new dashboard features or reporting unexpected functionality/bugs.
 - b. **Clinician**. Assistance with missing clinicians, adding new clinicians, or correcting existing clinician details displayed on the dashboard.

- c. **Location.** Assistance with missing locations, adding new locations, or correcting existing location details displayed on the dashboard.
- d. **MIPS Submission.** Requests for additional help or guidance specifically related to the MIPS Submission Module.

Verana Data Link (VDL)/ DPS Error Support Tickets

1. At the top of the **Community Portal** home page, click **Submit a Case**.



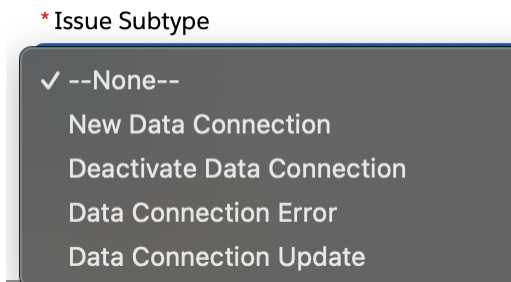
2. To start your new case, ensure that the following fields are complete:
 - a. **Contact.** This field is automatically populated from your user profile.
 - b. **Account Name.** This field is automatically populated from your user profile.
 - c. **Subject.** Manually enter a concise purpose/description for the case.
 - d. **Description.** Manually enter all necessary and relevant details related to the case you are opening.

A form titled 'Add Case Details Below' in blue text. It contains several input fields. The first field is labeled '* Contact' and has a small purple icon. Below it is 'Account Name' with a greyed-out field. Then '* Registry' with a greyed-out field, and 'IRIS' with a greyed-out field. Below these are two fields with green borders: '* Subject' and '* Description'. The form is set against a light grey background.

3. In **Issue Type**, and select **Data Link** from the dropdown menu.

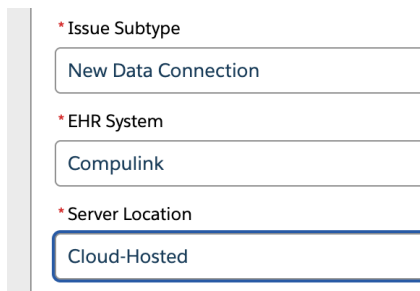
A dropdown menu for 'Issue Type'. The menu is open, showing a list of options. The first option is '✓ --None--'. Below it are 'User Access', 'Quality Measures Dashboard', 'Data Link', and 'Manual Data Entry'. The 'Data Link' option is highlighted in blue.

4. In **Issue Sub-Type**, select the option that best describes your request:
- a. **New Data Connection.** Your practice needs to set up a new connection for an EHR system.
 - b. **Deactivate Data Connection.** Your practice is discontinuing the use of an EHR data connection. This data will no longer be included on your Verana Quality Measures Dashboard for MIPS Submission.
 - c. **Data Connection Error.** You suspect a problem with the data extraction, either because your practice's IT team has confirmed the Remote Agent is disconnected, or you believe we are not fully extracting all necessary data from your EHR.
 - d. **Data Connection Update.** You are migrating or upgrading your server, or switching between a Cloud Hosted or Server On Site system.



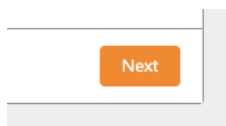
A screenshot of a dropdown menu titled '* Issue Subtype'. The menu is open, showing five options: '--None--' (which is selected and has a checkmark), 'New Data Connection', 'Deactivate Data Connection', 'Data Connection Error', and 'Data Connection Update'.

5. You will be required to populate certain fields based on the Issue Sub-Type and EHR your practice uses.



A screenshot of a form with three fields. The first field is labeled '* Issue Subtype' and contains the text 'New Data Connection'. The second field is labeled '* EHR System' and contains the text 'Compulink'. The third field is labeled '* Server Location' and contains the text 'Cloud-Hosted'.

6. To **submit** your case, click **Next**.



A screenshot of a button labeled 'Next'.

IRIS® Registry Renewal Services



The IRIS® Registry Renewal Services will be completed in the Community Portal. All contacts within your practice will see the following message when they access the Community Portal.

A screenshot of a web interface. At the top, a grey banner contains the text: "Verana Health is the American Academy of Ophthalmology's IRIS Registry® partner." followed by "Our Renewal Services for 2026 are now LIVE! Please follow the process below to complete". Below this is a white rectangular box with the text "Click Next below to begin Registry Renewal". In the bottom right corner of this box is an orange button labeled "Next".

Verana Health is the American Academy of Ophthalmology's IRIS Registry® partner.
Our Renewal Services for 2026 are now LIVE! Please follow the process below to complete

Click Next below to begin Registry Renewal

Next

Note: MIPS consultants will see multiple practices. The administrative contact for each practice is responsible for completing the Registry Renewal process.

The Community Portal is fully functional for all users regardless of Registry Renewal status.

To Complete the Registry Renewal Process

Access the Community Portal

To begin the Registry Renewal process, follow these steps:

1. On the **Community Portal's** home page on the **Registry Renewal** prompt, click **Next**.

A screenshot of the same web interface as above. A green arrow points from the right side of the white box towards the orange "Next" button.

Verana Health is the American Academy of Ophthalmology's IRIS Registry® partner.
Our Renewal Services for 2026 are now LIVE! Please follow the process below to complete

Click Next below to begin Registry Renewal

Next

2. The **Review Practice Details** page opens.

Verana Health is the American Academy of Ophthalmology's IRIS Registry® partner.
Our Renewal Services for 2026 are now LIVE! Please follow the process below to complete

Running User Details
Name: [Redacted]
Email: [Redacted]
Title: [Redacted]

Review Practice Details

Current EHR:
[Redacted]

* Will the practice's EHR be changing in the next year?
☒ Yes
☐ No

* Does the practice have a secondary EHR? ⓘ
☐ Yes
☐ No

* Practice Billing Address

Search Address: [Redacted] 🔍

* Country
United States ▼

* Street
9823 Happy Jack Road

* City
Cheyenne

* State/Province
Wyoming ▼

* Zip/Postal Code
82009

Review Practice Details

Complete all of the sections of the **Review Practice Details** page.

Current EHR

The current EHR for your practice is listed.

Current EHR:

[Redacted]

* Will the practice's EHR be changing in the next year?

- ☐ Yes
☐ No

* Does the practice have a secondary EHR? ⓘ

- ☐ Yes
☐ No

Complete the following questions by selecting **Yes** or **No**:

- Will the practice's ER be changing in the next year?
 - If you select **Yes**, an additional section will appear. Complete all of the fields:
 - Current EHR Deactivation Date
 - New EHR

■ New EHR Activation Date

* Will the practice's EHR be changing in the next year?

☒ Yes
☐ No

* Current EHR Deactivation Date

* New EHR

* New EHR Activation Date

- If you select **No**, you can move on to the next question.
- Does the practice have a secondary EHR?
 - If you select **Yes**, an additional section will appear. Complete the field:

■ Secondary EHR

* Does the practice have a secondary EHR? ⓘ

☒ Yes
☐ No

* Secondary EHR

- If you select **No**, you can move on to the next question.

Practice Billing Address

Review the Practice Billing Address section to ensure that the correct address is listed.

* Practice Billing Address

Search Address

* Country

United States

* Street

9823 Happy Jack Road

* City

Cheyenne

* State/Province

Wyoming

* Zip/Postal Code

82009

You can update the entire practice billing address in two ways:

1. **Search.** Enter the address into the **Search Address** field and select the correct address from the results to automatically populate the Practice Billing Address section.
2. **Manual Entry.** Enter the address information directly into the appropriate fields within the Practice Billing Address section.

Search Address

123

1235 Mission Street
San Francisco, CA, USA

123 Mission Street
San Francisco, CA, USA

123 Battery Street
San Francisco, CA, USA

1233 Polk Street
San Francisco, CA, USA

123 Townsend Street
San Francisco, CA, USA

powered by Google

Contacts

The contact information for all of the members of your practice should be listed in this section.

Note: MIPS consultants will not appear on this list since they are not a member of your practice.

Update Contacts

1. Review the information for each person on the **Contacts** list.
2. Click the **pencil icon** next to a field (column) you wish to edit.

	First Name	Last Name	Email	Inactive
1	Chris	B		☐
2	CB Climber	Email Test		☐
3	Larry	Bobbyw		☐
4	Test	August	 you@example.com	☐
5	Test	Test	 testcp@example.com	☐

3. Update the relevant information as needed:
 - First Name
 - Last Name
 - Email
 - Inactive
 - Billing Contact (a checkmark indicates this designation)
 - Dashboard Administrator Contact (a checkmark indicates this designation)
 - Technical Contact (a checkmark indicates this designation)
4. At the bottom of the list, Click **Save**.
5. To proceed to the next page, click **Next**.
6. The **Review Clinicians Details** page opens.

Add Contacts

1. At the bottom of the page, click **Add Contact**.

☐ Add Contact

2. Click **Next**.

☒ Add Contact

Next

3. The **Add Contact** page opens.

Add Contact
Fill out details below

Name

Salutation
--None--

First Name
First Name

Middle Name
Middle Name

Last Name
Last Name

Suffix
Suffix

*Email
you@example.com

☐ Billing Contact

☐ Dashboard Administrator Contact

☐ Technical Contact

☐ Wants Quality Measures Dashboard Access

☐ Cancel New Contact

Next

4. Complete the contact information details, and then click **Next** to save the contact information and add it to the Contacts list.

Review Clinician Details

Complete all of the sections of the **Review Clinician Details** page.

Running User Details
Name: Peaches Schweitzer
Email: bschweitzer77@gmail.com
Title:

Review Clinician Details

- Click the pencil icon to edit any details for the Clinicians below.
- Select appropriate participation status for Clinicians and add Inactive Date for discontinuing clinicians.
- Check the box below to add new Clinicians to your practice.

Clinicians (13)

	NPI	First Name	Middle Name ...	Last Name	Clinician Crede...	Participatio...	Clinician Active Date	Clinician Inactive ...	Primary Specia...
1	1234567890	Larry		Bobbyw	Od	Discontinue		Sep 1, 2025	
2	12345789	Bobbie		Bobbie Bobbie	TYTM	Discontinue		Apr 14, 2025	
3	6789876212	New		Gal		Discontinue	Dec 3, 2024	Apr 14, 2025	
4	1098765432	John TEST		Clinician	MD	Renew	Sep 28, 2024	Aug 13, 2025	
5	4567898765	Jane		Provider	PhD	Renew	Oct 3, 2024		
6	0987656789	Peoni		Prove		Renew	Sep 21, 2024		
7	5678987643	New		Prov1		Renew	Oct 8, 2024		

The contact information for all of the clinicians in your practice should be listed in this section.

Update Clinicians

1. Review the information for each person on the **Clinicians** list.
2. Click the **pencil icon** next to a field (column) you wish to edit.
3. Update the relevant information as needed:
 - NPI
 - First Name
 - Middle Name
 - Last Name
 - Clinician Credentials
 - Participation Status (indicates IRIS® Registry participation)
 - None
 - Renew (prompted to add **Active Date**)
 - Discontinue (prompted to add **Inactive Date**)
 - New (prompted to add **Active Date**)
 - Clinician Active Date (indicates IRIS® Registry participation active date)
 - Clinician Inactive Date (indicates IRIS® Registry participation inactive date)
 - Primary Specialty
4. At the bottom of the list, Click **Save**.
5. To proceed to the next page, click **Next**.
6. The **Please finalize your information below** page opens.

Note: If the **Required Clinician Details Missing** page opens, use the pencil icon next to the field (column) to update missing information (as indicated in the message above the list), click **Save**, and then click **Next**.

Required Clinician Details Missing

Ensure that the follow is correct

1. Discontinuing Clinicians have a Clinician Inactive Date
2. New Clinicians have a Clinician Active Date

Instructions for updating missing details

	NPI	First Name	Middle Name or Initial	Last Name	Clinician Cre...	Participation Status	Clinician Active Date	Clinician Inactive Date	P.
1						New	Nov 1, 2025	Nov 7, 2025	C
2						New			C

Format: Dec 31, 2024

Cancel Save

Next

Add Clinician

- 1. At the bottom of the page, click **Add Clinician**



- 2. Click **Next**.
- 3. The **Add Clinician** page opens.
- 4. Complete the clinician information details, and then click **Next** to save the clinician information and add it to the Clinicians list.

Finalize Details

Review the information on this page.

Running User Details

Name:

Email:

Title:

Please finalize your information below!

Once you've verified your details please select a contact at your practice to receive a participation agreement.

Practice changing EHR: No

Secondary EHR: No

Practice changing PM System:

Final Review Contact Details

	First Name	Middle Name	Last Name	Inactive	Billing Contact	Dashboard Administrator...	Technical Contact
1	Chris		B				✓
2	CB Climber		Email Test			✓	
3	Larry		Bobbyw				
4	Test		August				
5	Test		Test				
6	Holly		Baldwin		✓		
7	Dalal		Test				
8	Holly		Test				

Final Review Clinician Details

	NPI	First Name	Middle Name ...	Last Name	Clinician Crede...	Participation S...	Clinician Active Date	Clinician Inactive ...	Primary Specia...
1	2345678667	James		Clinician		Renew			
2	1098765432	John TEST		Clinician	MD	Renew	Sep 28, 2024	Aug 13, 2025	
3	4567898765	Jane		Provider	PhD	Renew	Oct 3, 2024		
4	0987656789	Peoni		Prove		Renew	Sep 21, 2024		
5	5678987643	New		Prov1		Renew	Oct 8, 2024		
6	6789876543	Henry	P	Test	MD	Renew	Jan 1, 2025		
7	3098709876	Jane		Clinician		Renew	Sep 1, 2024		
8	9276912983	Eric		Clin		Renew	Sep 16, 2024		
9	1234565432	Test		Clin Support Site		New	Apr 1, 2025		
10		Test Aug		Com Port		New	Sep 1, 2025		
11	12345	Test		COM PORT		New	Sep 1, 2025		

* Details Correct?

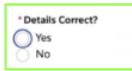
Yes

No

Next

Note: Clinicians with a **Discontinued Participation Status** will not appear on this list.

Complete the **Details Correct?** section at the bottom of the page by selecting **Yes** or **No**.

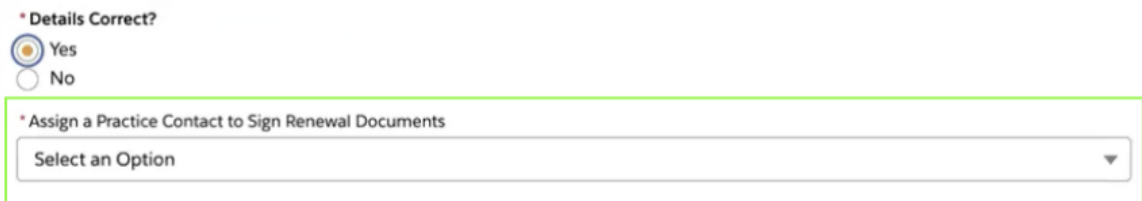


* Details Correct?
☒ Yes
☐ No

Next

Select Yes

1. If you select **Yes**, you will receive a prompt to **Assign a Practice Contact to Sign Renewal Documents**.



* Details Correct?
☒ Yes
☐ No

* Assign a Practice Contact to Sign Renewal Documents
Select an Option ▼

2. Select a practice contact option from the dropdown menu.

Note: MIPS consultants will not be an available option for this section as they cannot sign for the practice.

3. Click **Next**.
4. The **AAO Membership Status** page opens.

Select No

1. If you select **No**, you will receive the following prompt:

Note: We noticed you indicated “no” your details are incorrect. When you click “Next” you’ll be brought back to the Start to redo this Renewal Form.”



* Details Correct?
☐ Yes
☒ No

Note: We noticed you indicated “No” your details are incorrect. When you click “Next” you’ll be brought back to the Start to redo this Renewal Form.

2. Click **Next**.

Note: The previous updates are present when you navigate to the Start page.

3. Navigate to the appropriate page(s) to update incorrect information.

AAO Membership Status

This page provides an overview of the AAO Membership Status for AAO membership dues after you finalize the details for the practice.

Note: If the record indicates that membership fees are outstanding for any of your clinicians, please contact AAO Support directly to remit payment.

AAO Membership Status

Good news, according to our records these clinicians are in good standing with their AAO Membership dues and are ready for submission!

Related Clinicians Records (9)

Clinician Name	Medical Association Member ID	Registry Membership Status
		✓
		✓
		✓
		✓
		✓
		✓
		✓
		✓
		✓

According to our records the Clinicians below are due for their membership fees. Please reach out to AAO Support directly to resolve any outstanding dues.

Related Clinicians Records (1)

Clinician Name	Medical Association Member ID	Registry Membership Status
1		

Next

To correct inaccurate membership dues information (e.g., the record shows outstanding fees despite payment), please contact AAO directly for resolution.

1. Click **Next** to continue.
2. Choose the plan that works for your practice.
 - **Basic** (no additional fee). This plan includes:
 - Assigned Practice Experience Manager (PEM)
 - Support via email
 - Ticket support via online platform
 - Determine practice setup/reporting needs/eligibility
 - Coordination with EHR vendors
 - Submission assistance
 - **Coaching** (standard list price, contact Verana Health for pricing). This plan includes:
 - Monthly meetings to review data on practice-specific MIPS categories
 - MIPS training session to help your team understand program requirements

- Guidance on best practices for improving performance on selected measures
 - Assistance with measure selection
 - Ongoing support via email or phone
 - Personalized support for ticket submission
 - Continuous performance monitoring throughout the reporting period
 - Data validation guidelines to ensure accuracy and completeness
 - Personalized, guided MIPS submission
 - Penalty avoidance when the established protocol is followed
- **Advisory** (standard list price, contact Verana Health for pricing). This plan includes:
 - Access to training materials
 - Run and review measure reports to validate performance
 - Comprehensive quality data validation
 - Internal ticket submission management
 - Audit preparation and ongoing support during CMS reviews
 - High rating potential and maximum positive payment adjustment when the established protocol is followed
 - Direct EHR access for independent data validation and performance audits
 - Flexible Verana Health internal deadlines

Choose the plan that works for your practice

Basic	Coaching	Advisory
- Assigned Practice Experience Manager (PEM) - Support via email - Ticket support via online platform - Determine practice setup/ reporting needs/eligibility - Coordination with EHR vendors - Submission assistance	Includes all Basic features plus: - Monthly meetings to review data on practice-specific MIPS categories - MIPS training session to help your team understand program requirements - Guidance on best practices for improving performance on selected measures - Assistance with measure selection - Ongoing support via email or phone - Personalized support for ticket submission - Continuous performance monitoring throughout the reporting period - Data validation guidance to ensure accuracy and completeness - Personalized, guided MIPS submission - Penalty avoidance when the established protocol is followed	Includes all Coaching features plus: - Access to training materials - Run and review measure reports to validate performance - Comprehensive quality data validation - Internal ticket submission management - Audit preparation and ongoing support during CMS reviews - High rating potential and maximum positive payment adjustment when the established protocol is followed - Direct EHR access for independent data validation and performance audits - Flexible Verana Health internal deadlines
Included in Registry Agreements	Contact Us for Pricing →	Contact Us for Pricing →

Product Name	Standard List Price
☐ MIPS Basic Services 2026	\$0.00
☐ MIPS Coaching Services 2026	\$1,500.00
☐ MIPS Advisory Services 2026	\$2,500.00
Clear Selection	

3. To select an option, mark the appropriate button, and then the **Estimated Total Renewal Price** for enrolling all active clinicians at your practice displays.

- **MIPS Basic Services 2026**

This service is included at no additional cost

Product Name	Standard List Price
☒ MIPS Basic Services 2026	\$0.00
☐ MIPS Coaching Services 2026	\$1,500.00
☐ MIPS Advisory Services 2026	\$2,500.00

[Clear Selection](#)

Active Clinician Count: 11
Estimated Total Renewal Price: \$0.00

The above estimate includes all active clinicians at your practice for the selected service.
If not enrolling all active clinicians, please uncheck the checkbox below and provide additional comment.

☒ Enrolling all active clinicians ⓘ

[Next](#)

- **MIPS Coaching Services 2026**

This service at Standard List Price is an additional \$1,500 per clinician.

Estimated Total Renewal Price is the price to include all active clinicians in your practice (e.g., \$1,500 per clinician x 11 active clinicians = \$16,500 estimated total).

Product Name	Standard List Price
☐ MIPS Basic Services 2026	\$0.00
☒ MIPS Coaching Services 2026	\$1,500.00
☐ MIPS Advisory Services 2026	\$2,500.00

[Clear Selection](#)

Active Clinician Count: 11
Estimated Total Renewal Price: \$16,500.00

The above estimate includes all active clinicians at your practice for the selected service.
If not enrolling all active clinicians, please uncheck the checkbox below and provide additional comment.

☒ Enrolling all active clinicians ⓘ

- **MIPS Advisory Services 2026**

This service at Standard List Price is an additional \$2,500 per clinician.

Estimated Total Renewal Price is the price to include all active clinicians in your practice (e.g., \$2,500 per clinician x 11 active clinicians = \$27,500 estimated total).

- If not enrolling all active clinicians, please uncheck the checkbox below and provide an additional comment.

Active Clinician Count: 11
Estimated Total Renewal Price: \$0.00

The above estimate includes all active clinicians at your practice for the selected service.
If not enrolling all active clinicians, please uncheck the checkbox below and provide additional comment.

☒ Enrolling all active clinicians ⓘ

- Enter your comment in the **Additional Comment** field.

☐ Enrolling all active clinicians ⓘ

Additional Comment

Next

Note: When the menu appears, you can use the auto-fill prompts to populate the **Additional Comment** field. After selecting a prompt, you can edit the text to include specific details, such as the number or name of clinicians.

Clear Selection

Active Clinician

Estimated Total

The above estimate includes all active clinicians at your practice for the selected service.
If not enrolling all active clinicians, please uncheck the checkbox below and provide additional comment.

☐ Enrolling all active clinicians ⓘ

Additional Comment

I only want test clinician #45...

I would like to remove 1 clinician (dr. clinician) X

I want a discount! I have a lot of...

I want Clinician 2 to receive...

I want advisory service for 1...

Why is it 0??? it should be li...

I would like to remove 1 clinician (dr. clinician)

Note: Verana Health will process any necessary pricing adjustments only after the completed Registry Renewal is received, as indicated by comment instructions.

- Click **Next** to continue.
- After the next page opens, click **Finish**.

Thank you for confirming your details and selecting a service.

We appreciate your continued participation in the American Academy of Ophthalmology's IRIS® Registry.
After you click "Finish," we'll send an updated Participation Agreement to your designated contact via DocuSign for signature.
Please complete the renewal by January 31, 2026

Finish

- Registry Renewal is complete. The **Participation Agreement** will be sent to your designated contact via DocuSign for signature.

Registry Renewal Complete!

A Practice Experience Manager will be sending a package for signature to the email address provided.

Support FAQs



Patient does not meet on the encounter date showing in VQM

The date a patient is showing for is the date of the first denominator eligible encounter.

Patient has multiple MRNs

A patient will have multiple MRNs if your practice has added or switched EHRs within the measurement year.

Patient is duplicated (on visit/procedure based measures)

The measure specifications are allowing patients to be included more than once per measurement period.

Patient is duplicated (on patient based measure)

Patients will be included in the denominator for every provider and/or location associated with a denominator eligible visit within the measurement period. In order to deduplicate these patients based on planned Group submissions, please create a Custom Group on your dashboard.

My Custom Group isn't showing data

It takes 24 hours for Custom Group data to populate on your dashboard after being created. If it has been 24 hours, please ensure the locations and clinicians selected should have data populated (e.g., make sure clinicians A & B did have relevant data documented with locations 1 & 2).

"Plan of care" is documented, but my patient is not meeting (could be any data component that requires keyphrase curation)

Locate approved keyphrases held in the community portal. It is recommended that practices use one of the approved keyphrases.

My provider is missing

Please ensure your provider is set up correctly in your EHR database and has billed CPT® codes relevant to measures for the current reporting year.

My provider has low or missing data

Please ensure your provider has billed CPT codes relevant to measures for the current reporting year.

My location is missing

Please ensure your location is set up correctly in your EHR database and has billed CPT codes relevant to measures for the current reporting year.

My location has low or missing data

Please ensure your location has billed CPT codes relevant to measures for the current reporting year.

I have no cataract measures

Please ensure your providers are documenting the required CPT codes per the measure specification and anatomical modifiers (RT or LT) within the EHR system.



Verana Quality Measures Dashboard User Guide: Manual Data Entry v3.0

May 2024

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Manual Data Entry Introduction



This user guide provides practice and clinical administrators who do not have an EHR or use an EHR that does not integrate EHR data into the Registry platform, instructions for using the Verana Quality Measures Dashboard Manual Data Entry feature to manually populate, modify, delete, and view quality measures data for quality reporting through MIPS.

Administrator-level users can download a template from the manual data entry dashboard and upload a patient list to attribute quality measure performance to those patients and their associated visits.

Recommended Browsers

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

Practice Support

Contact Verana Health Practice Experience via a Support Ticket, email request to datalink@veranahealth.com, or call 877-VERANA-1.

- Enable Manual Data Entry feature
- Help with your Verana Quality Measures Dashboard
- Help with logging in
- Reset password
- Modify practice clinicians

Manual Data Entry – Administrator Level



Participant Practice and Clinical Administrators

Administrator-level users signed in to the Verana Quality Measures Dashboard can manually enter, modify, and upload patient data.

Enable Manual Data Entry Functionality

To enable Manual Data Entry functionality, Participant Practice Administrators or Clinical Administrators should contact Verana Health Practice Experience via a Support Ticket, email request to datalink@veranahealth.com, or call 877-VERANA-1. Once you receive access to this feature, go to your Verana Quality Measures Dashboard and log in.

Get Started

For **step-by-step instructions** on how to log in, work with Okta, and set your dual-factor authentication to go to your text messages rather than your email, please see the companion guide: [Verana Quality Measures Dashboard User Guide: Logging In](#).

1. Go to <https://vqm.veranahealth.com>.
2. In the **Sign in** dialog, enter your **Username** and **Password**, and then click **Sign in**.

A screenshot of the Verana Health Sign In dialog. At the top is the Verana Health logo. Below it is the title "Sign In". There are two input fields: "Username" with the text "practiceadmin@practicehealth.com" and a small icon to the right, and "Password" which is empty and also has a small icon to the right. Below the password field is a red error message: "Please enter a password". There is a checkbox labeled "Remember me" which is currently unchecked. At the bottom is a blue button labeled "Sign In". Below the button is a link that says "Need help signing in?".

Verana Health

Sign In

Username

practiceadmin@practicehealth.com

Password

Please enter a password

☐ Remember me

Sign In

Need help signing in?

3. The **Verana Quality Measures** landing page opens, and you can continue to the next steps.

IRIS® Registry Quality Measures
The American Academy of Ophthalmology IRIS Registry (Intelligent Research in Sight)

Practice: Select Practice | Locations: All Locations (8) | Clinicians: All Clinicians (8) | Custom Groups: --None Applied-- | Date Range: Select Date

Show Measures: With Data | Search | Filters | DOWNLOAD CSV

Welcome 🎉

Your new quality measures dashboard from Verana Health is ready.

Select your practice from the 'Practices' dropdown to get started.

Data Last Updated on 03-23-2023 ⓘ

Access Manual Data Entry

To access the **Manual Data Entry** feature of the **Verana Quality Measures Dashboard** application, follow these steps:

1. Select a **Practice** from the **Practices** dropdown menu.

Practice: Select Practice | Locations: All Locations (8) | Clinicians: All Clinicians (8)

2. Click **Update Measure Data**.

Verana Quality Measures Dashboard | Help & Documentation ⓘ

IRIS® Registry Quality Measures
The American Academy of Ophthalmology IRIS Registry (Intelligent Research in Sight)

Practice: A&B Eye Assoc... | Locations: All Locations (8) | Clinicians: All Clinicians (8) | Custom Groups: --None Applied-- | Date Range: 2024

Show Measures: With Data | Search | Filters | DOWNLOAD CSV

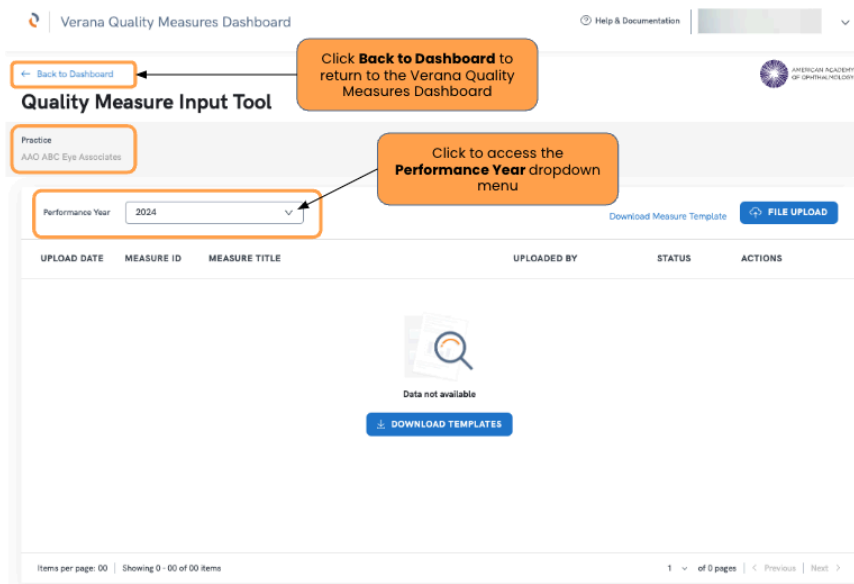
Click Update Measure Data → Update Measure Data

ROWID	TYPE	ID	MEASURE	MEASURE TYPE	BENCHMARK	PERFORMANCE RATE	STATUS

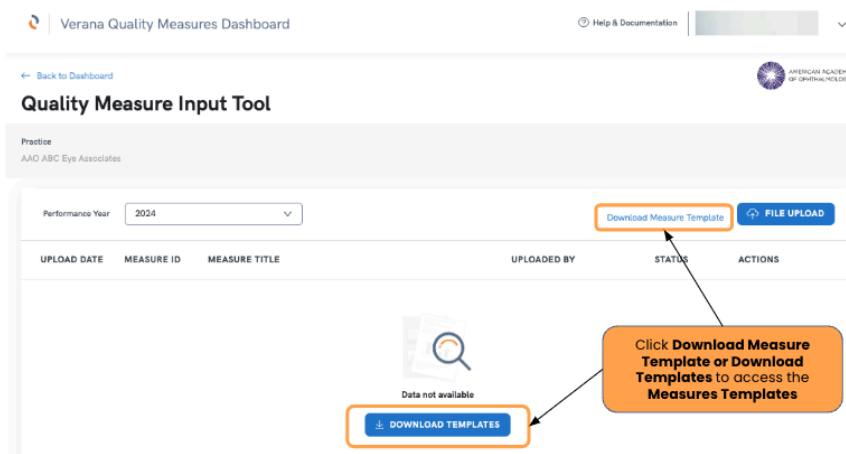
Note: If the **Update Measure Data** is **not** displayed, or if you believe you are receiving the **Data not available message** as an error, click **support ticket** to request additional assistance.

3. The **Quality Measures Input Tool** page opens, and the **Practice** field is pre-populated with the practice that you selected on the previous page. The current year displays in the **Performance Year** field. Use the dropdown menu to change the year.

Note: The **Practice** field is disabled on this page. If you need to change this field, click **Back to Dashboard** to update.



4. To access the **Measures Templates**, click **Download Templates** or **Download Measure Templates**.



5. In the **Download Measure Templates** dialog, follow these steps:

- a. Search for a specific template by entering keywords (e.g., eCQM, QPP, QCDR), or select a template from the measures listed in the table.

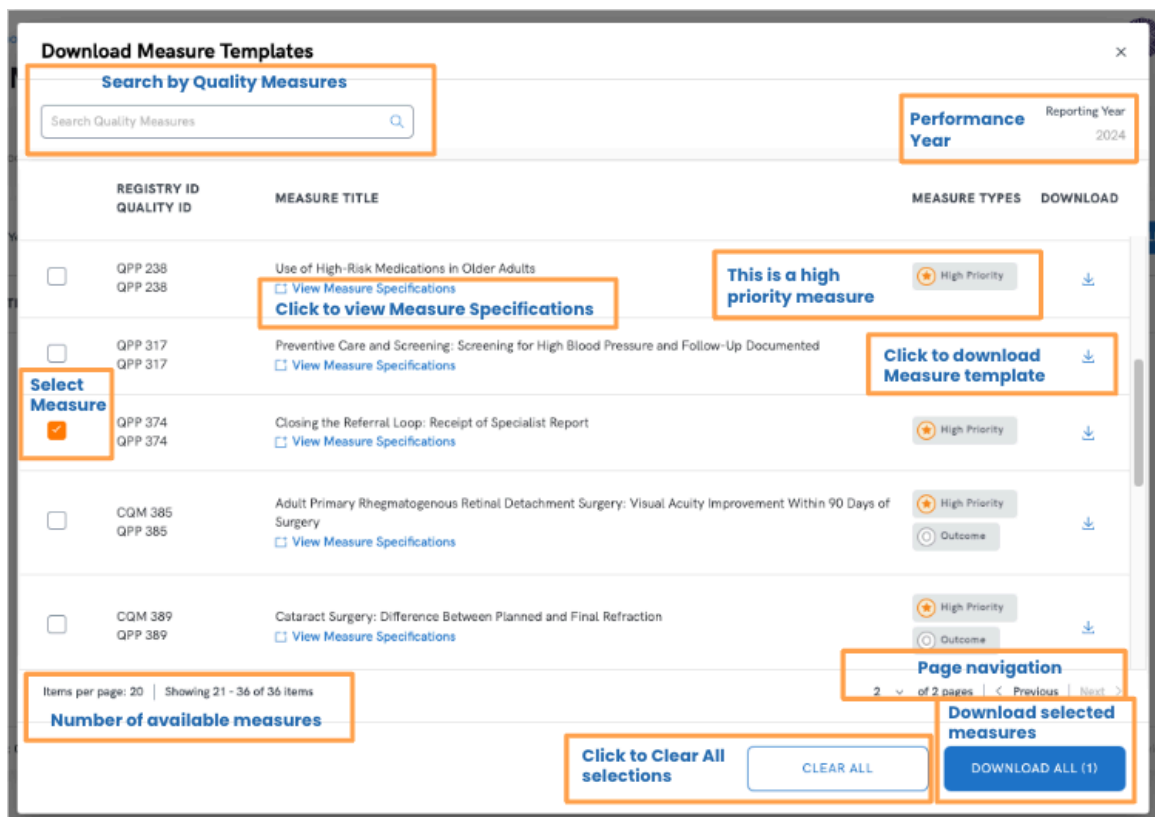
Note: The number of available measures is displayed at the bottom of the page. If more than one page is available, click **Next** at the bottom right to view additional measure templates.

- b. To download a template for a single measure, click the download icon  in the **Download** column for the specific measure.

or

- c. To download templates for multiple measures, choose the measures by marking the box next to each measure, and then click **Download All**.

Note: To view the specification associated with a measure, click **View Measure Specifications** below a measure title.



The screenshot shows the 'Download Measure Templates' dialog with the following highlighted elements:

- Search by Quality Measures:** A search bar at the top left.
- Performance Year:** A dropdown menu at the top right set to '2024'.
- Table Headers:** 'REGISTRY ID QUALITY ID', 'MEASURE TITLE', 'MEASURE TYPES', and 'DOWNLOAD'.
- Measure 1 (QPP 238):** 'Use of High-Risk Medications in Older Adults'. Callouts include 'This is a high priority measure' (pointing to a star icon) and 'Click to view Measure Specifications' (pointing to a link).
- Measure 2 (QPP 317):** 'Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented'. Callout: 'Click to download Measure template' (pointing to a download icon).
- Measure 3 (QPP 374):** 'Closing the Referral Loop: Receipt of Specialist Report'. Callout: 'Select Measure' (pointing to a checkbox).
- Measure 4 (CQM 385):** 'Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery'. Callouts: 'High Priority' (star icon) and 'Outcome' (cyclical icon).
- Measure 5 (CQM 389):** 'Cataract Surgery: Difference Between Planned and Final Refraction'. Callouts: 'High Priority' (star icon) and 'Outcome' (cyclical icon).
- Footer:** 'Items per page: 20 | Showing 21 - 36 of 36 items' and 'Number of available measures'.
- Page navigation:** '2 of 2 pages | < Previous | Next >'.
- Action Buttons:** 'Click to Clear All selections' (with a 'CLEAR ALL' button), 'Download selected measures' (with a 'DOWNLOAD ALL (1)' button), and 'Download selected measures'.

Excel Quality Measure Templates

Use the Excel Quality Measure templates to enter patient protected health information (PHI), clinician information, and to answer questions related to the patient visit that you can upload into the Verana Quality Measures Dashboard with the Manual Data Entry feature. The spreadsheets provide:

- The measure name with a link to the measure specifications.
- The description for the measure.
- Multiple sections with fields that you will populate with the patient and clinician information:
 - [Demographics](#)
 - [Eye](#)
 - [Identifiers](#)
- Multiple sections with fields related to the measure specifications for the patient visit that you will populate with **Yes** or **No** from a dropdown menu:
 - Denominator/Initial Population
 - Denominator Exclusion
 - Numerator
 - Denominator Exception
 - Numerator Not Met

The spreadsheets have built-in data validation rules that restrict the type of data that can be entered into each field.

Before you begin to enter information into the spreadsheet, please review the following guidelines:

- It is recommended that you use Excel to open the spreadsheet to ensure that the format/formulas/automation are present in the templates.
- Do not leave any answer fields blank for patient demographics and identifiers. If any Yes/No measure criteria questions are left blank, the assumed answer will be **No**. Make sure that you enter the appropriate information and answer all questions.
- Do not enter information that is not accurate. Make sure that you answer the questions accurately based on the patient's record and the question presented.
- Do not remove or insert columns or headings on the spreadsheet.
- Do not modify or rearrange cell formulas or validation rules.
- Do not hide/unhide columns or cells.
- Do save your progress regularly while you enter information to avoid any potential data loss. You can save the file in XLSX format. You might also consider backing up the spreadsheet to prevent accidental deletions or modifications.
- Do prioritize data privacy and security. Make sure that the spreadsheets are stored on a secure, password-protected device and that access is restricted to authorized personnel only. Avoid sharing protected health information (PHI) outside of the designated system or with individuals who do not have the appropriate clearance.

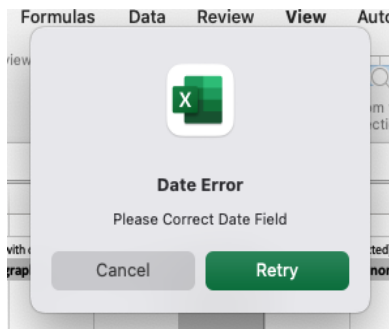
Patient and Clinician Information

Enter PHI

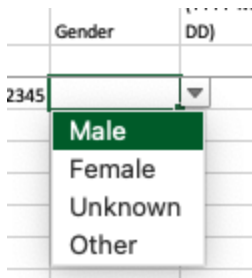
To enter PHI into the Excel Quality Measure templates for each patient record, go to **line 6**, and follow these instructions for the fields in each section.

Demographics

1. **Patient First Name.** Enter the patient's first name.
2. **Patient Last Name.** Enter the patient's last name.
3. **DOB (YYYY-MM-DD).** Enter the patient's date of birth in the **YYYY-MM-DD** or **MM-DD-YY** format (you must include hyphens [-] or slashes [/]). The date must be valid. An incorrect format may result in a validation error that will display an alert.



4. **MRN.** This is the medical record number. Enter the unique identifier assigned to the patient's medical record.
5. **Gender.** Select **Male**, **Female**, **Unknown**, or **Other** from the dropdown menu.



6. **Visit Date (YYYY-MM-DD).** Enter the patient's date of visit in the **YYYY-MM-DD** or **MM-DD-YY** format (you must include hyphens [-] or slashes [/]). The date must be valid. An incorrect format may result in a validation error that will display an alert.

Eye

If the patient eye does not need to be specified for the measure, the column will be grayed out. Select **N/A** from the dropdown menu.

Note: This is a required field. If the field is grayed out and not applicable, you must still select **N/A** from the dropdown menu.

A screenshot of a web form. The 'Eye' field is highlighted in gray, indicating it is not applicable. A dropdown menu is open, showing 'N/A' as the selected option. The 'Pro' field is also visible and grayed out.

If the patient eye needs to be specified for the measure, select **OD** or **OS** from the dropdown menu.

A screenshot of a web form. The 'Eye' field is active, and a dropdown menu is open, showing 'OD' and 'OS' as options. The 'Pro' field is also visible and grayed out.

Identifiers

1. **Provider NPI.** Enter a valid numeric 10-digit individual NPI for the healthcare clinician associated with the patient's visit. This is specific to the practice location.
2. **Location ID:** Enter the unique identifier for the location where the patient's visit took place. This is specific to the practice location.

Note: A practice may choose any naming convention. If the practice has multiple locations where visits occur, it is recommended that the practice use a different naming convention for each location.

Measure Specifications Information

After you enter the patient and clinician information, you will move on to the following sections related to the measure specifications for the patient visit that you will populate with **Yes** or **No** in the corresponding fields from dropdown menus:

- Denominator/Initial Population
- Denominator Exclusion
- Numerator

- Denominator Exception
- Numerator Not Met

Note: The spreadsheet may automatically populate a question based on certain conditions or formulas (e.g., questions for age during the patient visit which is automatically calculated). If a measure specifications question is left blank, it is treated as **No** when processed.

Denominator/Initial Population		Numerator	Numerator Not Met
Is the patient 18 years or older?	Does the patient have a diagnosis of involution entropion ?	Did the patient have a surgery for their involtuion entropion?	Did the patient NOT ha a normalized lid positio within 90 days postoperatively?
ICD/CPT Codes	(ICD-10: H02.031, H02.03	(CPT: 67950, 67917, 67924, 67961, 67966)	
Yes	No Yes		
	Input Error - Select/Enter Yes or No		

Upload Quality Measure Patient Data Files

To upload the quality measure patient data files in the **Quality Measures Input Tool** page of the **Verana Quality Measures Dashboard**, follow these steps:

Note: For added security, a virus scan is implemented as part of the upload process.

1. On the **Quality Measures Input Tool** page, click **File Upload**.

Verana Quality Measures Dashboard

Help & Documentation

Back to Dashboard

Quality Measure Input Tool

Practice
AAD ABC Eye Associates

Performance Year: 2024

Download Measure Template

FILE UPLOAD

UPLOADED BY

STATUS

ACTIONS

Data not available

DOWNLOAD TEMPLATES

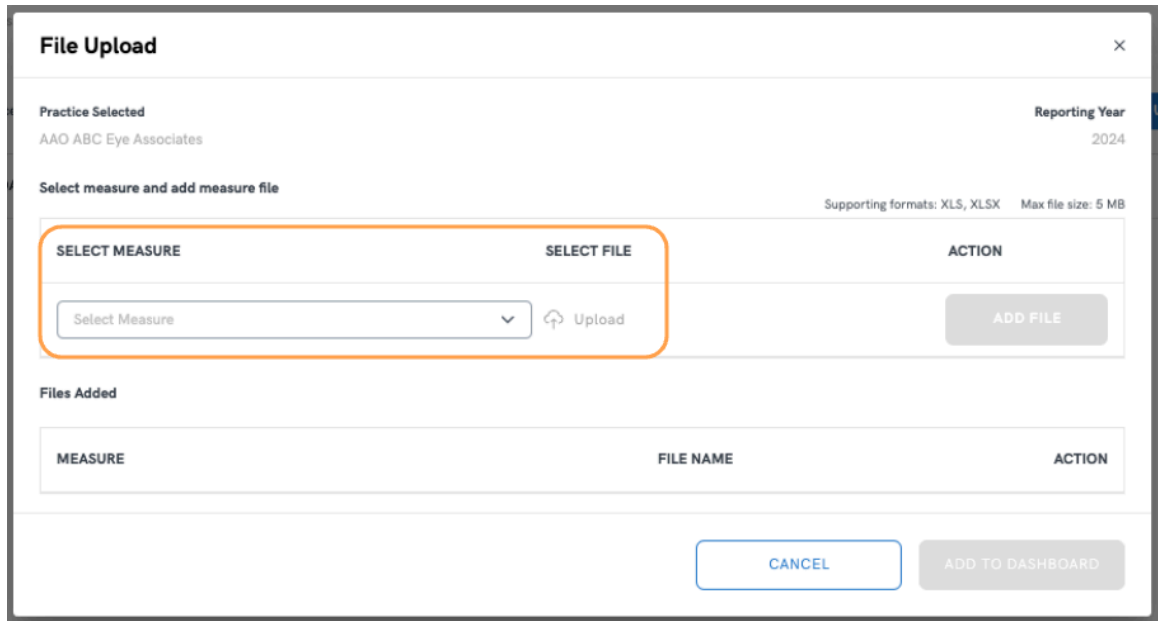
Click File Upload

Items per page: 00 | Showing 0 - 00 of 00 items

1 of 0 pages | Previous | Next

- In the **File Upload** dialog, go to the **Select Measure** field, and then select the quality measure patient data file that you saved on your computer or network files.

Note: The supported file formats are **XLSX, XLS, and OpenOffice**. The file size should not exceed 5 MB.



File Upload [X]

Practice Selected: AAO ABC Eye Associates Reporting Year: 2024

Select measure and add measure file Supporting formats: XLS, XLSX Max file size: 5 MB

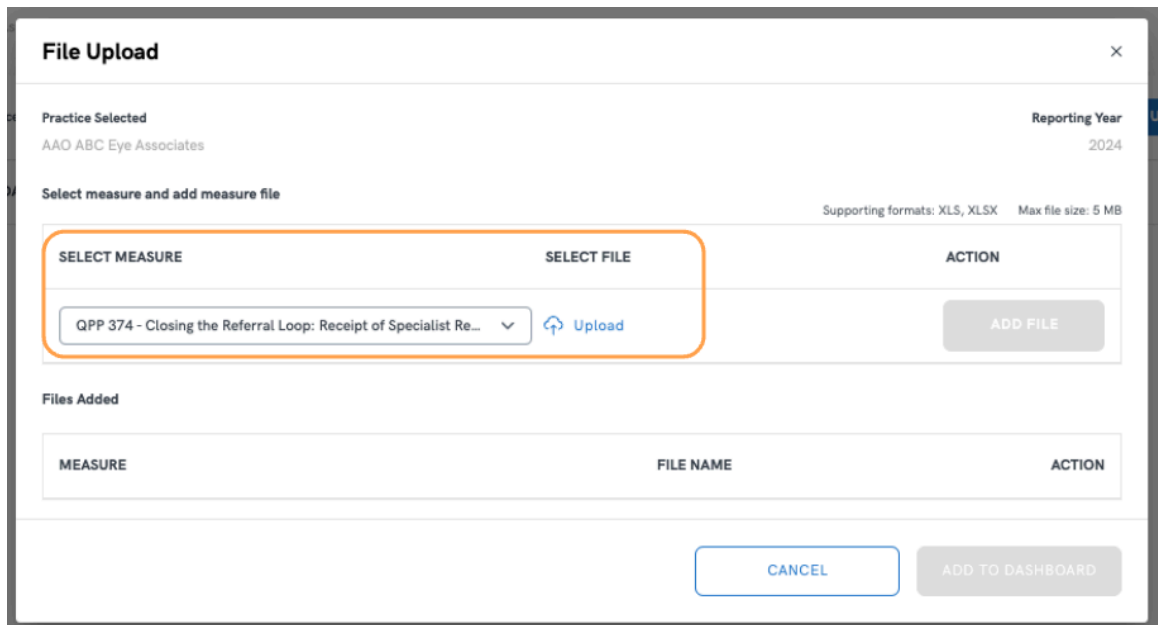
SELECT MEASURE	SELECT FILE	ACTION
Select Measure	Upload	ADD FILE

Files Added

MEASURE	FILE NAME	ACTION

CANCEL ADD TO DASHBOARD

- Click **Upload**.



File Upload [X]

Practice Selected: AAO ABC Eye Associates Reporting Year: 2024

Select measure and add measure file Supporting formats: XLS, XLSX Max file size: 5 MB

SELECT MEASURE	SELECT FILE	ACTION
QPP 374 - Closing the Referral Loop: Receipt of Specialist Re...	Upload	ADD FILE

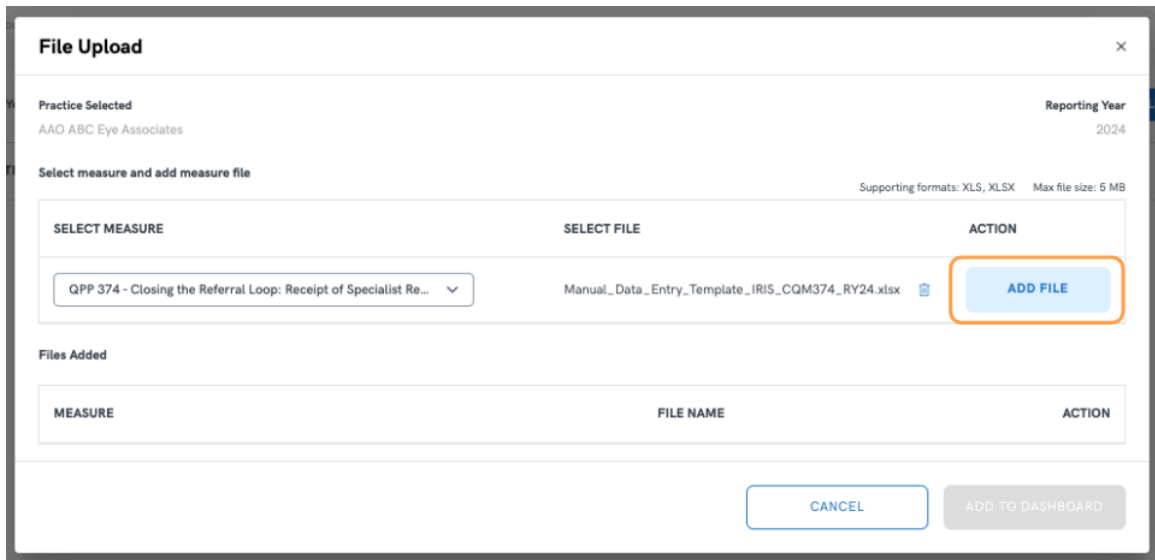
Files Added

MEASURE	FILE NAME	ACTION

CANCEL ADD TO DASHBOARD

4. Click **Add File**.

Note: If you do not want to add this file, click the trash can  icon to delete the file.



File Upload [X]

Practice Selected: AAO ABC Eye Associates Reporting Year: 2024

Select measure and add measure file Supporting formats: XLS, XLSX Max file size: 5 MB

SELECT MEASURE	SELECT FILE	ACTION
QPP 374 - Closing the Referral Loop: Receipt of Specialist Re...	Manual_Data_Entry_Template_IRIS_CQM374_RY24.xlsx 	ADD FILE

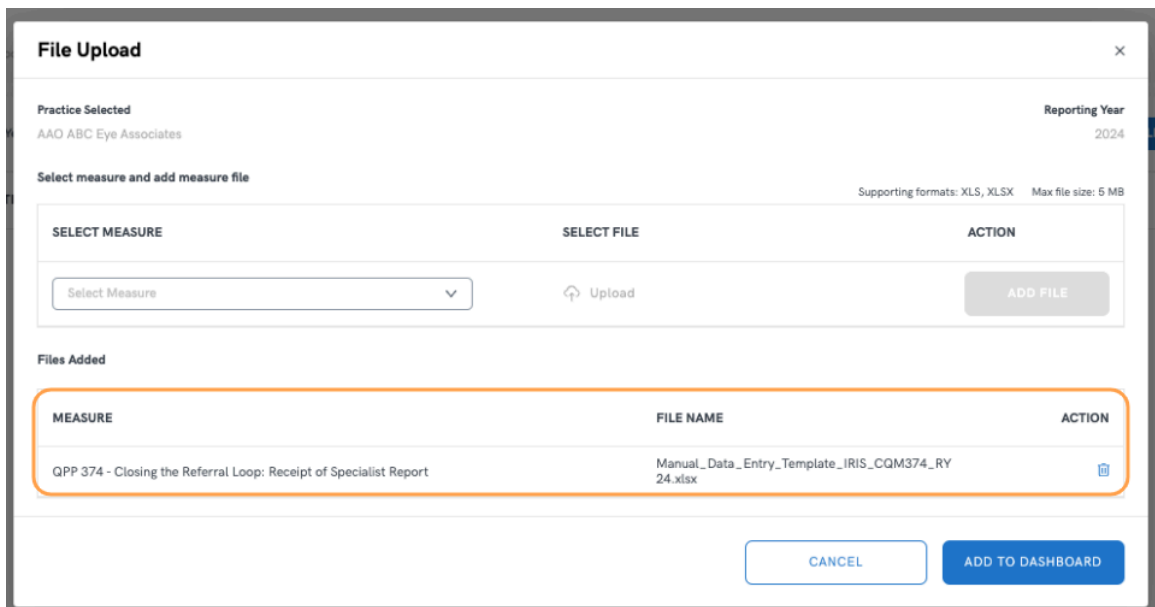
Files Added

MEASURE	FILE NAME	ACTION

[CANCEL] [ADD TO DASHBOARD]

5. The file appears in the **Files added** section. To add additional files, repeat steps [2](#) through [4](#). If you are done adding files, continue to the next step.

Note: If you do not want to add this file, click the trash can  icon to delete the file.



File Upload [X]

Practice Selected: AAO ABC Eye Associates Reporting Year: 2024

Select measure and add measure file Supporting formats: XLS, XLSX Max file size: 5 MB

SELECT MEASURE	SELECT FILE	ACTION
Select Measure	 Upload	ADD FILE

Files Added

MEASURE	FILE NAME	ACTION
QPP 374 - Closing the Referral Loop: Receipt of Specialist Report	Manual_Data_Entry_Template_IRIS_CQM374_RY24.xlsx 	

[CANCEL] [ADD TO DASHBOARD]

6. Click **Add to Dashboard**.

File Upload

Practice Selected: AAO ABC Eye Associates Reporting Year: 2024

Select measure and add measure file

Supporting formats: XLS, XLSX Max file size: 5 MB

SELECT MEASURE	SELECT FILE	ACTION
Select Measure	Upload	ADD FILE

Files Added

MEASURE	FILE NAME	ACTION
QPP 374 - Closing the Referral Loop: Receipt of Specialist Report	Manual_Data_Entry_Template_IRIS_CQM374_RY24.xlsx	

CANCEL ADD TO DASHBOARD

7. An **Upload Confirmation** pop-up window appears “You have successfully uploaded the following files: *[list of files]*.”

Upload Confirmation

You have successfully uploaded the following files:

- Manual_Data_Entry_Template_IRIS_CQM374_RY24.xlsx

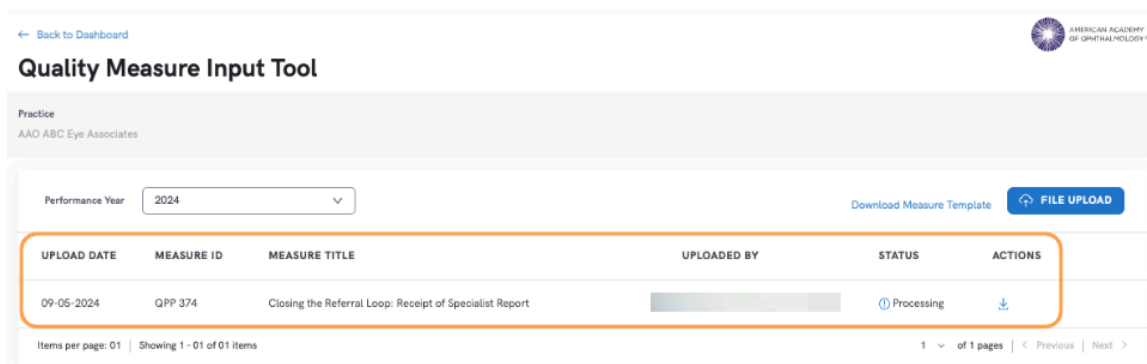
CLOSE

Click **Close**.

If there are any validation errors in the file, such as the wrong reporting year or template, notes with the specific error(s) and steps to take to resolve the error(s) will display.

8. The **Status** of the file upload is **Processing** and will change to **Available** when the upload process is complete (usually within 72 hours).

Tip: In the **Actions** column, you can download the file by clicking the download  icon.



← Back to Dashboard

Practice
AAO ABC Eye Associates

Performance Year: 2024

Download Measure Template

FILE UPLOAD

UPLOAD DATE	MEASURE ID	MEASURE TITLE	UPLOADED BY	STATUS	ACTIONS
09-05-2024	QPP 374	Closing the Referral Loop: Receipt of Specialist Report		Processing	

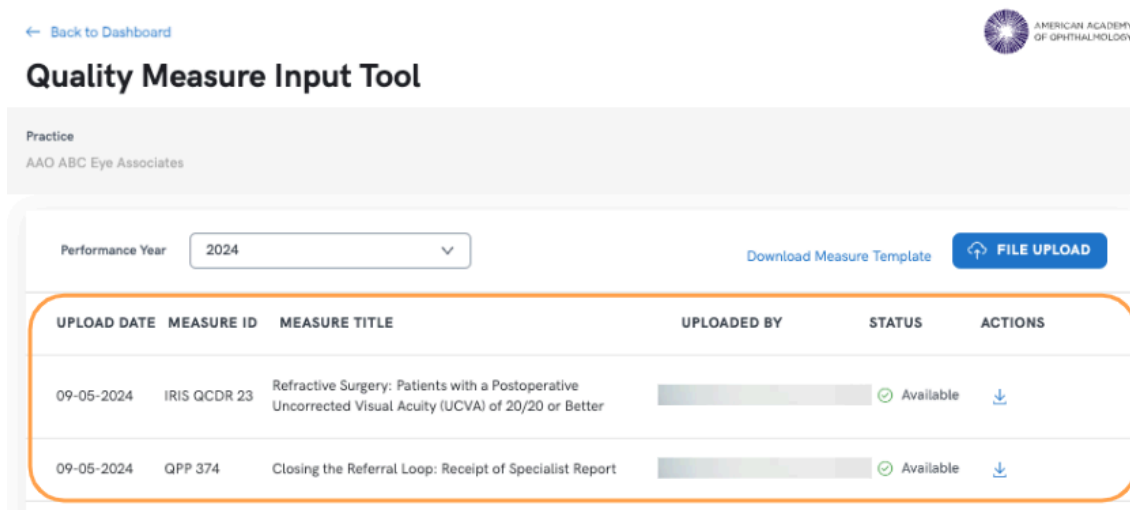
Items per page: 01 | Showing 1 - 01 of 01 items

1 of 1 pages | < Previous | Next >

Note: The **Status** of the file upload is **Processing Failed** if there are issues with the uploaded file, such as incorrect dates or system errors. Check to make sure that you are using the correct template for the reporting year and that the template is filled out correctly before attempting to upload the file again.

UPLOAD DATE	MEASURE ID	MEASURE TITLE	UPLOADED BY	STATUS	ACTIONS
2024-03-07	CQM 128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan		Processing Failed	

9. All of the files that you upload will appear on the **Quality Measures Input Tool** page. After the file **Status** becomes **Available**, the associated data will be reflected in the Verana Quality Measures Dashboard.



← Back to Dashboard

Practice
AAO ABC Eye Associates

Performance Year: 2024

Download Measure Template

FILE UPLOAD

UPLOAD DATE	MEASURE ID	MEASURE TITLE	UPLOADED BY	STATUS	ACTIONS
09-05-2024	IRIS GCDR 23	Refractive Surgery: Patients with a Postoperative Uncorrected Visual Acuity (UCVA) of 20/20 or Better		Available	
09-05-2024	QPP 374	Closing the Referral Loop: Receipt of Specialist Report		Available	

- After the file is processed (usually within 72 hours), click **Back to Dashboard** to return to the **Verana Quality Measures Dashboard** page to see the dashboard populated with measures data from the patient details.

Quality Measures
MIPS Submission

IRIS® Registry Quality Measures

The American Academy of Ophthalmology IRIS Registry (Intelligent Research in Sight)

Practices

Locations

Clinicians

Custom Groups

Date Range

EyeMD

All Locations (4)

All Clinicians (1)

--None Applied--

Year to date

Show Measures

With Data

Search

Filters

Update Measures Data

DOWNLOAD

FAVORITE	TYPE	ID	MEASURE	MEASURE TYPES	BENCHMARK	PERFORMANCE RATE	STATUS
☆	QPP	QPP 141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	High Priority Outcome	CMS Benchmark : 85.64%	100%	Open
☆	QCDR	IRIS QCDR 55	Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery	Outcome	CMS Benchmark : 39.13%	100%	Not Tracking

[View STRATA Measures](#)

Verana Quality Measures Dashboard Interface



Quality Measures Dashboard

The Verana Quality Measures Dashboard provides users with a summary of the performance rates for each of their measures and also features many options that allow users to customize their measure details list. Users can access support and documentation (e.g., submit a request for support, view user guides and release notes) by clicking the **Help & Documentation** link.

The screenshot displays the Verana Quality Measures Dashboard interface. Key components and their highlighted areas include:

- Top Navigation:** Verana Quality Measures Dashboard, Support & Documentation (Help & Documentation link), and a user profile icon.
- Quality Measures Section:** MIPS Submission Module and MIPS Submission link.
- IRIS® Registry Quality Measures:** The American Academy of Ophthalmology IRIS Registry (Intelligent Research in Sight).
- Filter by Practice, Location, Clinicians, or Custom Group:** Includes dropdowns for Practices, Locations (All Locations (6)), Clinicians (All Clinicians (1)), and Custom Groups (None Applied).
- Select Date Range:** A date range selector set to 2023.
- Filter by data availability:** A dropdown menu set to 'With Data'.
- Sort:** A label with a downward arrow pointing to the 'MEASURE TYPES' column header.
- Search by Measure name or ID:** A search bar with a magnifying glass icon.
- Filter data:** A button labeled 'Filters'.
- Download:** A button labeled 'DOWNLOAD'.
- Table Headers:** FAVORITE, TYPE, ID, MEASURE, MEASURE TYPES, BENCHMARK, PERFORMANCE RATE, and STATUS.
- Table Rows:**
 - Row 1: QCDR, IRIS QCDR 17, Acute Anterior Uveitis: Post-treatment Grade 0 anterior chamber cells, High Priority, Outcome, 100%, Open.
 - Row 2: QCDR, IRIS QCDR 1, Endothelial Keratoplasty - Post-Operative Improvement in Best Corrected Visual Acuity to 20/40 or Better, Outcome, 100%, Open.
 - Row 3: QCDR, IRIS QCDR 55, Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery, Outcome, 100%, Verified.
 - Row 4: QCDR, IRIS QCDR 54, Complications After Cataract Surgery, Outcome, 0%, Open.
- Annotations:**
 - Mark Favorites:** A star icon next to the 'FAVORITE' header.
 - Click to view Measure Details:** A link labeled 'View STRATA Measures (3)' under the third row.
 - Practice or Clinician Performance Rate:** A label pointing to the 'PERFORMANCE RATE' column.
- Footer:** Data Last Updated on 08-16-2023.

Filter by Practices, Locations, or Clinicians. Options to select your **Practice**, **Location**, and **Clinicians** from the dropdown menus.

Select Date Range. Option to select **Year to Date**, **Year**, **Quarter**, or **Month** from the dropdown menu.

Filter by Data Availability. Options to choose **With Data**, **Without Data**, or **All** from the dropdown menu.

Search by Measure. Option to manually enter measure information to quickly find a specific measure.

Filter Data. Option to add additional filters from the filter dialog.



Filter options include **Favorite Measures**, **Measure Status**, **Measure Criteria**, **Measure Specialty**, and **Measure Type**.

CLEAR ALL
APPLY

☐ Favorite Measures (0)

Measure Status ^

☐ Open (20)

☐ Selected (0)

☐ Refinement (0)

☐ Verified (1)

☐ Not Tracking (1)

Clear

Measure Criteria ^

☐ High Priority (12)

☐ Intermediate Outcome (1)

☐ Outcome (8)

☐ Process (13)

☐ Structure (0)

Clear

Measure Specialty ^

☐ Cataract (4)

☐ Cornea (0)

☐ Cross-Cutting (0)

☐ Dermatology (0)

☐ Glaucoma (4)

☐ Headache (0)

☐ Health Equity (0)

☐ Neuro-Ophthalmology (1)

☐ None (0)

☐ Oculofacial Plastics (0)

☐ Ophthalmology (0)

☐ Pathology (0)

☐ Preventive Health (10)

☐ Refractive Surgery (0)

☐ Retina (2)

☐ Strabismus (0)

☐ Uveitis (1)

Clear

Measure Type ^

☐ QCDR (5)

☐ QPP (6)

☐ eCQM (11)

Clear

CLEAR ALL
APPLY

Download Measures List. Option to download a CSV file of available measures with performance details.

A **Download Protected Health Information** dialog appears “You are about to download patients’ information. These patient files contain Protected Health Information (PHI). Please follow your organization’s HIPAA/Security policies and procedures as they relate to handling PHI.”



www.veranahealth.com

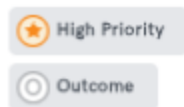
Sort headings by ascending or descending. Option to sort any of the headings by ascending  or descending  order including **Favorite, Type, Measure, Measure Types, Performance Rate,** and **Status.**

FAVORITE 	TYPE 	ID 	MEASURE 	MEASURE TYPES 	BENCHMARK	PERFORMANCE RATE 	STATUS 

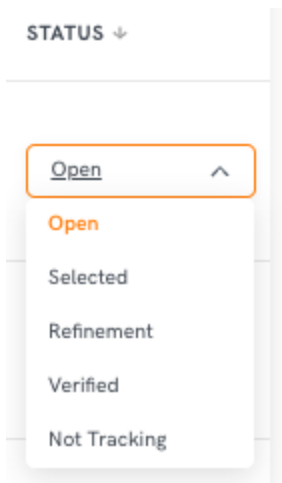
Click measure to view the [Measure Details page](#). Option to view additional measure details.

FAVORITE 	TYPE 	ID 	MEASURE 	MEASURE TYPES 	BENCHMARK	PERFORMANCE RATE 	STATUS 
	QPP	QPP 141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	 High Priority  Outcome	 CMS Benchmark : 85.64%	100%	Open

Measure Types. Shows if the measure is **High Priority** or **Outcome**



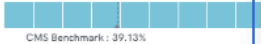
Status. Option to select **Open, Selected, Refinement, Verified,** or **Not Tracking** from the dropdown menu.



Mark Favorites. Option to add or remove a favorite by marking or unmarking the ☆ in the Favorite column adjacent to the measures.

FAVORITE	TYPE	ID	MEASURE	MEASURE TYPES	BENCHMARK	PERFORMANCE RATE	STATUS
☆	QPP	QPP 141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	High Priority Outcome	 CMS Benchmark : 85.64%	100%	Open

Practices or Clinicians Performance Rate. Option to hover over the performance rate to view additional performance rate details.

FAVORITE	TYPE	ID	MEASURE	MEASURE TYPES	BENCHMARK	PERFORMANCE RATE	STATUS
☆	QPP	QPP 141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	High Priority Outcome	 CMS Benchmark : 85.6%	100%	Open
☆	QCDR	IRIS QCDR 55	Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery View STRATA Measures (3)	Outcome	 CMS Benchmark : 39.13%	100%	Open

100%

PR =

Numerator

Denominator

100% = $\frac{220}{220}$

Measure Details Page

The Measure Details page provides additional details for the measure and includes the following sections:

- Measure Specifications
- Performance Rate
- Patients List

Verana Quality Measures Dashboard

Quality Measures / MIPS Submission

Quality Measure / Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

MIPS Quality ID: QPP 141 Measure Type: QPP Measure Specialty: Glaucoma Measure Criteria: Outcome; High Priority

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

[View Measure Specifications](#) **Click to View Measure Specifications**

Practices: 65940 20/20 Eye Ph... Locations: All Locations (9) Clinicians: All Clinicians (8) Date Range: 2023

Performance Rate

Numerator: 580 Denominator: 867 = 66.9% CMS Benchmark: 65.64%

Patients List [Download CSV](#) **Click to Download CSV of Patients List**

Initial Patient Population: 867	Denominator: 867	Numerator: 580	Numerator Not Met: 287			
LAST NAME	FIRST NAME	MRN	DATE OF BIRTH	AGE	SEX	ENCOUNTER DATE
LN-49584	FN-67432	2370099970	01-01-1951	73	Female	01-31-2023
LN-95376	FN-95142	2514903730	01-01-1948	76	Male	01-28-2023

Measure Specifications. The Measure Specifications information includes the **MIPS Quality ID**, **Measure Type**, **Measure Specialty**, **Measure Criteria**, and the **description**. Click **View Measure Specifications** to view the complete specifications document.

Quality Measure / Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

MIPS Quality ID: QPP 141 Measure Type: QPP Measure Specialty: Glaucoma Measure Criteria: Outcome; High Priority

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

[View Measure Specifications](#) **Click to View Measure Specifications**

Practices: 65940 20/20 Eye Ph... Locations: All Locations (9) Date Range: 2023

Performance Rate. The Performance Rate provides a summary of the **Numerator**, **Denominator**, and estimated performance rate.



Patients List. The Patients List provides a complete list of the patients related to the measure. The top section shows the **Initial Patient Population**, number of patients in the **Denominator**, **Numerator**, and **Numerator Not Met**. Click any of these headings to view a list of the patients related to the specific category.

Patients List Filter by Denominator, Numerator, or Numerator Not Met

Search by Name/MRN [Download CSV](#)

Initial Patient Population: 867	Denominator: 867	Numerator: 500	Numerator Not Met: 287			
LAST NAME ↓	FIRST NAME ↓	MRN ↑	DATE OF BIRTH ↓	AGE ↓	SEX ↓	ENCOUNTER DATE ↓
LN-49584	FN-67432	2370096970	01-01-1951	73	Female	01-31-2023
LN-95376	FN-95142	2514903730	01-01-1948	76	Male	01-26-2023

- Option to sort any of the headings by ascending ↑ or descending ↓ order including **Last Name**, **First Name**, **MRN**, **Date of Birth**, **Age**, **Sex**, or **Encounter Date**.

Sort column headings in ascending or descending order

LAST NAME ↓	FIRST NAME ↓	MRN ↑	DATE OF BIRTH ↓	AGE ↓	SEX ↓	ENCOUNTER DATE ↓
LN-49584	FN-67432	2370096970	01-01-1951	73	Female	01-31-2023
LN-95376	FN-95142	2514903730	01-01-1948	76	Male	01-26-2023

- Search by Patient/MRN.** Option to manually enter patient name or MRN to quickly find a specific patient. There is also an option to **Download a CSV** file of the **Patients List** details for the measure.

Patients List

Search by Name/MRN [Download CSV](#)

Initial Patient Population: 867	Denominator: 867	Numerator: 500	Numerator Not Met: 287			
LAST NAME ↓	FIRST NAME ↓	MRN ↑	DATE OF BIRTH ↓	AGE ↓	SEX ↓	ENCOUNTER DATE ↓
LN-49584	FN-67432	2370096970	01-01-1951	73	Female	01-31-2023
LN-95376	FN-95142	2514903730	01-01-1948	76	Male	01-26-2023

Search by Patient/MRN

Click to Download CSV of Patients List

Data Security and Privacy



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Once the registry data have been de-identified and can no longer be traced back to any individual patient, Verana Health curates and analyzes de-identified, aggregate data in the Verana Health data platform, VeraQ®, to calculate performance measures and to provide insights to life science companies and research institutions with the goal of advancing research and discovery. These life science companies are also under strict requirements expressly prohibiting any attempts or efforts to re-identify any of the patient data provided. **In compliance with HIPAA, personal protected health information (PHI) cannot, and will not, be sold.**

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Quality ID #001 (CBE 0059): Diabetes: Glycemic Status Assessment Greater Than 9%

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:

Intermediate Outcome – High Priority

- *INVERSE MEASURE: LOWER SCORE – BETTER*

DESCRIPTION:

Percentage of patients 18-75 years of age with diabetes who had a glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) > 9.0% during the measurement period.

INSTRUCTIONS:

Reporting Frequency:

This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients with diabetes. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation of this measure, this patient-intermediate measure is submitted a minimum of once per patient for the performance period. The most recent quality data code (QDC) will be used if the measure is submitted more than once.

This is an inverse measure which means 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.

Telehealth:

TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third

party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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.A2, 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, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, G0270, G0271, G0402, 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 an advanced illness diagnosis during the measurement period or the year prior to the measurement period: G2091

Reference Coding/Medication:

Table 1: Denominator Exclusion for a dispense medication for dementia [G2090] is defined by the following Dementia Medications only:

Description	Prescription
Cholinesterase inhibitors	Donepezil Galantamine Rivastigimine
Miscellaneous central nervous system agents	Memantine
Dementia combinations	Donepezil-memantine

Denominator Exclusion for Frailty [G2090 and G2091] is defined by the following coding only:

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, R26.2, R26.89, R26.9, R29.6,

R53.1, R53.81, 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

Denominator Exclusion for Advanced Illness [G2091] is defined by the following coding only:

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, F01.511, 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, F02.811, 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, F03.911, 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.A1, G20.A2, G20.B1, G20.B2, G20.C, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G35.A, G35.B0, G35.B1, G35.B2, G35.C0, G35.C1, G35.C2, G35.D, 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 glycemic status assessment (HbA1c or GMI) (performed during the measurement period) is > 9.0% or is missing, or was not performed during the measurement period.

Numerator Instructions:

Patient is numerator compliant if most recent HbA1c or GMI level >9.0%, the most recent HbA1c or GMI result is missing, or if there are no HbA1c or GMI 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 or GMI levels reported by the patient.

NUMERATOR NOTE:

If multiple glycemic status assessments were recorded for a single date, use the lowest result.

Numerator Options:

Performance Not Met:

Most recent glycemic status assessment (HbA1c or GMI) level < 7.0% (M1371)

OR

Performance Not Met:

Most recent glycemic status assessment (HbA1c or GMI) level ≥ 7.0% and < 8.0% (M1372)

OR

Performance Not Met:

Most recent glycemic status assessment (HbA1c or GMI) level $\geq 8.0\%$ and $\leq 9.0\%$ (M1373)

OR

Performance Met:

Most recent glycemic status assessment (HbA1c or GMI) level $> 9.0\%$ (M1211)

OR

Performance Met:

Glycemic status assessment (HbA1c or GMI) level is missing, or was not performed during the measurement period (M1212)

RATIONALE:

Diabetes is the seventh leading cause of death in the United States (Centers for Disease Control and Prevention, 2022a). In 2019, diabetes affected more than 37 million Americans (11.3 percent of the U.S. population) and killed more than 87,000 people (American Diabetes Association [ADA], 2022). Diabetes is a long-lasting disease marked by high blood glucose levels, resulting from the body's inability to produce or use insulin properly (Centers for Disease Control and Prevention, 2022a). 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 (Centers for Disease Control and Prevention, 2022b).

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).

Controlling A1c blood levels helps reduce the risk of microvascular complications (eye, kidney and nerve diseases) (American Diabetes Association, 2022)

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (2023): (ElSayed, et al., 2023)

- Assess glycemic status (A1C or other glycemic measurement such as time in range or glucose management indicator) at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control). (Level of evidence: E)
- 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 health care professional 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: B)
- Less stringent A1C goals (such as $<8\%$ [64 mmol/mol]) may be appropriate for patients limited life expectancy, or where the harms of treatment are greater than the benefits. (Level of evidence: B)
- Standardized, single-page glucose reports from continuous glucose monitoring (CGM) devices with visual cues, such as the ambulatory glucose profile, should be considered as a standard summary for all CGM devices. (Level of evidence: E)

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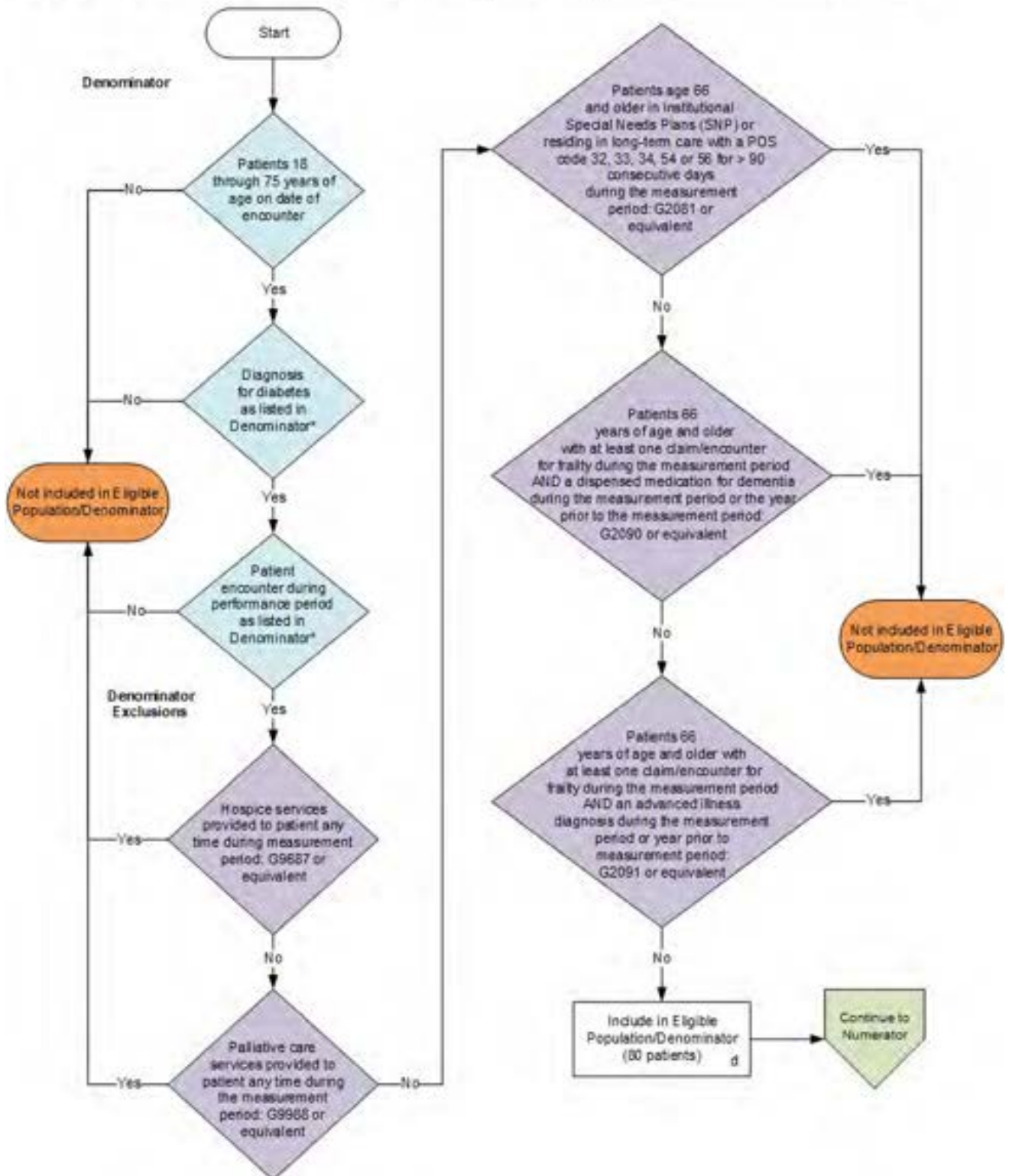
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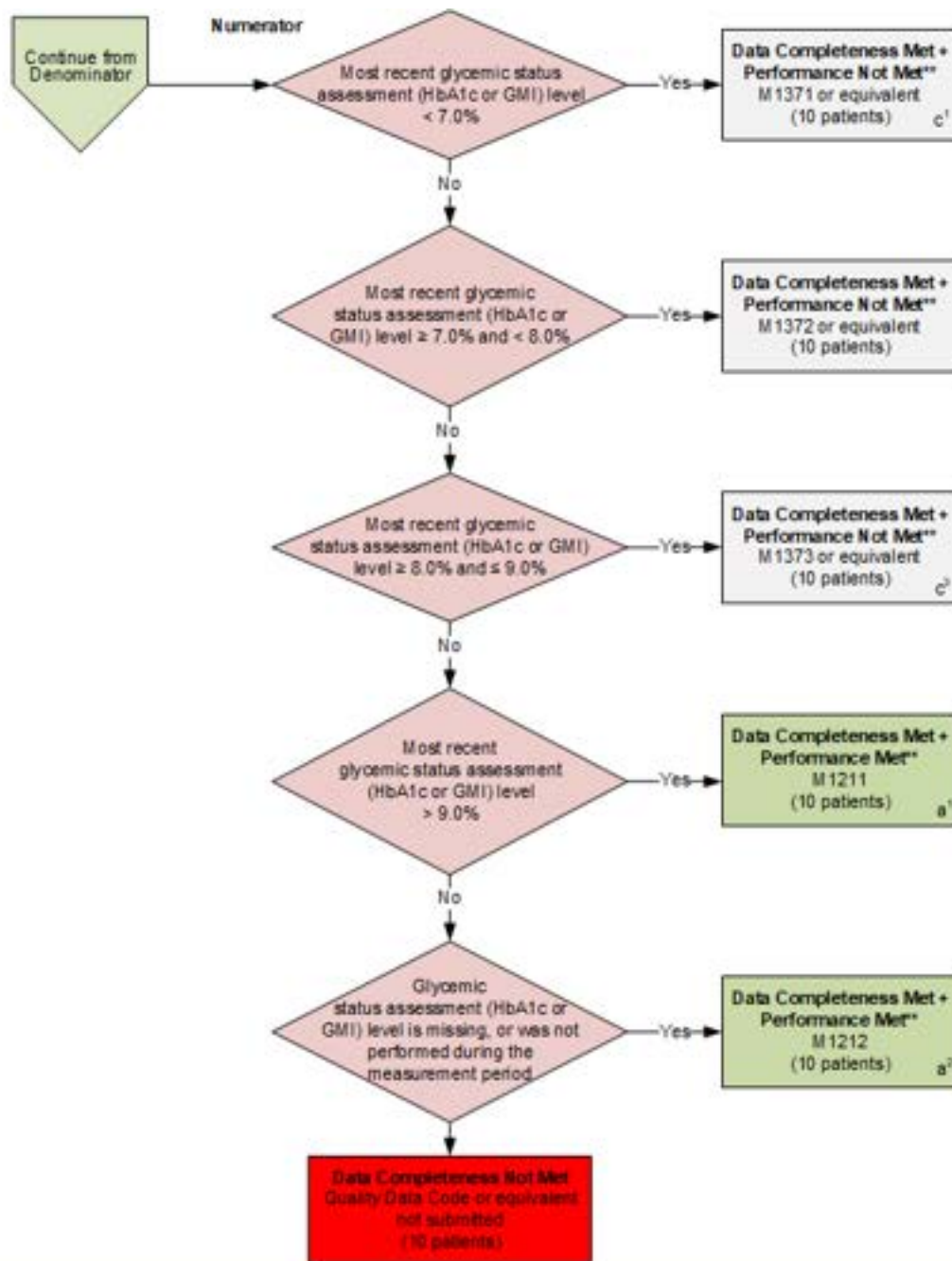
2026 Clinical Quality Measure Flow for Quality ID #001 (CBE 0059):

Diabetes: Glycemic Status Assessment Greater Than 9%

INVERSE MEASURE: LOWER SCORE – BETTER

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.





SAMPLE CALCULATIONS

Data Completeness=

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=20 patients)} + \text{Performance Not Met (c}^1\text{+c}^2\text{+c}^3\text{=30 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{50 \text{ patients}}{80 \text{ patients}} = 62.50\%$$

Performance Rate=**

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=20 patients)}}{\text{Data Completeness Numerator (50 patients)}} = \frac{20 \text{ patients}}{50 \text{ patients}} = 40\%$$

*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

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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.

v10

2026 Clinical Quality Measure Flow Narrative for Quality ID #001 (CBE 0059):
Diabetes: Glycemic Status Assessment Greater Than 9%

INVERSE MEASURE: LOWER SCORE – BETTER

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 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 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 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 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 glycemic status assessment (HbA1c or GMI) level is less than 7.0 percent:
 - a. If Most recent glycemic status assessment (HbA1c or GMI) 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 c¹ equals 10 patients in the Sample Calculation.
 - b. If Most recent glycemic status assessment (HbA1c or GMI) level is less than 7.0 percent equals No, proceed to check Most recent glycemic status assessment (HbA1c or GMI) level greater than or equal to 7.0 percent and less than 8.0 percent.

13. Check *Most recent glycemic status assessment (HbA1c or GMI) level greater than or equal to 7.0 percent and less than 8.0 percent*:
- If *Most recent glycemic status assessment (HbA1c or GMI) 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 c² equals 10 patients in the Sample Calculation.
 - If *Most recent glycemic status assessment (HbA1c or GMI) level greater than or equal to 7.0 percent and less than 8.0 percent* equals No, proceed to check *Most recent glycemic status assessment (HbA1c or GMI) level greater than or equal to 8.0 percent and less than or equal to 9.0 percent*.
14. Check *Most recent glycemic status assessment (HbA1c or GMI) level greater than or equal to 8.0 percent and less than or equal to 9.0 percent*:
- If *Most recent glycemic status assessment (HbA1c or GMI) 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 c³ equals 10 patients in the Sample Calculation.
15. If *Most recent glycemic status assessment (HbA1c or GMI) level greater than or equal to 8.0 percent and less than or equal to 9.0 percent* equals No, check *Most recent glycemic status assessment (HbA1c or GMI) level is greater than 9.0 percent*:
16. Check *Most recent glycemic status assessment (HbA1c or GMI) level is greater than 9.0 percent*:
- If *Most recent glycemic status assessment (HbA1c or GMI) 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 a¹ equals 10 patients in the Sample Calculation.
 - If *Most recent glycemic status assessment (HbA1c or GMI) level is greater than 9.0 percent* equals No, proceed to check *Glycemic status assessment (HbA1c or GMI) level is missing, or was not performed during the measurement period*.
17. Check *Glycemic status assessment (HbA1c or GMI) level is missing, or was not performed during the measurement period*:
- If *Glycemic status assessment (HbA1c or GMI) level is missing, or was not performed during 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 a² equals 10 patients in the Sample Calculation.
 - If *Glycemic status assessment (HbA1c or GMI) level is missing, or was not performed during the measurement period* equals No, proceed to check equals No, check *Data Completeness Not Met*.

18. 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 20 patients) plus Performance Not Met (c^1 plus c^2 plus c^3 equals 30 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 62.50 percent.

Performance Rate** equals Performance Met (a^1 plus a^2 equals 20 patients) divided by Data Completeness Numerator (50 patients). All equals 20 patients divided by 50 patients. All equals 40 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 #117: Diabetes: Eye Exam

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

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 during the measurement period or in the 12 months prior to the measurement period.

INSTRUCTIONS:

Reporting Frequency:

This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients with diabetes mellitus. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient during the performance period. The most advantageous quality data code (QDC) will be used if the measure is submitted more than once.

For Numerator Option: Performance Met: Low risk for retinopathy (no evidence of retinopathy in the prior year) 3072F

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.

Telehealth:

TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria:

Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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.A2, 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, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, G0402, 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 an advanced illness diagnosis during the measurement period or the year prior to the measurement period: G2107

OR

Patients who have bilateral absence of eyes any time during the patient's history through the end of the measurement period: M1428

Reference Coding/Medication:

Table 1: Denominator Exclusion for a dispensed medication for dementia [G2106] is defined by the following Dementia Medications only:

Description	Prescription
Cholinesterase inhibitors	Donepezil Galantamine Rivastigmine
Miscellaneous central nervous system agents	Memantine
Dementia combinations	Donepezil-memantine

Denominator Exclusion for Frailty [G2106 and G2107] is defined by the following coding only:

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, R26.2, R26.89, R26.9, R29.6, R53.1, R53.81, 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

Denominator Exclusion for Advanced Illness [G2107] is defined by the following coding only:

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, F01.511, 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, F02.811, 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, F03.911, 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.A1, G20.A2, G20.B1, G20.B2, G20.C, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G35.A, G35.B0, G35.B1, G35.B2, G35.C0, G35.C1, G35.C2, G35.D, 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 patients with diabetes who had one of the following:

- 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
- 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
- An autonomous eye exam in the measurement period
- A retinal exam finding with a retinopathy severity level in any part of the measurement period
- A retinal exam finding with no retinopathy severity level in 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 and documented as with or without retinopathy (reporting of CPT 92229 meets the intent of the quality action for performance met). 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 or artificial intelligence (AI) interpretation documented and reviewed; with evidence of retinopathy (M1220)

OR

Performance Met:

Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (AI) interpretation documented and reviewed; without evidence of retinopathy (M1221)

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)

OR

Performance Met:

Retinal exam finding with evidence of retinopathy in left, right or both eyes with severity level documented (M1429)

OR

Performance Met:

Retinal exam finding without evidence of retinopathy in both eyes with severity level documented (in measurement year or in the prior year) (M1430)

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 eighth leading cause of death in the United States. In 2021, diabetes affected more than 38 million Americans (11.6 percent of the U.S. population) and killed more than 103,000 people (American Diabetes Association [ADA], 2024). Diabetes is a long-lasting disease marked by high blood glucose levels, resulting from the body's inability to produce or use insulin properly (Centers for Disease Control [CDC], 2025a). 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, 2025b).

In 2022, diabetes cost the U.S. an estimated \$413 billion: \$307 billion in direct medical costs and \$106 billion in reduced productivity. The direct medical cost of diabetes increased by 7% between 2017 and 2022 (Parker et al., 2022). Diabetes is the leading cause of new cases of blindness among adults aged 18–64 years (CDC, 2025c). Diabetic

retinopathy is progressive damage to the small blood vessels in the retina that may result in loss of vision. Approximately 4.1 million adults are affected by diabetic retinopathy (CDC, 2025c).

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (2025):

- 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 exams and glycemic indicators are within goal range, 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 by an ophthalmologist will be required more frequently. (Level of evidence: B)
- Programs that use retinal photography with remote reading or the use of U.S. Food and Drug Administration–approved artificial intelligence algorithms to improve access to diabetic retinopathy screening are appropriate screening strategies for diabetic retinopathy. Such programs need to provide pathways for timely referral for a comprehensive eye examination when indicated. (Level of Evidence: B)

REFERENCES:

American Diabetes Association. (2024). Statistics About Diabetes. Retrieved from <https://diabetes.org/about-diabetes/statistics/about-diabetes>

Centers for Disease Control and Prevention. (2025a). Diabetes Basics Retrieved from <https://www.cdc.gov/diabetes/about/index.html>

Centers for Disease Control and Prevention. (2025b). National Diabetes Statistics Report. Retrieved from <https://www.cdc.gov/diabetes/php/data-research/index.html>

Centers for Disease Control and Prevention. (2025c). About Common Eye Disorders and Diseases. Retrieved from <https://www.cdc.gov/vision-health/about-eye-disorders/index.html>

Parker E, Lin J, Mahoney T, et al. Economic Costs of Diabetes in the U.S. in 2022. *Diabetes Care*. 2024;47(1):26-43. doi:10.2337/dci23-0085

American Diabetes Association Professional Practice Committee. 12. Retinopathy, neuropathy, and foot care: Standards of Care in Diabetes—2025. *Diabetes Care* 2025;48 (Suppl. 1):S252–S265

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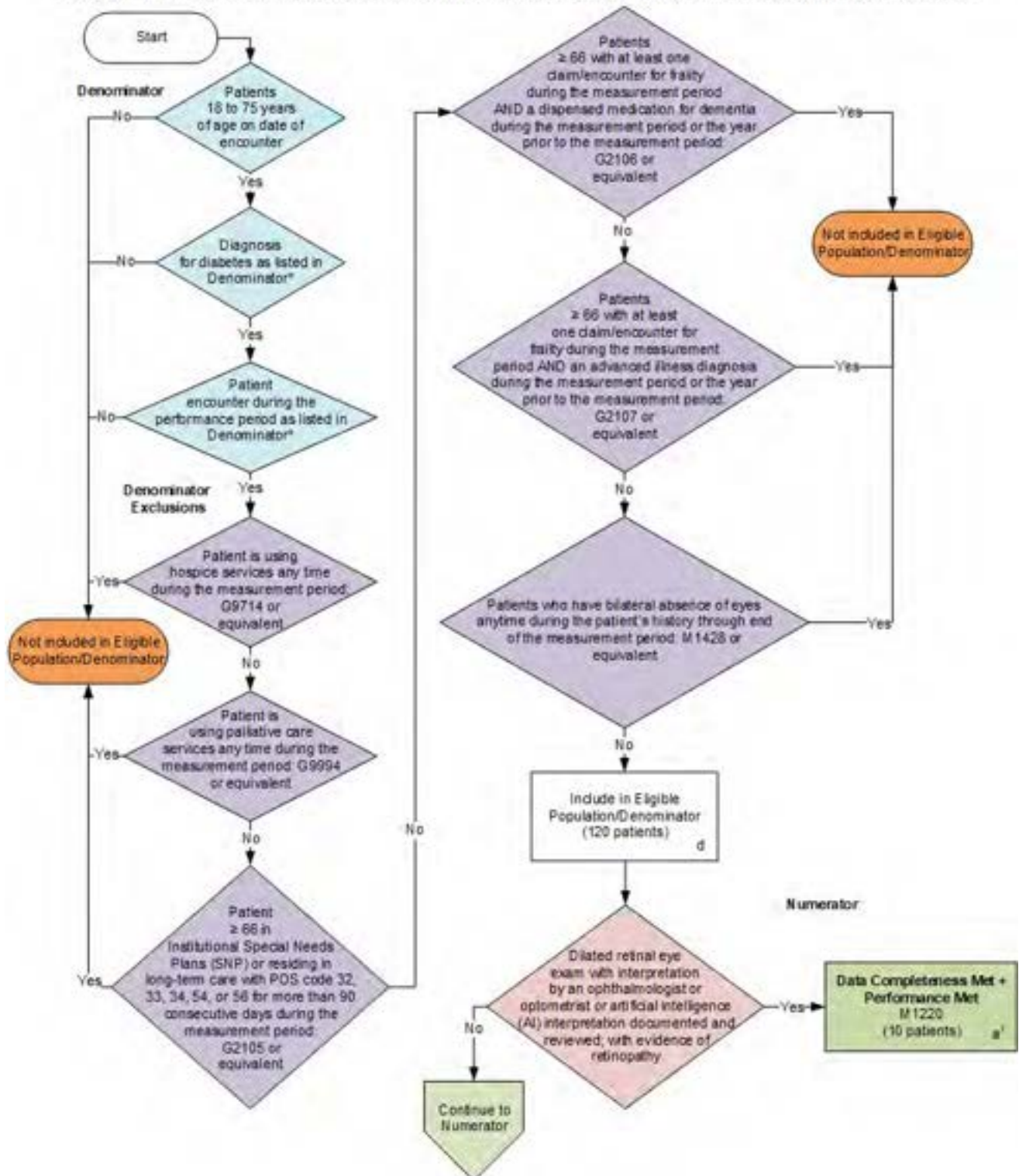
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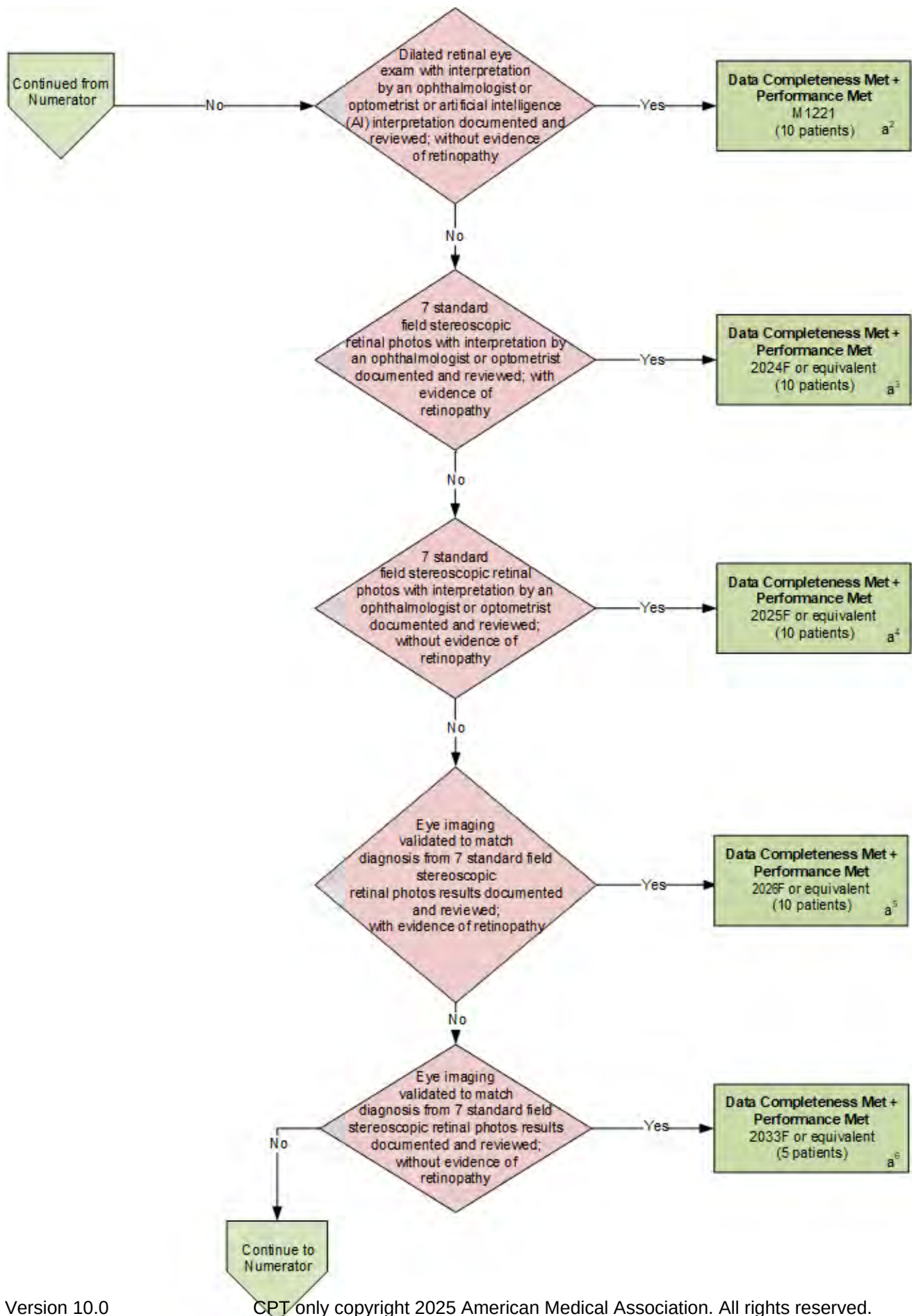
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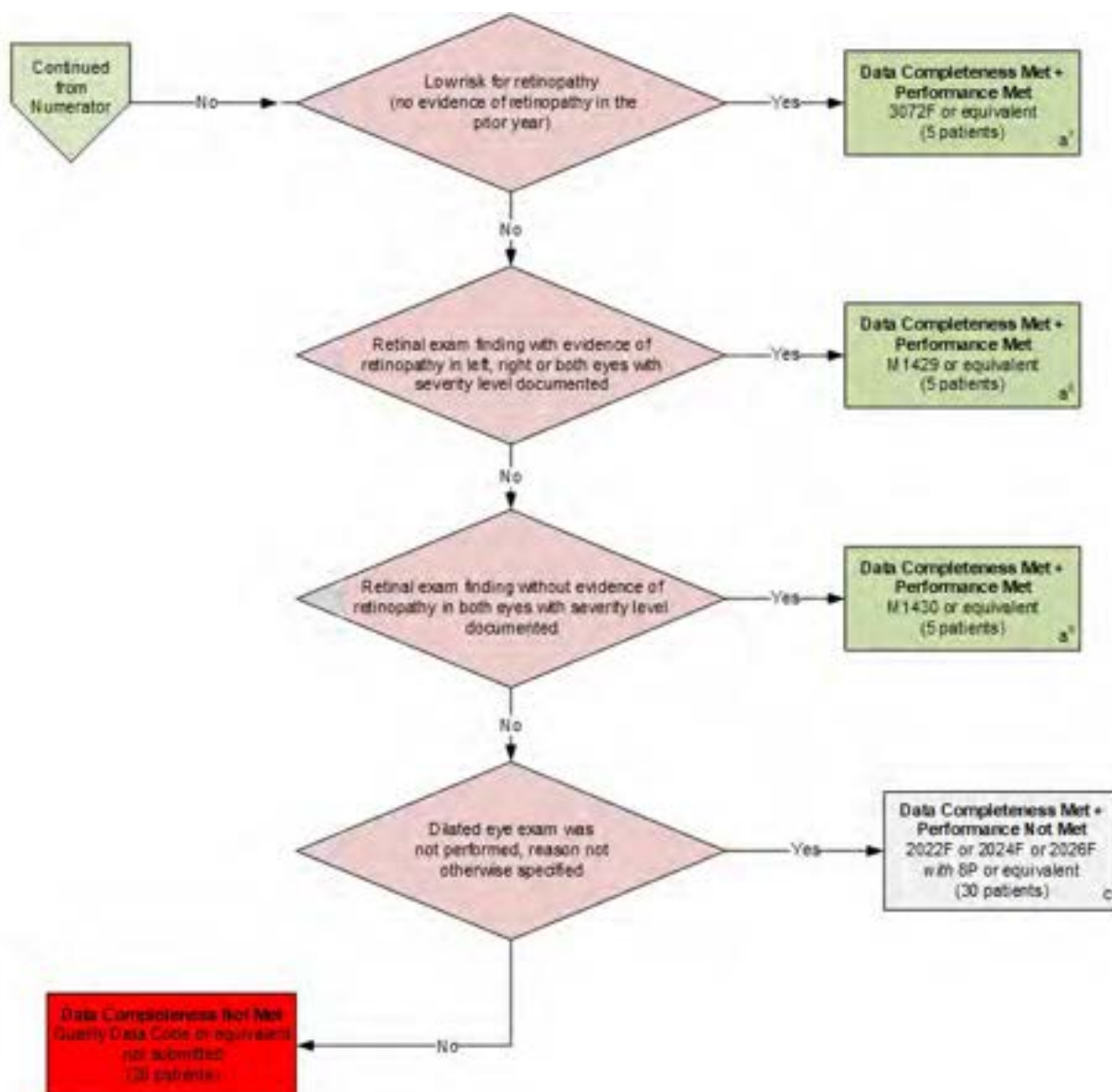
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2026 Clinical Quality Measure Flow for Quality ID #117: Diabetes: Eye Exam

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.







SAMPLE CALCULATIONS

Data Completeness=

$$\frac{\text{Performance Met (a}^1 + \text{a}^2 + \text{a}^3 + \text{a}^4 + \text{a}^5 + \text{a}^6 + \text{a}^7 + \text{a}^8 + \text{a}^9 = 70 \text{ patients)}}{\text{Eligible Population / Denominator (d=120 patients)}} = \frac{100 \text{ patients}}{120 \text{ patients}} = 83.33\%$$

Performance Rate=

$$\frac{\text{Performance Met (a}^1 + \text{a}^2 + \text{a}^3 + \text{a}^4 + \text{a}^5 + \text{a}^6 + \text{a}^7 + \text{a}^8 + \text{a}^9 = 70 \text{ patients)}}{\text{Data Completeness Numerator (100 patients)}} = \frac{70 \text{ patients}}{100 \text{ patients}} = 70.00\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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v10

2026 Clinical Quality Measure Flow Narrative for Quality ID #117:
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 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 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 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 an advanced illness diagnosis during the measurement period or the year prior to the measurement period equals No, include check Patients who have bilateral absence of eyes anytime during the patient's medical history through end of the measurement period.
10. Check Patients who have bilateral absence of eyes anytime during the patient's medical history through end of the measurement period:
 - a. If Patients who have bilateral absence of eyes anytime during the patient's medical history through end of the measurement period, equals Yes, do not include in Eligible Population/Denominator. Stop processing.
 - b. If Patients who have bilateral absence of eyes anytime during the patient's medical history through end of the measurement period, equals No, include in Eligible Population/ Denominator.
11. 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.

13. Check *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (AI) interpretation documented and reviewed; with evidence of retinopathy*:
 - a. If *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (AI) interpretation 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 a¹ equals 10 patients in the Sample Calculation.
 - b. If *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (AI) interpretation documented and reviewed; with evidence of retinopathy* equals No, proceed to check *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (AI) interpretation documented and reviewed; without evidence of retinopathy*.
14. Check *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (AI) interpretation documented and reviewed; without evidence of retinopathy*.
 - a. If *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (AI) interpretation 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 a² equals 10 patients in the Sample Calculation.
 - b. If *Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (AI) interpretation 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*.
15. 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 a³ 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*.
16. 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 a⁴ 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*.
17. 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 a⁵ 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*.
18. 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 a⁶ equals 5 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)*.
19. 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 a⁷ equals 5 patients in the Sample Calculation.
- b. If *Low risk for retinopathy (no evidence of retinopathy in the prior year)* equals No, proceed to check *Retinal exam finding with evidence of retinopathy in left, right or both eyes with severity level documented*.
20. Check *Retinal exam finding with evidence of retinopathy in left, right or both eyes with severity level documented*

- a. If Retinal exam finding with evidence of retinopathy in left, right or both eyes with severity level 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 a⁸ equals 5 patients in the Sample Calculation.
 - b. If Retinal exam finding with evidence of retinopathy in left, right or both eyes with severity level documented equals No, proceed to check *Retinal exam finding without evidence of retinopathy in both eyes with severity level documented*
21. Check *Retinal exam finding without evidence of retinopathy in both eyes with severity level documented*
- a. If Retinal exam finding without evidence of retinopathy in both eyes with severity level 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 a⁹ equals 5 patients in the Sample Calculation.
 - b. If Retinal exam finding without evidence of retinopathy in both eyes with severity level documented equals No, proceed to check *Dilated eye exam was not performed, reason not otherwise specified*
22. 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*.
23. Check *Data Completeness Not Met*:
- 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 (a¹ plus a² plus a³ plus a⁴ plus a⁵ plus a⁶ plus a⁷ plus a⁸ plus a⁹ 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 (a¹ plus a² plus a³ plus a⁴ plus a⁵ plus a⁶ plus a⁷ plus a⁸ plus a⁹ 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 #130: Documentation of Current Medications in the Medical Record

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:

Process – High Priority

DESCRIPTION:

Percentage of visits 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:

Reporting Frequency:

This measure is to be submitted at each denominator eligible visit for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients on medications. This measure may be submitted by MIPS eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this visit measure is submitted each time a patient has a denominator eligible encounter during the performance period. 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.

By submitting the action described in this measure, the provider attests to having documented a list of current medications utilizing all immediate resources available on the day of the encounter. G8427 should be submitted if the MIPS eligible clinician documented that the patient is not currently taking any medications.

Telehealth:

TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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 performance 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):

Any patient, regardless of age

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, 92549, 92650*, 92651, 92652, 92653, 92550, 92557, 92567, 92568, 92570, 92588, 92622, 92626, 96116, 96156, 96158, 97129, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 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-counter, herbals, vitamins, minerals, dietary (nutritional) supplements, and cannabis/cannabidiol (CBD) 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 (CBD) products AND **must** contain the medications' name, dosage, frequency and route of administration.*

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 acute health crisis where time is of the essence and delay of treatment would jeopardize the patient's health status) (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 patients (74 of 80) admitted to the emergency room. Of 80 patients included in the study, the home medications were re-ordered for 65% of patients on their admission. Of the 65%, 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 electronic health record (EHR) documentation with an overall risk ratio (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].

CLINICAL RECOMMENDATION STATEMENTS:

The Joint Commission's 2023 Ambulatory Health Care National Patient Safety Goals guide clinicians to maintain and communicate accurate patient medication information (2023). Specifically, the section NPSG.03.06.01 "Maintain and communicate accurate patient medication information" states the following: "Obtain and/or update information on the medications the patient is currently taking. This information is documented in a list or other format that is useful to those who manage medication. Compare the medication information the patient brought to the organization with the medications ordered for the patient by the organization in order to identify and resolve discrepancies." [12]

The Joint Commission's 2023 Hospital National Patient Safety Goals also addressed documenting current medications (2023). Specifically, the section NPSG.03.06.01 "Maintain and communicate accurate patient information" states the following: "Obtain information on the medications the patient is currently taking when they are admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications." [13]

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". [14]

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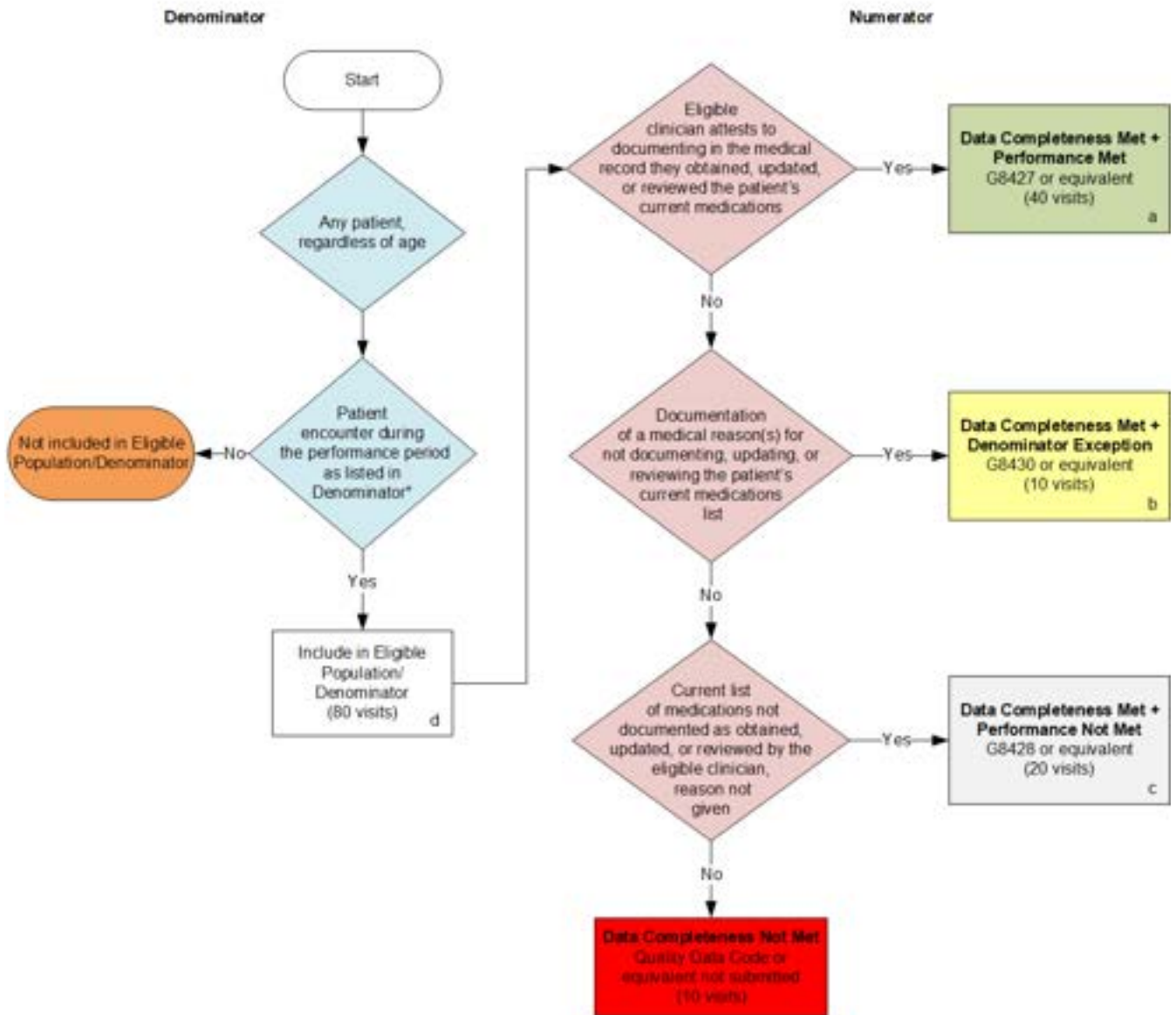
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2026 Clinical Quality Measure Flow for Quality ID #130: Documentation of Current Medications in the Medical Record

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.



SAMPLE CALCULATIONS

Data Completeness*

$$\frac{\text{Performance Met (a=40 visits)} + \text{Denominator Exception (b=10 visits)} + \text{Performance Not Met (c=20 visits)}}{\text{Eligible Population / Denominator (d=80 visits)}} = \frac{70 \text{ visits}}{80 \text{ visits}} = 87.50\%$$

Performance Rate*

$$\frac{\text{Performance Met (a=40 visits)}}{\text{Data Completeness Numerator (70 visits) - Denominator Exception (b=10 visits)}} = \frac{40 \text{ visits}}{60 \text{ visits}} = 66.67\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Visit

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v1.0

2026 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 *Any patient, regardless of age*
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 #141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

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 20% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 20% from the pre-intervention level, a plan of care was documented within the 12 month performance period.

INSTRUCTIONS:

Reporting Frequency:

This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients with glaucoma. 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 Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient during the performance period. The most advantageous quality data code will be used if the measure is submitted more than once.

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. Patient encounters for this measure conducted via telehealth should be removed from the denominator eligible patient population. Therefore, if the patient meets all denominator criteria but the encounter is conducted via telehealth, it would be appropriate to remove them from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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 on date of encounter (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

Encounters conducted via telehealth: M1432

WITHOUT

Place of Service (POS): 12

NUMERATOR:

Patients whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 20% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 20% 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 20% in the affected eye or if both eyes were affected, the reduction of at least 20% occurred in both eyes from pre-intervention levels.

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 M1223. Patients whose POAG is well managed are assumed to have met the requirement to reduce their IOP by greater than or equal to 20% and should submit M1225.

Numerator Options:

Performance Met:

Intraocular pressure (IOP) reduced by a value of greater than or equal to 20% from the pre-intervention level (M1225)

OR

Performance Met:

Glaucoma plan of care documented (M1223)

AND

Intraocular pressure (IOP) reduced by a value less than 20% from the pre-intervention level (M1224)

OR

Performance Not Met:

Glaucoma plan of care not documented, reason not otherwise specified (M1222)

AND

Intraocular pressure (IOP) reduced by a value less than 20% from the pre-intervention level (M1224)

OR

Performance Not Met:

IOP measurement not documented, reason not otherwise specified (M1226)

RATIONALE:

1. Scientific basis for intraocular pressure (IOP) control as outcomes measure (intermediate):

In a recent randomized clinical trial comparing phaco/Kahook Dual Blade to phaco/iStent, success was defined as at least a 20% reduction in IOP or reduction of 1 or more glaucoma medications from baseline (Falenberry S et al 2020). In the only multicenter randomized clinical trial comparing minimally invasive glaucoma surgery standalone procedures, the COMPARE Study defined success as an unmedicated IOP reduction of at least 20% from baseline or unmedicated IOP less than or equal to 18 mmHg (Ahmed IIK et al. 2020). As such, an appropriate “failure” indicator is to NOT achieve at least a 20% 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).

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.

REFERENCES:

Ahmed IIK et al. A prospective randomized trial comparing Hydrus and iStent microinvasive glaucoma surgery implants for standalone treatment of open-angle glaucoma: The COMPARE Study. *Ophthalmology*. 2020;127:52-61.

Falenberry S et al. Excisional goniotomy vs trabecular microbypass stent implantation: A prospective randomized clinical trial in eyes with mild to moderate open-angle glaucoma. *J Cataract Refract Surg*. 2020;46:1165-1171.

Gedde SJ, Vinod K, Wright MW et al and American Academy of Ophthalmology Glaucoma Panel. Preferred Practice Pattern® Guidelines. Primary Open-Angle Glaucoma. Ophthalmology. 2021;128:P71-P150.

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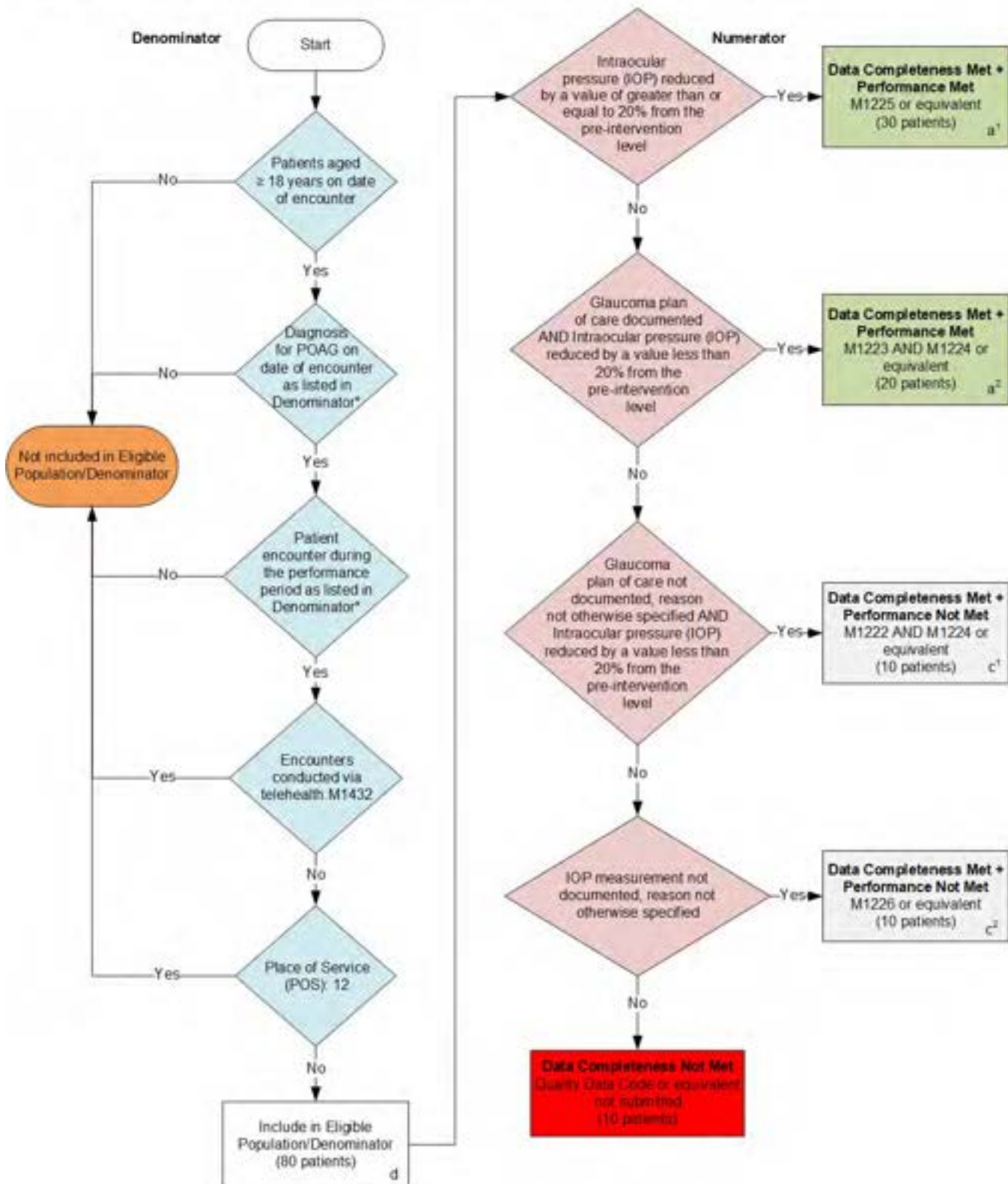
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**2026 Clinical Quality Measure Flow for Quality ID #141:
Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR
Documentation of a Plan of Care**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.



SAMPLE CALCULATIONS

Data Completeness*

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=50 patients)} + \text{Performance Not Met (c}^1\text{+c}^2\text{=20 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate*

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=50 patients)}}{\text{Data Completeness Numerator (70 patients)}} = \frac{50 \text{ patients}}{70 \text{ patients}} = 71.43\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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in conjunction with the measure specifications. They should not be used alone or as a
substitution for the measure specification.

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2026 Clinical Quality Measure Flow Narrative for Quality ID #141:
Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20%
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 on date of encounter as listed in Denominator**.
3. Check *Diagnosis for POAG on date of encounter as listed in Denominator**:
 - a. If *Diagnosis for POAG on date of encounter as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Diagnosis for POAG on date of encounter 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 *Encounters conducted via telehealth as listed in Denominator**.
5. Check *Encounters conducted via telehealth as listed in Denominator**:
 - a. If *Encounters conducted via telehealth as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Encounters conducted via telehealth as listed in Denominator** 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:
 - 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 20 percent from the pre-intervention level*:

- a. If *Intraocular pressure (IOP) reduced by a value of greater than or equal to 20 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 a¹ equals 30 patients in the Sample Calculation.
 - b. If *Intraocular pressure (IOP) reduced by a value of greater than or equal to 20 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 20 percent from the pre-intervention level*.
10. Check *Glaucoma plan of care documented AND Intraocular pressure (IOP) reduced by a value less than 20 percent from the pre-intervention level*:
- a. If *Glaucoma plan of care documented AND Intraocular pressure (IOP) reduced by a value less than 20 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 a² equals 20 patients in the Sample Calculation.
 - b. If *Glaucoma plan of care documented AND Intraocular pressure (IOP) reduced by a value less than 20 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 20 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 20 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 20 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 c¹ 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 20 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 c² 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*:

- 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

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: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

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:

Reporting Frequency:

This measure is to be submitted each time for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

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.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this procedure measure is submitted each time a procedure is performed. 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 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 between January 1st and September 30th of the performance period. This will allow the post-operative period to occur within the performance period.
- 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 clinician will record laterality in the patient medical record, as quality care and clinical documentation should include laterality.

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. This measure is procedure based and therefore doesn't allow for the denominator criteria to be conducted via telehealth. It would be appropriate to remove these patients from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:

All cataract surgeries performed between January and September of the performance period for patients 18 years and older.

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

AND NOT

DENOMINATOR EXCLUSION:

Any of the following significant ocular conditions that impact the visual outcome of surgery: M1439

Reference Coding:

Denominator Exclusion for Significant Ocular Conditions [M1439] may be defined by the following coding only: Table 1 (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

Significant Ocular Condition	Corresponding ICD-10-CM Codes
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
Disorders of Cornea Including Cornea Opacity	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, 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 and 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, H36.811, H36.812, H36.813, H36.819, H36.821, H36.822, H36.823, H36.829, H36.89
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

Significant Ocular Condition	Corresponding ICD-10-CM Codes
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, 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 Lenticulus	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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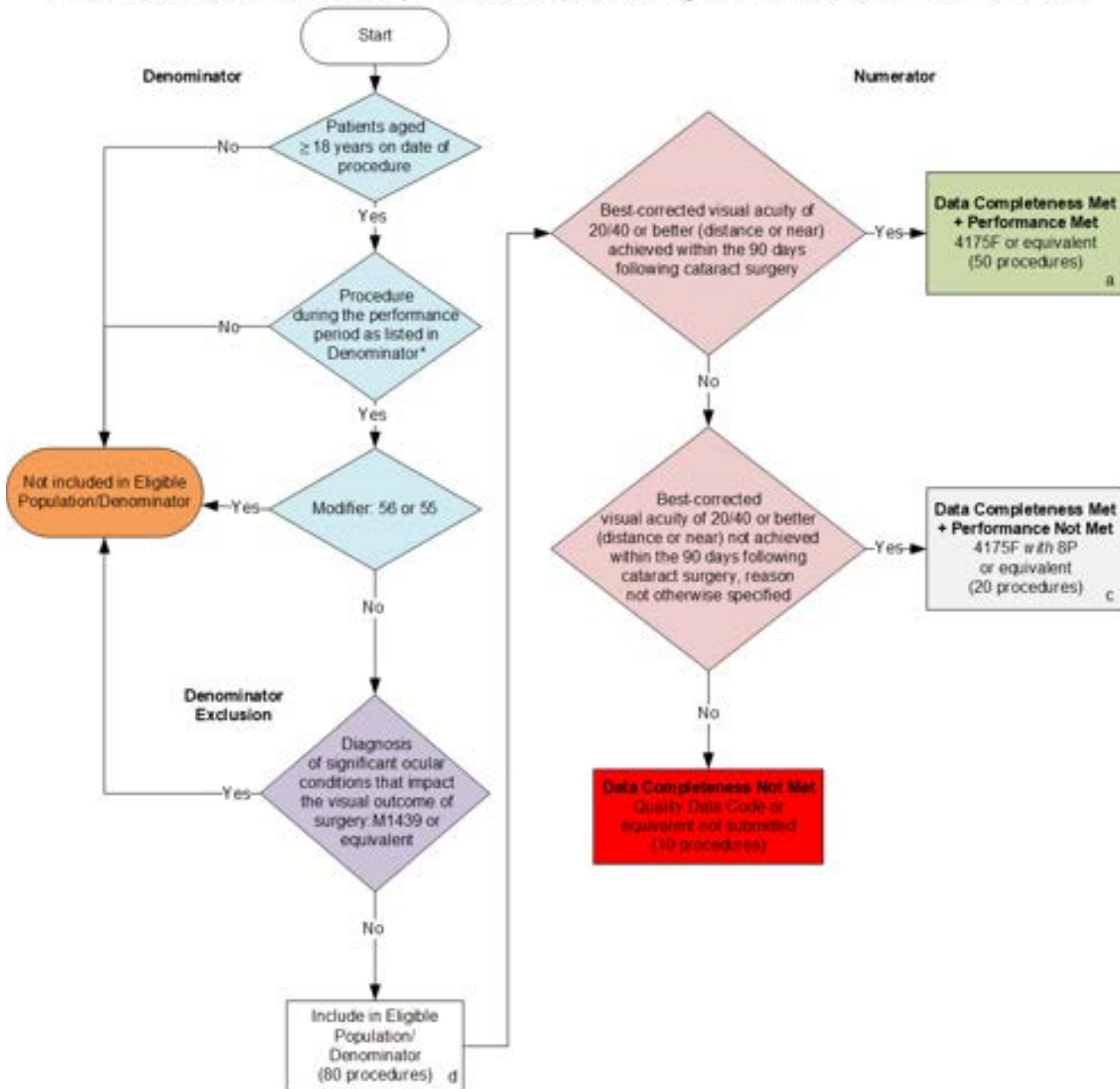
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**2026 Clinical Quality Measure Flow for Quality ID #191:
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.



SAMPLE CALCULATIONS

Data Completeness*

$$\frac{\text{Performance Met (a=50 procedures)} + \text{Performance Not Met (c=20 procedures)}}{\text{Eligible Population / Denominator (d=80 procedures)}} = \frac{70 \text{ procedures}}{80 \text{ procedures}} = 87.50\%$$

Performance Rate*

$$\frac{\text{Performance Met (a=50 procedures)}}{\text{Data Completeness Numerator (70 procedures)}} = \frac{50 \text{ procedures}}{70 \text{ procedures}} = 71.43\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure

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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.
V 10

2026 Clinical Quality Measure Flow Narrative for Quality ID #191 : 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: 56 or 55* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Modifier: 56 or 55* equals No, proceed to check *Diagnosis of significant ocular conditions that impact the visual outcome of surgery as listed in Denominator**
5. 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*.
6. Denominator Population:
 - 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.
7. Start Numerator

8. 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*.
9. 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*.
10. 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 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

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 (CBE 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients aged 12 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:

Reporting Frequency:

This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients who were screened for tobacco use. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:

This measure contains three strata defined by three submission criteria.

This measure produces three performance rates.

There are 3 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.

This measure will be calculated with 3 performance rates:

- 1) Percentage of patients aged 12 years and older who were screened for tobacco use one or more times within the measurement period
- 2) Percentage of patients aged 12 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 12 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 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. For the purposes of submitting this measure, use the data completeness determined in Submission Criteria 1.

Implementation Considerations:

For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient during the performance period. The most advantageous quality data code (QDC) will be used if the measure is submitted more than once.

Telehealth:

TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

SUBMISSION CRITERIA 1: ALL PATIENTS WHO WERE SCREENED FOR TOBACCO USE

DENOMINATOR (CRITERIA 1):

All patients aged 12 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 ≥ 12 years on date of encounter

AND

At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92622, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98979, 98980, 99024, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347,

99348, 99349, 99350, 99421, 99422, 99423, 99457, 99470, G0270, G0271, G2250, G2251, G2252

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0402, G0438, G0439

AND NOT

DENOMINATOR EXCLUSION:

Hospice services provided to patient any time during the measurement period: M1159

NUMERATOR (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)

AND

SUBMISSION CRITERIA 2: ALL PATIENTS WHO WERE IDENTIFIED AS A TOBACCO USER AND WHO RECEIVED TOBACCO CESSATION INTERVENTION

DENOMINATOR (CRITERIA 2):

All patients aged 12 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 ≥ 12 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 or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92622, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98979, 98980, 99024, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99421, 99422, 99423, 99457, 99470, G0270, G0271, G2250, G2251, G2252

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0402, G0438, G0439

AND NOT

DENOMINATOR EXCLUSION:

Hospice services provided to patient any time during the measurement period: M1159

NUMERATOR (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)

AND

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 (CRITERIA 3):

All patients aged 12 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 ≥ 12 years on date of encounter

AND

At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92622, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98979, 98980, 99024, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99421, 99422, 99423, 99457, 99470, G0270, G0271, G2250, G2251, G2252

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0402, G0438, G0439

AND NOT

DENOMINATOR EXCLUSION:

Hospice services provided to patient any time during the measurement period: M1159

NUMERATOR (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, 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).

The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents (Grade B Statement) (U.S. Preventive Services Task Force, 2020).

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care--feasible interventions for the cessation of tobacco use among school-aged children and adolescents (Grade I Statement) (U.S. Preventive Services Task Force, 2020).

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)

REFERENCES:

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

US Preventive Services Task Force. (2020). Primary Care Interventions for Prevention and Cessation of Tobacco Use in Children and Adolescents. US Preventive Services Task Force Recommendation Statement. JAMA, 2020;323(16):1590-1598. doi:10.1001/jama.2020.4679

US Department of Health and Human Services. (2008). 6, Evidence and Recommendations. Treating Tobacco Use and Dependence: 2008 Update. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK63943/>

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**2026 Clinical Quality Measure for Quality ID #226 (CBE 0028):
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Multiple Performance Rates**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

ACCOUNTABILITY REPORTING IN THE CMS MIPS PROGRAM: SAMPLE CALCULATION 5

Overall Data Completeness (Submission Criteria 1)*=

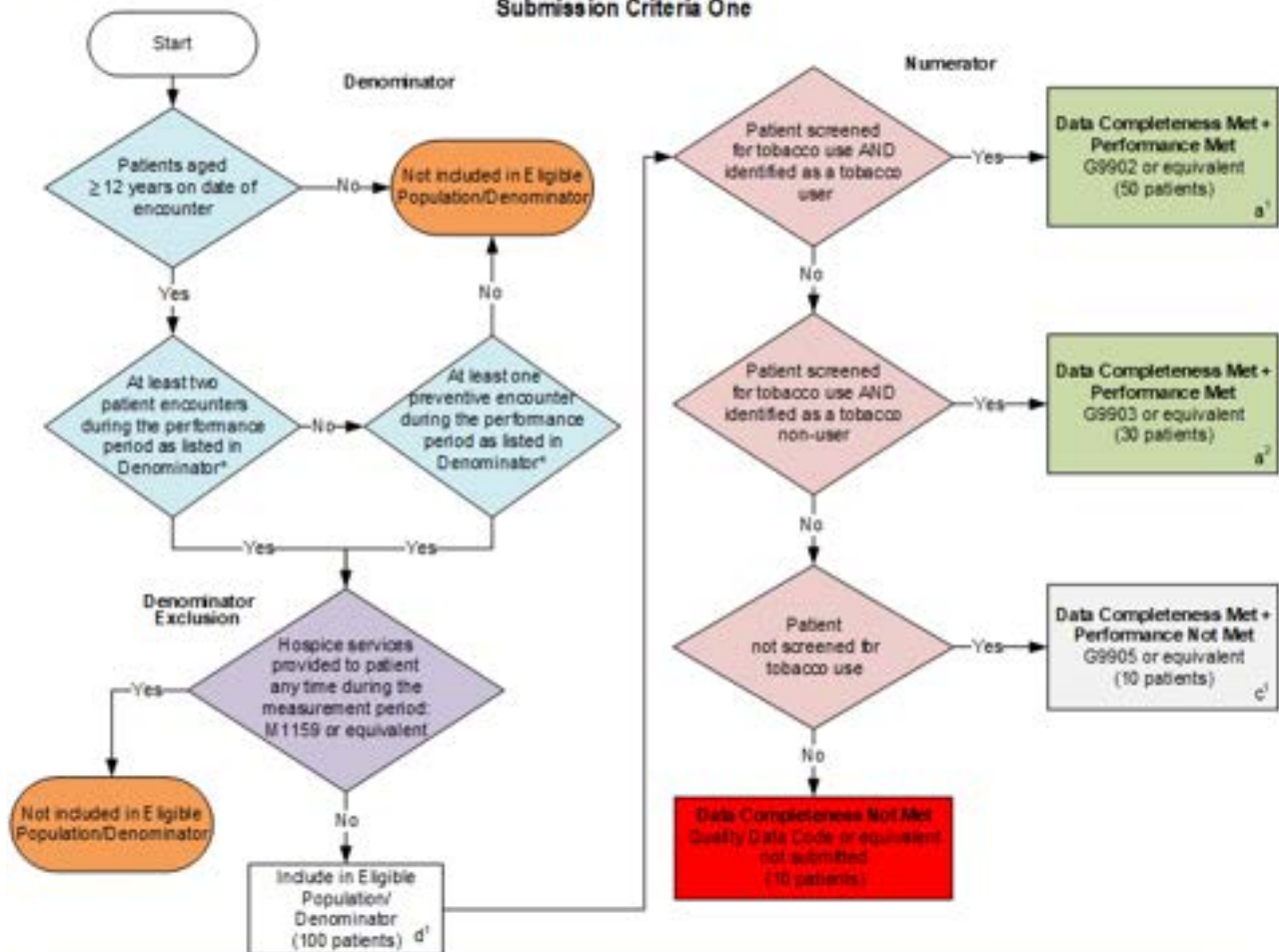
Performance Met (a ¹ +a ² =80 patients)	+	Performance Not Met (c ¹ =10 patients)	=	90 patients	=	90.00%
Eligible Population / Denominator (d ¹ =100 patients)			=	100 patients		

Overall Performance Rate (Submission Criteria 2)*=

Performance Met (a ¹ +a ² =80 patients)	=	80 patients	=	80.00%
Data Completeness Numerator (40 patients)	=	40 patients		

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE : Submission Frequency: Patient-Process

Submission Criteria One



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=

Performance Met (a ¹ +a ² =80 patients)	+	Performance Not Met (c ¹ =10 patients)	=	90 patients	=	90.00%
Eligible Population / Denominator (d ¹ =100 patients)			=	100 patients		

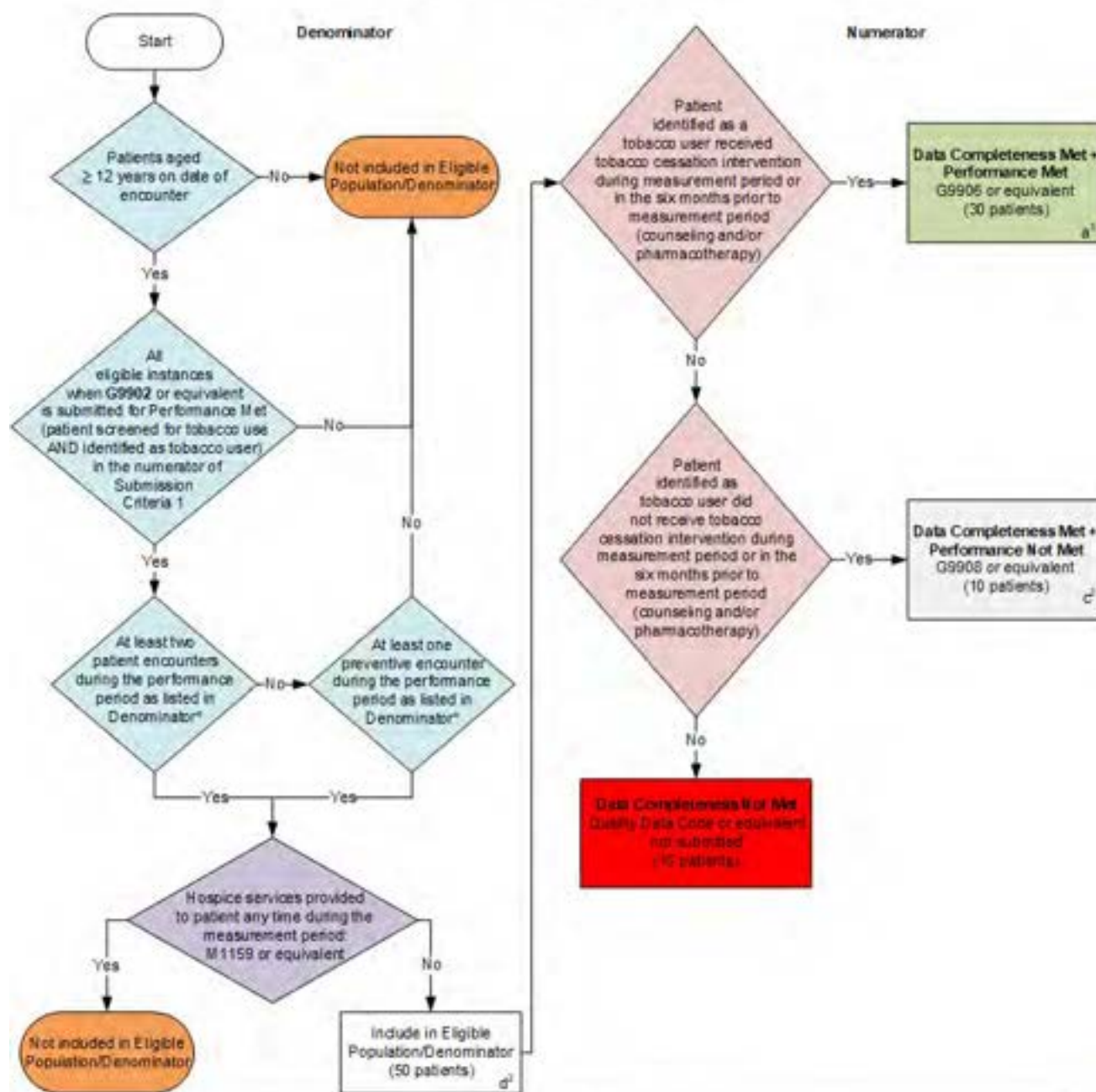
Performance Rate=

Performance Met (a ¹ +a ² =80 patients)	=	80 patients	=	88.89%
Data Completeness Numerator (90 patients)	=	90 patients		

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE : Submission Frequency: Patient-Process

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in conjunction with the measure specifications. They should not be used alone or as a
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Submission Criteria Two



SAMPLE CALCULATION S: SUBMISSION CRITERIA TWO

Data Completeness=

Performance Met (a ¹ =30 patients)	+	Performance Not Met (c ² =10 patients)	=	40 patients	=	80.00%
Eligible Population / Denominator (d ¹ =50 patients)			=	50 patients		

Performance Rate=

Performance Met (a ¹ =30 patients)	=	30 patients	=	75.00%
Data Completeness Numerator (40 patients)	=	40 patients		

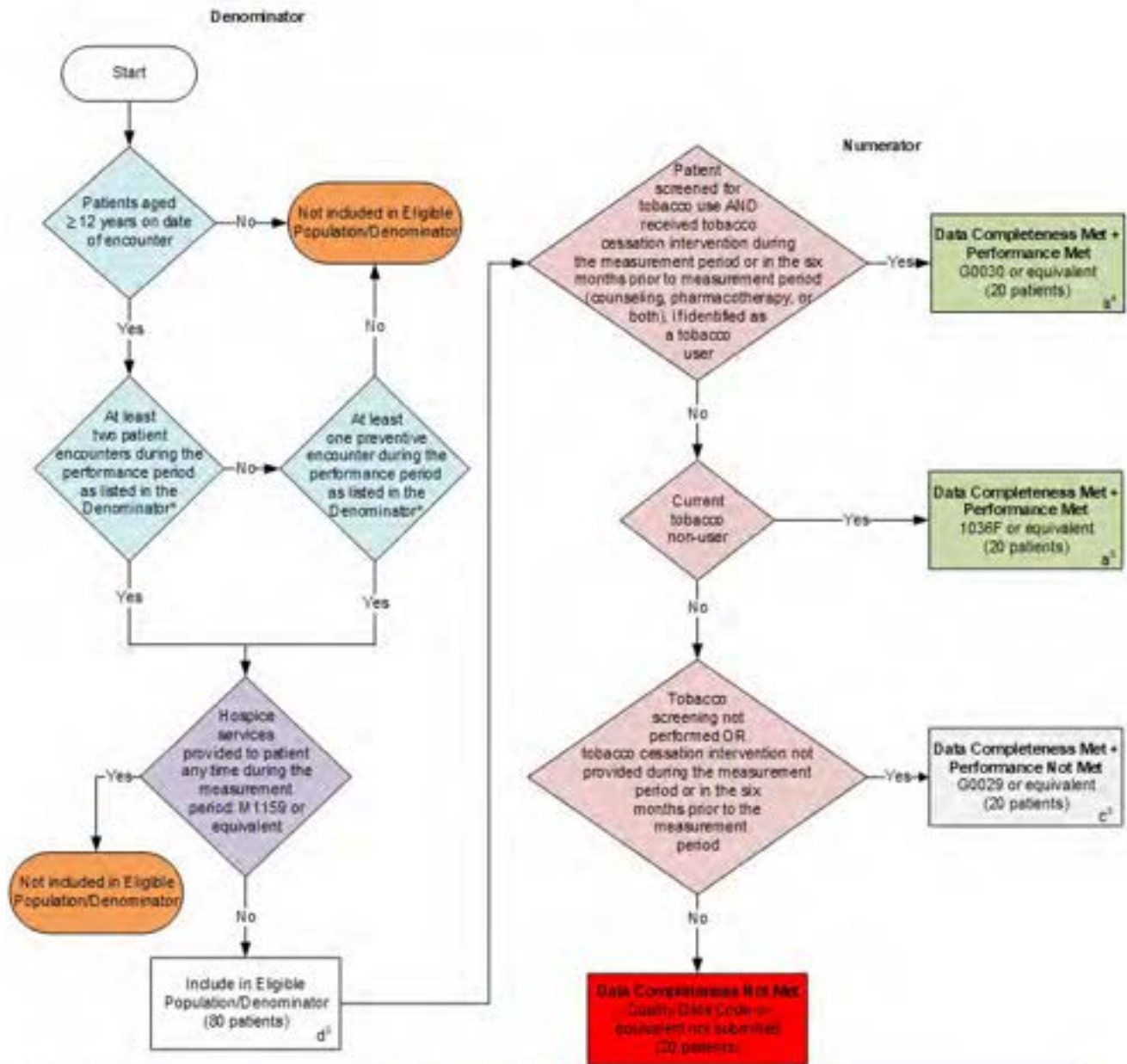
*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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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.

v10

Submission Criteria Three



SAMPLE CALCULATIONS: SUBMISSION CRITERIA THREE

Data Completeness=

$$\frac{\text{Performance Met (a}^1 + \text{a}^2 = 40 \text{ patients)} + \text{Performance Not Met (c}^1 = 20 \text{ patients)}}{\text{Eligible Population / Denominator (d}^1 = 60 \text{ patients)}} = \frac{60 \text{ patients}}{80 \text{ patients}} = 75.00\%$$

Performance Rate=

$$\frac{\text{Performance Met (a}^1 + \text{a}^2 = 40 \text{ patients)}}{\text{Data Completeness Numerator (60 patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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2026 Clinical Quality Measure Flow Narrative for Quality ID #226 (CBE 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

Accountability Reporting in the CMS MIPS Program: Sample Calculations

Overall Data Completeness (Submission Criteria 1)* equals Performance Met (a^1 plus a^2 equals 80 patients) plus Performance Not Met (c^1 equals 10 patients) divided by Eligible/Denominator Population (d^1 equals 100 patients). All equals 90 patients divided by 100 patients. All equals 90.00 percent.

Overall Performance Rate (Submission Criteria 2)* 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

Submission Criteria One:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 12 years on date of encounter*:
 - a. If *Patients aged greater than or equal to 12 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 12 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 d1 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 a¹ 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 a² 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 c¹ 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*:
 - 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 (a¹ plus a² equals 80 patients) plus Performance Not Met (c¹ equals 10 patients) divided by Eligible Population/Denominator (d¹ equals 100 patients). All equals 90 patients divided by 100 patients. All equals 90.00 percent.

Performance Rate equals Performance Met (a¹ plus a² 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 12 years on date of encounter*:
 - a. If *Patients aged greater than or equal to 12 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 12 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 d² 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 a³ 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 c² 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*:

- 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 (a³ equals 30 patients) plus Performance Not Met (c² equals 10 patients) divided by Eligible Population/Denominator (d² equals 50 patients). All equals 40 patients divided by 50 patients. All equals 80.00 percent.

Performance Rate equals Performance Met (a³ 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 12 years on date of encounter*:
 - a. If *Patient aged greater than or equal to 12 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 12 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 d3 equals 80 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 a⁴ equals 20 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 a⁵ equals 20 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 c³ 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 (a⁴ plus a⁵ equals 40 patients) plus Performance Not Met (c³ equals 20 patients) divided by Eligible Population/Denominator (d³ equals 80 patients). All equals 60 patients divided by 80 patients. All equals 75.00 percent.

Performance Rate equals Performance Met (a⁴ plus a⁵ equals 40 patients) divided by Data Completeness Numerator (60 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

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Quality ID #236: Controlling High Blood Pressure

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

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:

Reporting Frequency:

This measure is to be submitted a minimum of **once per performance period** for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients with hypertension seen during the performance period. The performance period for this measure is 12 months. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

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.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this patient-intermediate measure is submitted a minimum of once per patient during the performance period. The most recent quality data code (QDC) will be used if the measure is submitted more than once.

In reference to the numerator element, only blood pressure readings performed by a clinician or an automated blood pressure monitor or 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 an automated blood pressure monitor or device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm automated blood pressure monitor or 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.

Telehealth:

TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:

Patients 18-85 years of age who had a visit during the measurement period 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, 2025 - June 30, 2026).

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): 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98970, 98980, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99421, 99422, 99423, 99457, 99470, G0402, G0438, G0439, G2250, G2251, G2252

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 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

Reference Coding/Medication:

Table 1: Denominator Exclusion for a dispensed medication for dementia [G2115] is defined by the following Dementia Medications only:

Description		Prescription
Cholinesterase inhibitors	Donepezil	Rivastigmine
	Galantamine	
Miscellaneous central nervous system agents	Memantine	
Dementia combinations	Donepezil-memantine	

Denominator Exclusion for Frailty [G2115, G2116, and G2118] is defined by the following coding only:

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, R26.2, R26.89, R26.9, R29.6, R53.1, R53.81, 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

Denominator Exclusion for Advanced Illness [G2116] is defined by the following coding only:

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, F01.511, 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, F02.811, 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, F03.911, 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.A1, G20.A2, G20.B1, G20.B2, G20.C, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G35.A, G35.B0, G35.B1, G35.B2, G35.C0, G35.C1, G35.C2, G35.D, 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 an automated blood pressure monitor or 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 an automated blood pressure monitor or device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the automated blood pressure monitor or 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.

Numerator Options:

Performance Met: Most recent systolic blood pressure < 140 mmHg (G8752)

OR

Performance Not Met: Most recent systolic blood pressure $\geq$ 140 mmHg (G8753)

AND

Performance Met: Most recent diastolic blood pressure < 90 mmHg (G8754)

OR

Performance Not Met: Most recent diastolic blood pressure $\geq$ 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], 2023). 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 $\geq$ 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). In an analysis of adults with hypertension in NHANES, the estimated age-adjusted proportion with controlled BP increased from 31.8 percent in 1999 to 53.8 percent in 2014. However, that proportion declined to 43.7 percent in 2017 to 2018 (Tsao et al., 2022).

HBP increases risks of heart disease and stroke which are two of the leading causes of death in the U.S (CDC, 2023). 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, 2021). The National Center for Health Statistics reported that in 2020 there were over 670,000 deaths with HBP as a primary or contributing cause (CDC, 2022). Between 2009 and 2019 the number of deaths due to HBP rose by 65 percent (Tsao et al, 2022). 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). Age-adjusted death rates attributable to HBP in 2019 were more than twice as high in non-Hispanic Black males (56.7 percent) when compared to rates for non-Hispanic White males (25.7 percent) (Tsao et al., 2022).

HBP costs the U.S. approximately 131 billion dollars each year, averaged over 12 years from 2003 to 2014 (Kirkland et al., 2018). A study on cost-effectiveness on treating hypertension found that controlling HBP in patients with cardiovascular disease and systolic blood pressures of $\geq$ 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:

U.S. Preventive Services Task Force (USPSTF) (2021):

-The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment. This is a grade A recommendation
American Academy of Family Physicians (2017):

- Treat adults who have hypertension to a standard blood pressure target (less than 140/90 mm Hg) to reduce the risk of all-cause and cardiovascular mortality (strong recommendation; high-quality evidence). Treating to a lower blood pressure target (less than 135/85 mm Hg) does not provide additional benefit at preventing mortality; however, a lower blood pressure target could be considered based on patient preferences and values. (Grade: strong recommendation, Quality of evidence: high)

- Consider treating adults who have hypertension to a lower blood pressure target (less than 135/85 mm Hg) to reduce risk of myocardial infarction (weak recommendation; moderate-quality evidence). Although treatment to a standard blood pressure target (less than 140/90 mm Hg) reduced the risk of myocardial infarction, there was a small additional benefit observed with a lower blood pressure target. There was no observed additional benefit in preventing stroke with the lower blood pressure target. (Grade: weak recommendation, Quality of evidence: low)

American Diabetes Association (2022):

- For individuals with diabetes and hypertension at higher cardiovascular risk (existing atherosclerotic cardiovascular disease or 10-year atherosclerotic cardiovascular disease risk $\geq 15\%$), blood pressure target of $<130/80$ mmHg may be appropriate, if it can be safely attained (Level of evidence: B).

- 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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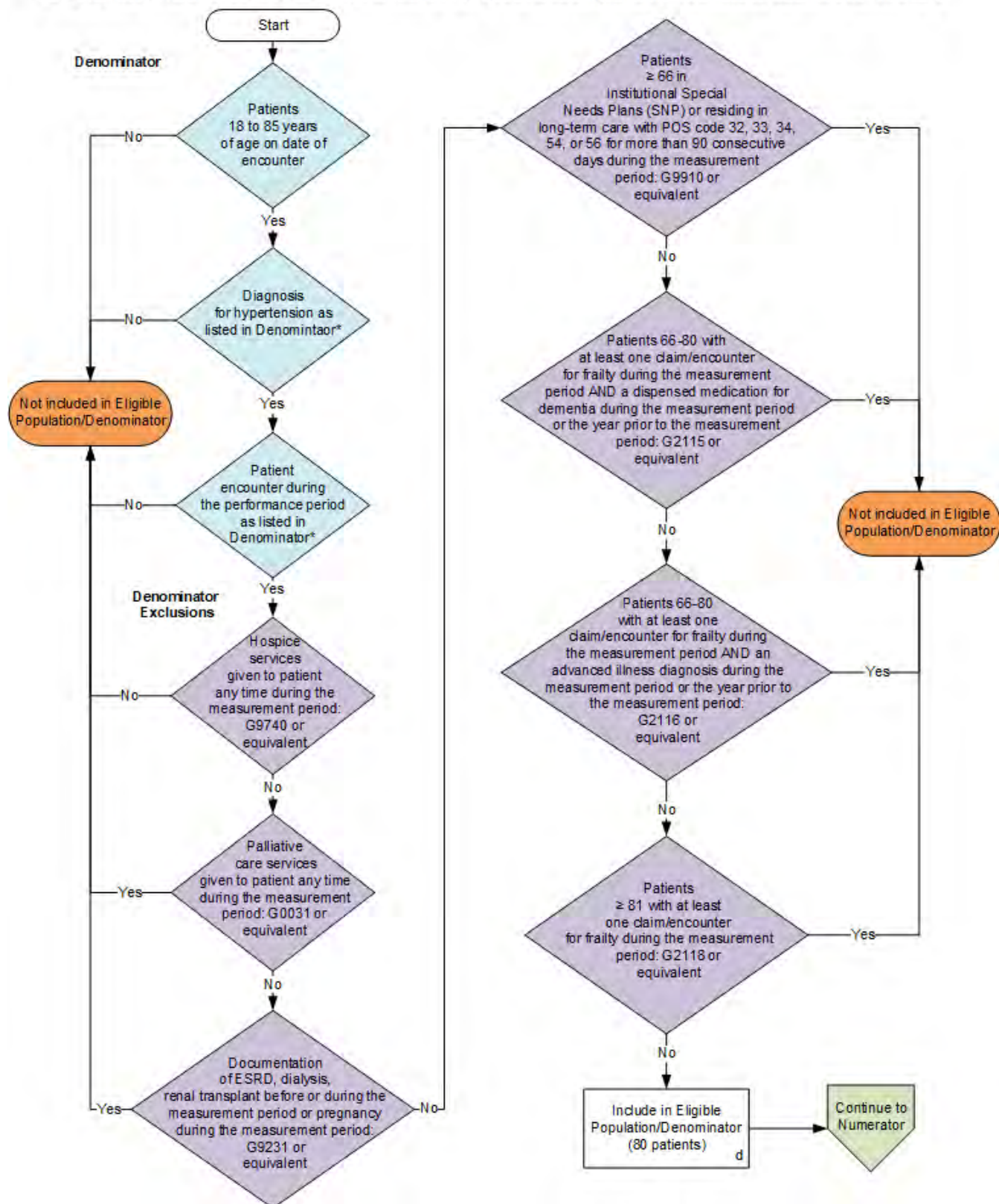
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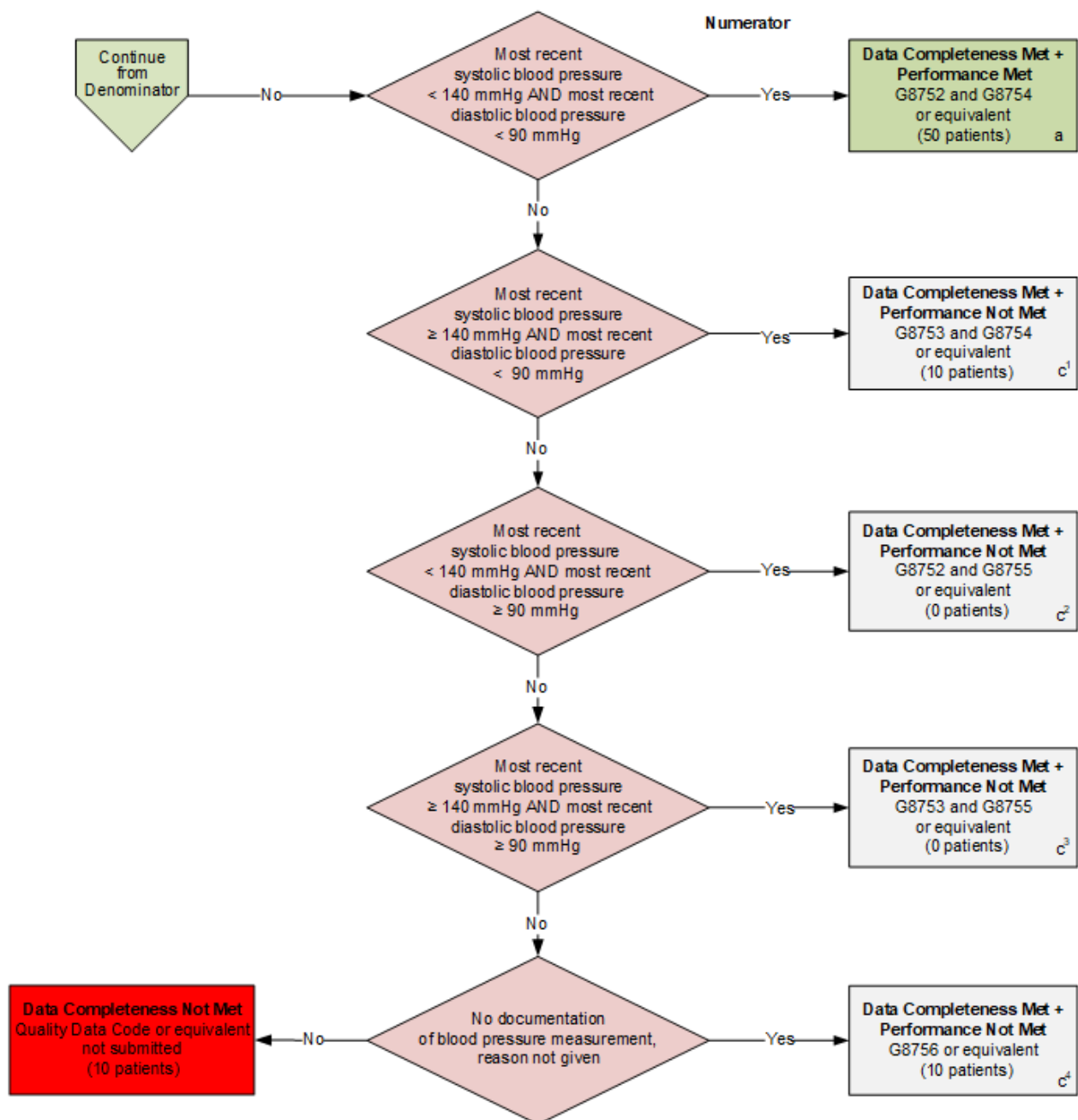
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2026 Clinical Quality Measure Flow for Quality ID #236: Controlling High Blood Pressure

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.





SAMPLE CALCULATIONS

Data Completeness=

$$\frac{\text{Performance Met (a=50 patients)} + \text{Performance Not Met (c}^1\text{+c}^2\text{+c}^3\text{+c}^4\text{=20 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a=50 patients)}}{\text{Data Completeness Numerator (70 patients)}} = \frac{50 \text{ patients}}{70 \text{ patients}} = 71.43\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE : Submission Frequency: Patient-Intermediate

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v10

2026 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 as listed in Denominator**.
3. Check *Diagnosis for hypertension as listed in Denominator**:
 - a. If *Diagnosis for hypertension as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Diagnosis for hypertension as listed in Denominator** 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 the measurement period or pregnancy during the measurement period*:
 - a. If *Documentation of ESRD, dialysis, renal transplant before or during the measurement period or pregnancy during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Documentation of ESRD, dialysis, renal transplant before or during the measurement period or pregnancy during the 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 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 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 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 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 *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg*:
- a. If *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 c¹ equals 10 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 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 c² 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 c³ 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 c⁴ 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 (c¹ plus c² plus c³ plus c⁴ 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 (CBE 0022): Use of High-Risk Medications in Older Adults

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:

Process – High Priority

- *INVERSE MEASURE: LOWER SCORE – BETTER*

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:

Reporting Frequency:

This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients aged 65 years of age and older who were ordered at least two high-risk medications. 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 as defined by the numerator 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.

Submission Criteria 1:

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.

Within the medication tables below, a row with one medication is considered a group (or drug class) of one; therefore, two orders of that same medication are numerator compliant.

Submission Criteria 2:

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 of 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.

Measure Strata and Performance Rates:

This measure contains two strata defined by two submission criteria.

This measure produces two performance rates.

There are 2 Submission Criteria for this measure:

- 1) Patients 65 years of age and older who were ordered at least two high-risk medications from the same drug class.
- AND
- 2) 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.

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.

Implementation Considerations:

For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient during the performance period. The most advantageous quality data code (QDC) will be used if the measure is submitted more than once.

This is an inverse measure which means 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.

Telehealth:

TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

SUBMISSION CRITERIA 1: PATIENTS 65 YEARS OF AGE AND OLDER WHO WERE ORDERED AT LEAST TWO HIGH-RISK MEDICATIONS FROM THE SAME DRUG CLASS.

DENOMINATOR (CRITERIA 1):

Patients 65 years and older who had 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 1(Eligible Cases):

Patients aged ≥ 65 years on date of encounter

AND

Patient encounter during performance period (CPT or HCPCS): 92002, 92004, 92012, 92014, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 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*, G0402, 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 (CRITERIA 1):

Patients ordered at least two high-risk medications from the same drug class during the measurement year.

Definitions:

Average Daily Dose – 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 $(30 \times 3) + (60 \times 2) = 210$ days over the 10 month period.

Reference Coding/Medication:

Numerator Option for At least two orders for high-risk medications [G9368] is defined by the following tables (1, 2, and 3), 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 1 - High-Risk Medications at any Dose or Duration

Description	Prescription	
Anticholinergics, first-generation antihistamines	Brompheniramine	Diphenhydramine
	Chlorpheniramine	(oral) Doxylamine
	Cyproheptadine	Hydroxyzine
	Dimenhydrinate	Meclizine
		Promethazine
		Triprolidine

Description	Prescription	
Anticholinergics, anti-Parkinson agents	Benztropine (oral)	Trihexyphenidyl
Antispasmodics	Atropine (exclude ophthalmic) Chlordiazepoxide-clidinium Dicyclomide	Hyoscyamine Scopolamine
Antithrombotics	Dipyridamole, (oral, excluding extended release)	
Cardiovascular, alpha agonists, central	Guanfacine	
Cardiovascular, other	Nifedipine (excluding extended release)	
Central nervous system, antidepressants	Amitriptyline Amoxapine Clomipramine Desipramine	Imipramine Nortriptyline Paroxetine
Central nervous system, barbiturates	Butalbital	Phenobarbital Primidone
Central nervous system, vasodilators	Ergoloid mesylates	
Central nervous system, other	Meprobamate	
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	Conjugated estrogen Esterified estrogen Estradiol Estropipate	
Endocrine system, sulfonylureas, long-duration	Glimepiride	Glyburide
Endocrine system, desiccated thyroid	Desiccated thyroid	
Endocrine system, megestrol	Megestrol	
Nonbenzodiazepine hypnotics	EszopicloneZaleplon	Zolpidem
Pain medications, skeletal muscle relaxants	Carisoprodol Chlorzoxazone Cyclobenzaprine	Metaxalone Methocarbamol Orphenadrine
Pain medications, meperidine	Meperidine	
Pain medications, other	Indomethacin	Ketorolac, includes parenteral and oral

*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.

**A row with one medication is considered a group (or drug class) of one; therefore, two orders of that same medication are numerator compliant.

Table 2 - High-Risk Medications With Days Supply Criteria

Description	Prescription	Days Supply Criteria

Anti-Infectives, other	Nitrofurantoin	Nitrofurantoin macrocrystals- monohydrate	> 90 days

Table 3 – High-Risk Medications With Average Daily Dose Criteria

Description	Prescription	Average Daily Dose Criteria
Cardiovascular, other	Digoxin	> 0.125 mg per day
Tertiary tricyclic antidepressants (TCAs) (as single agent or as part of combination products)	Doxepin	> 6 mg per day

Numerator Instructions:

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 NOTE:

The goal of this measure is to identify any patient that has been prescribed two high-risk medications. As such, patients are to be counted as numerator-compliant regardless of the condition(s) for which the medications are ordered.

Numerator Options:

Performance Not Met:

At least two orders for high-risk medications from the same drug class not ordered (G9368)

OR

Performance Met:

At least two orders for high-risk medications from the same drug class (G9367)

AND

SUBMISSION CRITERIA 2: 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 (CRITERIA 2):

Patients 65 years and older who had 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:

Patients aged ≥ 65 years on date of encounter

AND

Patient encounter during performance period (CPT or HCPCS): 92002, 92004, 92012, 92014, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016,

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*, G0402, 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 (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:

Index Prescription Start Date (IPSD) – The start date of the earliest prescription ordered for a high-risk medication during the measurement period.

Reference Coding/Medication:

Numerator Option for At least two orders for high-risk medications [M1209] is defined by the following table 4, 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 4 - High-Risk Medications

Description	Prescription
Antipsychotics, first (conventional) and second (atypical) generation	Aripiprazole
	Aripiprazole lauroxil
	Asenapine
	Brexipiprazole
	Cariprazine
	Chlorpromazine
	Clozapine
	Fluphenazine
	Haloperidol
	Iloperidone
	Loxapine
	Lurasidone
	Molindone
	Olanzapine
Benzodiazepines, long, short and intermediate acting	Paliperidone
	Perphenazine
	Pimavanserin
	Pimozide
	Quetiapine
	Risperidone
	Thioridazine
	Thiothixene
	Trifluoperazine
	Ziprasidone
	Lorazepam
	Midazolam
	Oxazepam
	Temazepam
	Triazolam
	Estazolam

*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:

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 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)

OR

Performance Met:

At least two orders for high-risk medications from the same drug class, (Table 4), without appropriate diagnoses (M1209)

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 (PIM) 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). Among Medicare beneficiaries it is estimated that the prevalence of PIM use was 77% among long-stay nursing home residents (defined as >101 consecutive days in a nursing home). The most common PIMs were benzodiazepines, antipsychotics, and insulin (Riester et al., 2023).

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 STATEMENT:

The measure is based on recommendations from the American Geriatrics Society Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (2023). 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 and, most recently the American Geriatrics Society Beers Criteria Update Expert Panel in 2023. 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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**2026 Clinical Quality Measure Flow for Quality ID #238 (CBE 0022):
Use of High-Risk Medications in Older Adults
INVERSE MEASURE: LOWER SCORE – BETTER
Multiple Performance Rates**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

ACCOUNTABILITY REPORTING IN THE CMS MIPS PROGRAM: SAMPLE CALCULATIONS

Overall Data Completeness (Submission Criteria One)*=

$$\frac{\text{Performance Met (a)=40 patients} + \text{Performance Not Met (c)=30 patients}}{\text{Eligible Population / Denominator (d)=80 patients}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

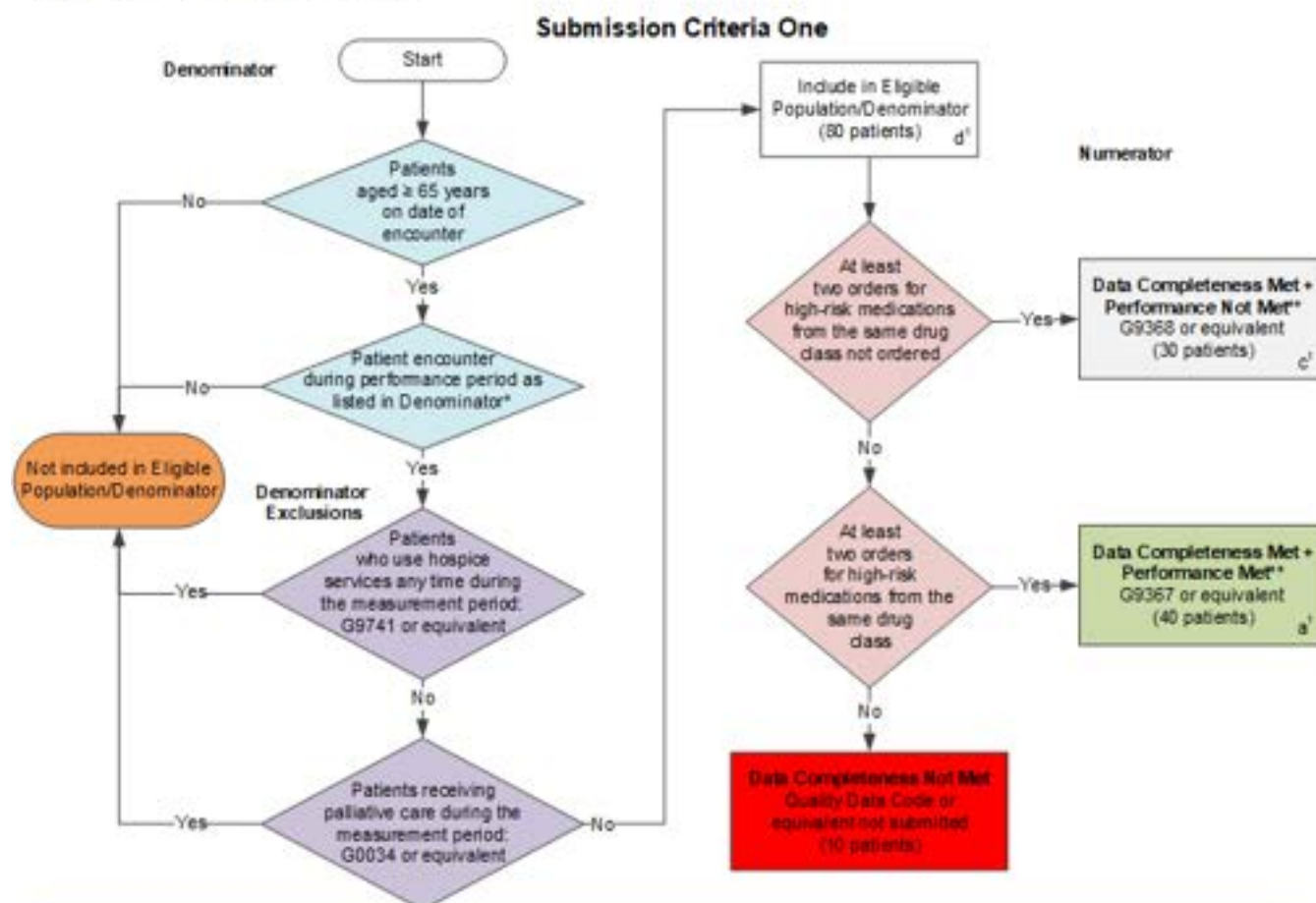
Overall Performance Rate (Submission Criteria One)**=

$$\frac{\text{Performance Met (a)=40 patients}}{\text{Data Completeness Numerator (70 patients)}} = \frac{40 \text{ patients}}{70 \text{ patients}} = 57.14\%$$

* 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



SAMPLE CALCULATION S: SUBMISSION CRITERIA ONE

Data Completeness=

$$\frac{\text{Performance Met (a)=40 patients} + \text{Performance Not Met (c)=30 patients}}{\text{Eligible Population / Denominator (d)=80 patients}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a)=40 patients}}{\text{Data Completeness Numerator (70 patients)}} = \frac{40 \text{ patients}}{70 \text{ patients}} = 57.14\%$$

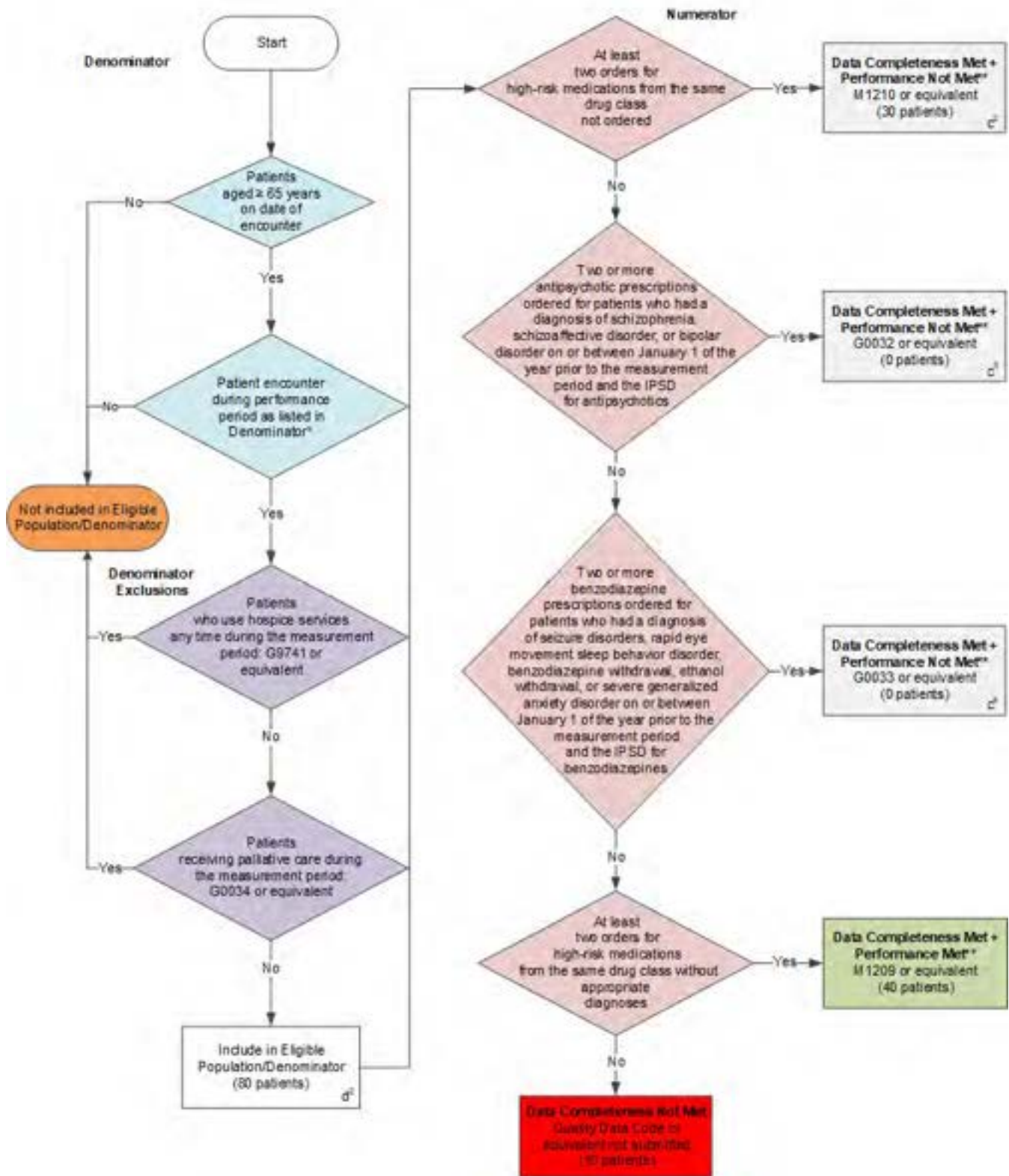
* See the posted measure specification for specific coding and instructions to submit this measure.

**A lower calculated performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Process

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 v10

Submission Criteria Two



SAMPLE CALCULATION S: SUBMISSION CRITERIA TWO

Data Completeness=

$$\frac{\text{Performance Met (a}^2=40 \text{ patients)} + \text{Performance Not Met (c}^2+c^3+c^4=30 \text{ patients)}}{\text{Eligible Population / Denominator (d}^2=80 \text{ patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a}^2=40 \text{ patients)}}{\text{Data Completeness Numerator (70 patients)}} = \frac{40 \text{ patients}}{70 \text{ patients}} = 57.14\%$$

* 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

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v10

2026 Clinical Quality Measure Flow Narrative for Quality ID #238 (CBE 0022): Use of High-Risk Medications in Older Adults

INVERSE MEASURE: LOWER SCORE – BETTER

Multiple Performance Rates

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

Accountability Reporting in the CMS MIPS Program: Sample Calculations:

Overall Data Completeness (Submission Criteria One)* equals Performance Met (a¹ equals 40 patients) plus Performance Not Met (c¹ equals 30 patients) divided by Eligible Population / Denominator (d¹ equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Overall Performance Rate (Submission Criteria One)** equals Performance Met (a¹ 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 calculation performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Process

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 d¹ 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 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 c¹ 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 *At least two orders for high-risk medications from the same drug class*.

9. 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 a¹ 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 *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 (a¹ equals 40 patients) plus Performance Not Met (c¹ equals 30 patients) divided by Eligible Population / Denominator (d¹ equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a¹ 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 d² 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 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 c² 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*.

9. 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 c³ 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*.
10. 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 c⁴ 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 *At least two orders for high-risk medications from the same drug class without appropriate diagnosis*.
11. Check *At least two orders for high-risk medications from the same drug class without appropriate diagnosis*:
- a. If *At least two orders for high-risk medications from the same drug class without appropriate diagnosis equals Yes*, include in *Data Completeness Met and Performance Met***.
- i. *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 a² equals 40 patients in Sample Calculation.
- b. If *At least two orders for high-risk medications from the same drug class without appropriate diagnosis 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

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patient visits for patients aged 18 years and older seen during the performance 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:

Reporting Frequency:

This measure is to be submitted at each visit for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

The intent of this measure is to screen patients for high blood pressure and provide recommended follow-up as indicated. 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 as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this visit measure is submitted each time a patient has a denominator eligible encounter during the performance period.

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".

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. Patient encounters for this measure conducted via telehealth should be removed from the denominator eligible patient population. Therefore, if the patient meets all denominator criteria but the encounter is conducted via telehealth, it would be appropriate to remove them from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When

implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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 performance 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 performance period

AND

Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92532, 92534, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92546, 92622, 92625, 97802, 97803, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99236, 99242, 99243, 99244, 99245, 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, D3921, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, G0101, G0270, G0402, G0438, G0439

WITHOUT

Encounters conducted via telehealth: M1442

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. The time periods for follow-up actions specified for the elevated and the second hypertensive (130-139 DBP OR 80-89 SBP) BP classifications slightly differ from time periods given in the 2017 Guideline. This allows for clinician discretion due to patient condition and stability of the measure specification over time.

Recommended Nonpharmacologic Interventions (Lifestyle Modifications) – The 2017 Guideline outlines

nonpharmacologic interventions which must include one or more of the following as indicated:

- Weight Reduction
- A “heart-healthy diet”, such as Dietary Approaches to Stop Hypertension (DASH) Eating Plan
- Dietary Sodium Restriction
- Increased Physical Activity
- Moderation in alcohol 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 within 6 months <u>AND</u> recommended nonpharmacologic interventions <u>OR</u> Referral to Alternate/Primary Care Provider
First Hypertensive BP Reading	>=130	OR >= 80	Rescreen BP within 4 weeks <u>AND</u> recommended nonpharmacologic interventions <u>OR</u> Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	130-139 and NOT >=140	OR 80-89 and NOT >=90	Recommended nonpharmacologic intervention <u>AND</u> reassessment within 6 months <u>AND</u> an order for laboratory test or ECG for hypertension <u>OR</u> Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	>=140	OR >=90	Recommended nonpharmacologic intervention <u>AND</u> BP-lowering medication <u>AND</u> reassessment within 4 weeks <u>AND</u> an order for laboratory test or ECG for hypertension <u>OR</u> 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 percent of the adult population has hypertension; the majority of people over aged 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 percent (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 percent (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 cardiovascular disease 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 atherosclerotic cardiovascular disease (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 percent 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 American College of Cardiology/American Heart Association (ACC/AHA) 2017 Guidelines provide updated recommendations for ASCVD risk. For additional information please refer to the 2017 ACC/AHA guidelines:

<https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/11/09/11/41/2017-guideline-for-high-blood-pressure-in-adults> (4).

Lifestyle modifications have demonstrated effectiveness in lowering blood pressure (6). 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 the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (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 (7). Follow-up intervals based on blood pressure control have been established by the 2017 ACC/AHA guideline and the United States Preventive Services Task Force (USPSTF).

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults aged 18 years and older. This is a grade A recommendation (8).

REFERENCES:

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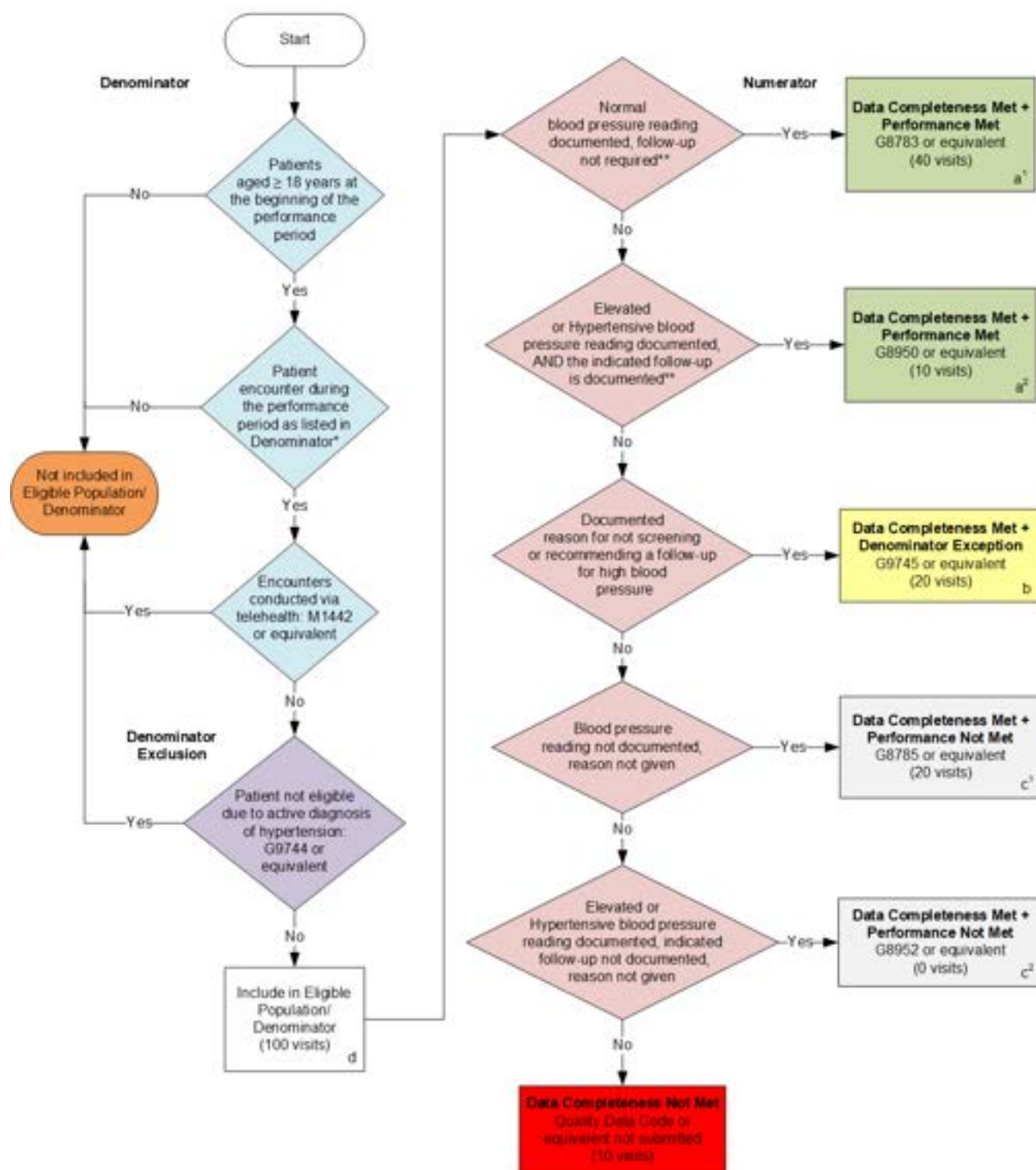
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**2026 Clinical Quality Measure Flow for Quality ID #317:
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.



SAMPLE CALCULATIONS

Data Completeness*

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=50 visits)} + \text{Denominator Exception (b=20 visits)} + \text{Performance Not Met (c}^1\text{+c}^2\text{=20 visits)}}{\text{Eligible Population / Denominator (d=100 visits)}} = \frac{90 \text{ visits}}{100 \text{ visits}} = 90.00\%$$

Performance Rate*

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=50 visits)}}{\text{Data Completeness Numerator (90 visits) – Denominator Exception (b=20 visits)}} = \frac{50 \text{ visits}}{70 \text{ visits}} = 71.43\%$$

*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

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v10

2026 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 performance period*:
 - a. If *Patients aged greater than or equal to 18 years at the beginning of the performance 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 performance 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 *Encounters conducted via telehealth*.
4. Check *Encounters conducted via telehealth*:
 - a. If *Encounters conducted via telehealth* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Encounters conducted via telehealth* 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:
 - 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 a¹ 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 a² 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 c¹ 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 c² 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

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

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

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:

Reporting Frequency:

This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for all patients. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient for the performance period. The most advantageous quality data code will be used if the measure is submitted more than once.

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.

Telehealth:

TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria:

Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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, 90791, 90792, 90839, 96112, 96116, 96136, 96138, 96156, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 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 their findings, provides summary of care information about findings, diagnostics, assessments and/or plans of care, or states the patient did not attend the appointment, 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 inadequate care pathways between specialty and primary care. Studies suggest that both specialists and primary care providers (PCPs) are not satisfied with current processes [1,2]. Breakdowns in referral communication lead to worse health outcomes, increased cost, and appointment delays [3,4]. A 2018 analysis of primary care referrals to specialists found that of the 103,737 referral scheduling attempts analyzed, only 36,072 (34.8%) resulted in documented complete appointments, defined by the specialty clinician providing report to the PCP after the referral visit [3].

Technological and process-based updates can improve the referral loop process and increase rates of closing the referral loop. Ramelson et. al (2018) enhanced an EHR's Referral Manager module to meet the Controlled Risk Insurance Company's best practice steps and the requirements of both the CMS EHR Incentive Program and the National Committee for Quality Assurance Patient-Centered Medical Home program. Following the updates, 76.8% of referrals were completed and all defined referral process steps were easier to accomplish [5]. Odisho et. al (2020) developed a referrals automation software to simplify the fax to referral process. Feedback from key stakeholder interviews noted that the software enhanced the referrals process by further streamlining and organizing the patient referral process [4]. The Institute for Healthcare Improvement and the National Patient Safety Foundation (2017) reviewed the referrals process in the ambulatory care setting and found that organizational leaders, EHR vendors, regulatory agencies, clinicians, and patients all play a role in creating a referrals system that is effective, safe, convenient, and patient-centered [1].

CLINICAL RECOMMENDATION STATEMENTS:

None

REFERENCES:

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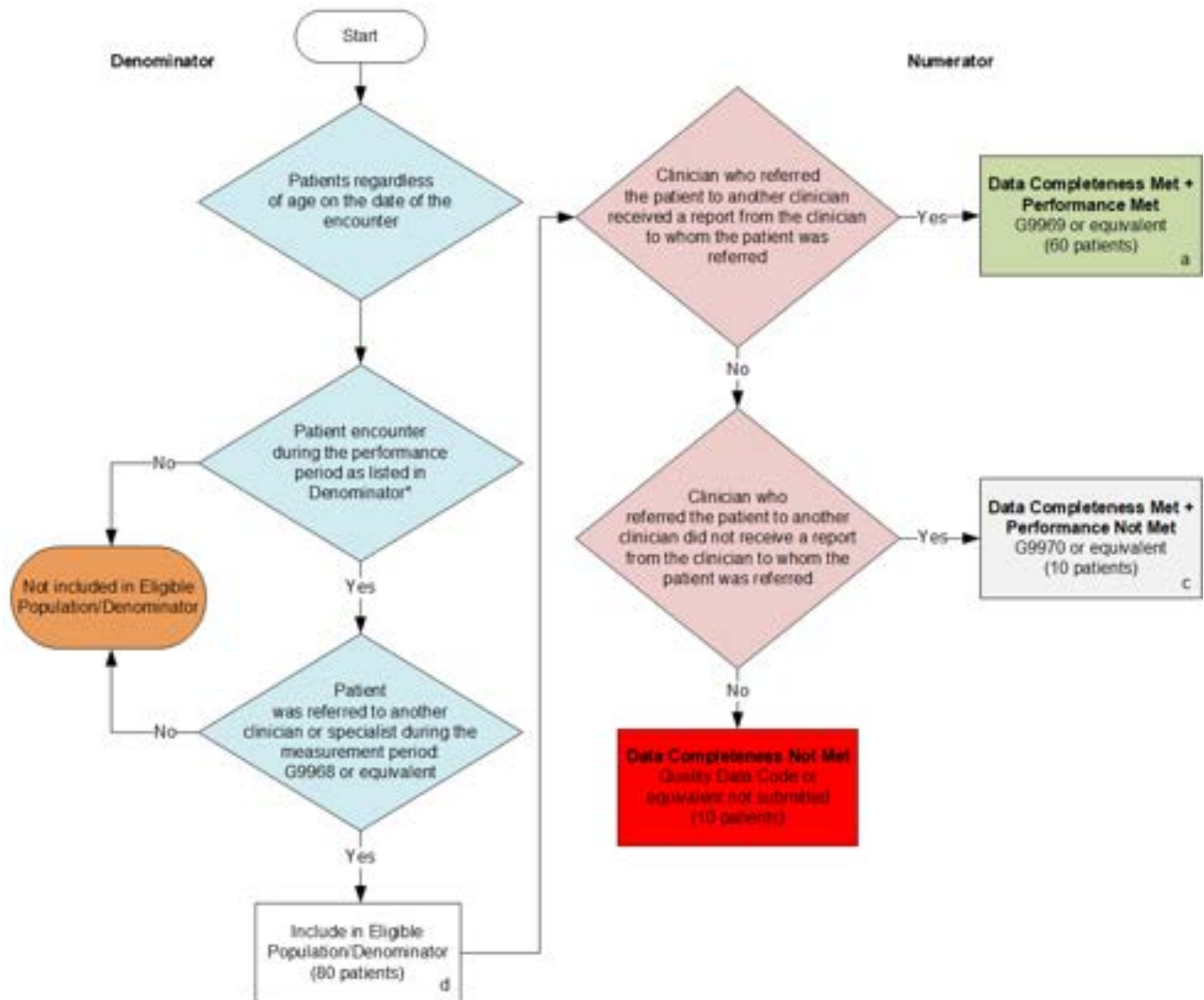
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2026 Clinical Quality Measure Flow for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.



SAMPLE CALCULATIONS

Data Completeness*

$$\frac{\text{Performance Met (a=60 patients)} + \text{Performance Not Met (c=10 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate*

$$\frac{\text{Performance Met (a=60 patients)}}{\text{Data Completeness Numerator (70 patients)}} = \frac{60 \text{ patients}}{70 \text{ patients}} = 85.71\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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2026 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. Check *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 in the 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* 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

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

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:

Reporting Frequency:

This measure is to be submitted each time for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients receiving primary rhegmatogenous retinal detachment surgery. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this procedure measure is submitted each time a procedure is performed.

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 between January 1st and September 30th of the performance period. This will allow the post-operative period to occur before third-party intermediaries must submit data to CMS.

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. This measure is procedure based and therefore doesn't allow for the denominator criteria to be conducted via telehealth. It would be appropriate to remove these patients from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When

implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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

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 NOTE:

For the purposes of meeting the numerator, complications are only those related to the following procedures: 67107, 67108, 67110

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.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcome measure. As such, no clinical recommendations are included.

REFERENCES:

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.

Flaxel CJ, Adelman RA, Bailey ST et al. Posterior Vitreous Detachment, Retinal Breaks, and Lattice Degeneration Preferred Practice Pattern®. Ophthalmology. 2020;127:P146-P181.

Ling, et al, Retinal detachment surgery in district general hospitals: An Audit of Changing Practice, Br J Ophthalmology 2002; 86:827-833.

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.

Sullivan PM, Luff AJ, Aylward GW. Results of primary retinal reattachment surgery: a prospective audit. Eye 1997; 11:869-71.

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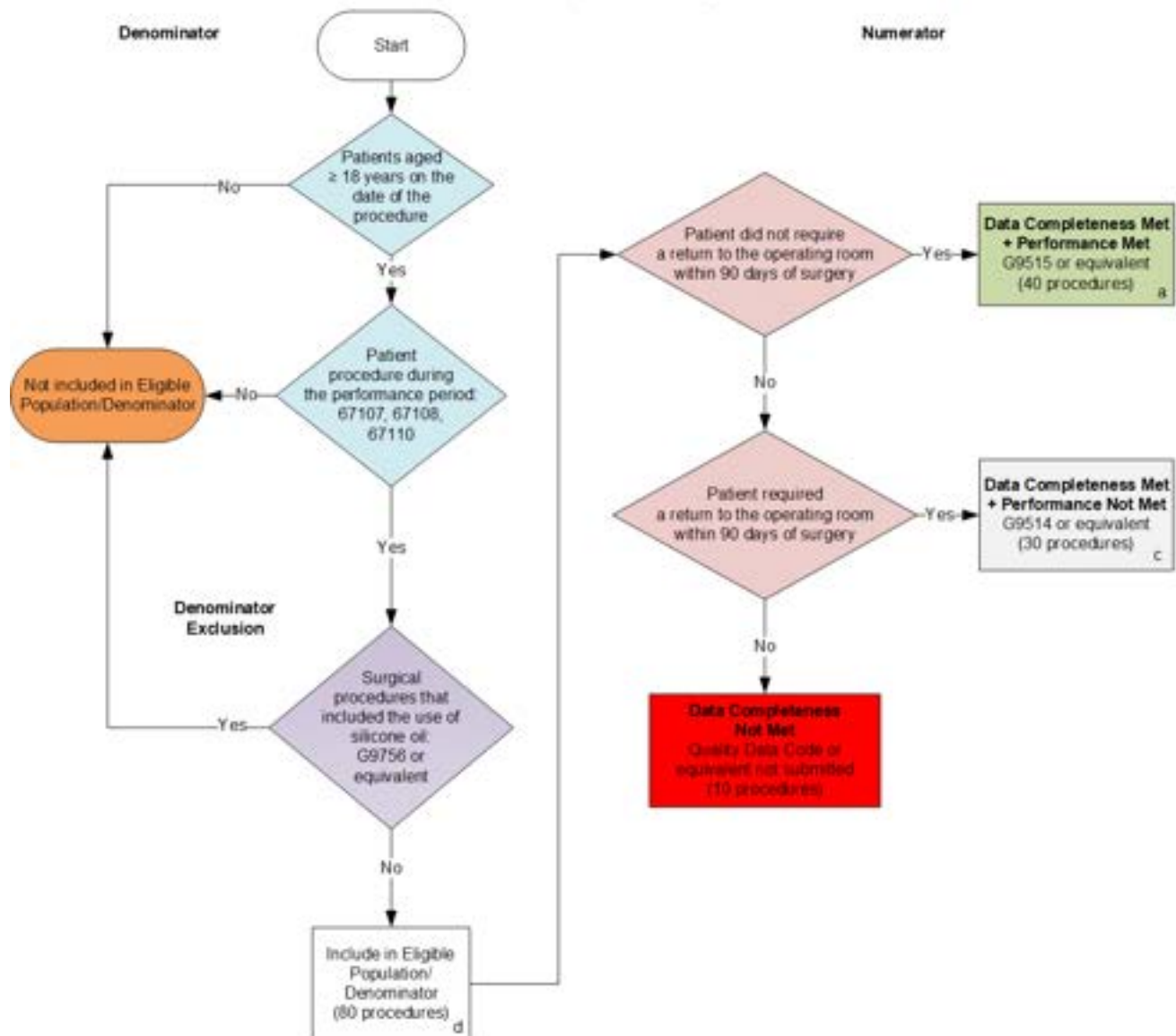
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**2026 Clinical Quality Measure Flow for Quality ID #384:
Adult Primary Rhegmatogenous Retinal Detachment Surgery:
No Return to the Operating Room Within 90 Days of Surgery**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.



SAMPLE CALCULATIONS

Data Completeness=

$$\frac{\text{Performance Met (a=40 procedures)} + \text{Performance Not Met (c=30 procedures)}}{\text{Eligible Population / Denominator (d=80 procedures)}} = \frac{70 \text{ procedures}}{80 \text{ procedures}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a=40 procedures)}}{\text{Data Completeness Numerator (70 procedures)}} = \frac{40 \text{ procedures}}{70 \text{ procedures}} = 57.14\%$$

See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure

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2026 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 *Surgical procedures that included the use of silicone oil*.
4. 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*.
5. 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.
6. Start Numerator
7. 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*.
8. 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*.
9. 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 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

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Quality ID #385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

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:

Reporting Frequency:

This measure is to be submitted each time for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for the patient receiving primary rhegmatogenous retinal detachment surgery.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this procedure measure is submitted each time a procedure is performed.

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 between January 1st and September 30th of the performance period. This will allow the post-operative period to occur before third-party intermediaries must submit data to CMS.

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. This measure is procedure based and therefore doesn't allow for the denominator criteria to be conducted via telehealth. It would be appropriate to remove these patients from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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

AND NOT

DENOMINATOR EXCLUSIONS:

Patients with a pre-operative visual acuity better than 20/40: M1453

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%.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcome measure. As such, no clinical recommendations are included.

REFERENCES:

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.

Flaxel CJ, Adelman RA, Bailey ST et al. Posterior Vitreous Detachment, Retinal Breaks, and Lattice Degeneration Preferred Practice Pattern®. Ophthalmology. 2020;127:P146-P181.

Sullivan PM, Luff AJ, Aylward GW. Results of primary retinal reattachment surgery: a prospective audit. Eye 1997; 11:869-71.

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.

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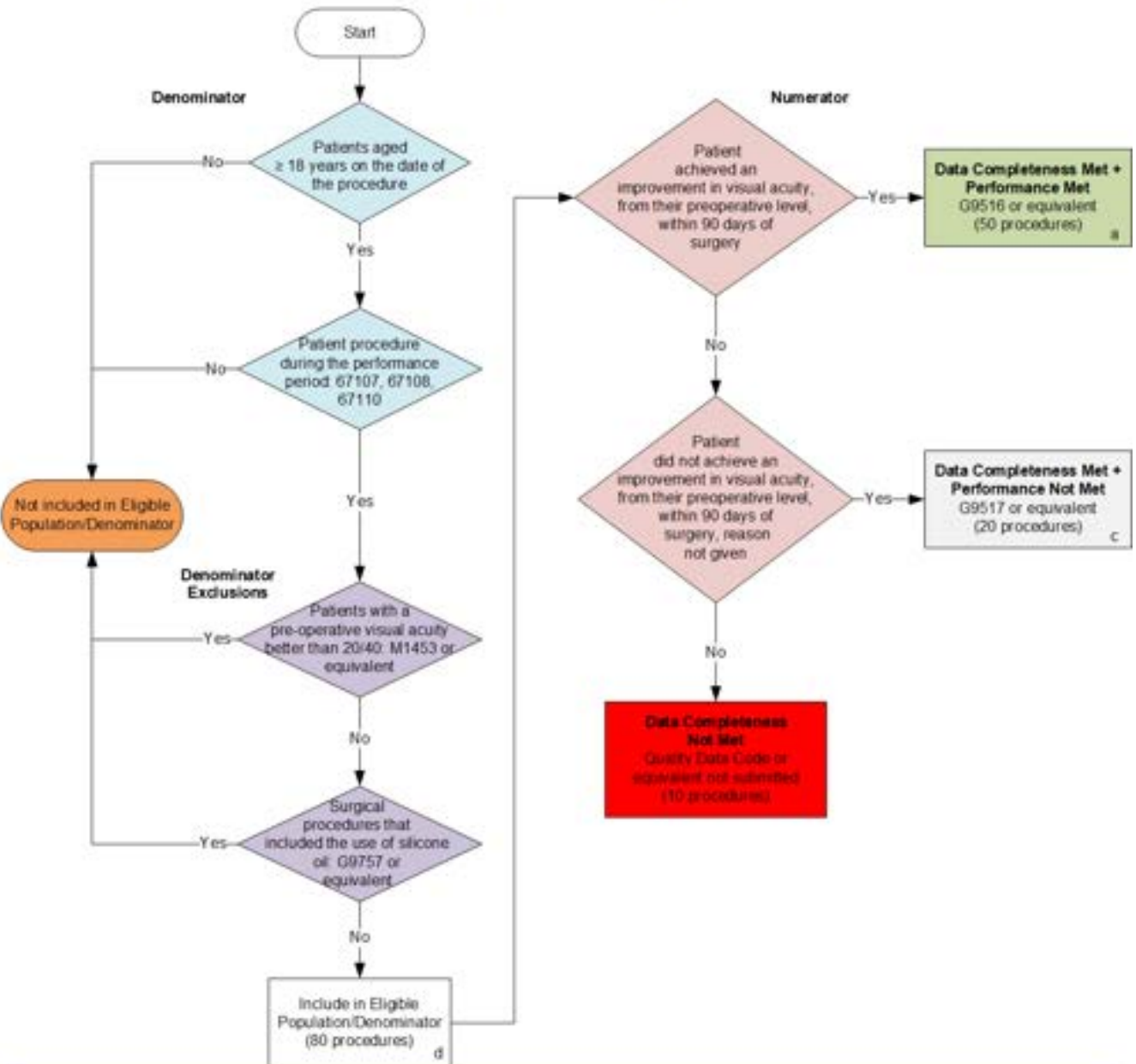
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**2026 Clinical Quality Measure Flow for Quality ID #385:
Adult Primary Rhegmatogenous Retinal Detachment Surgery:
Visual Acuity Improvement Within 90 Days of Surgery**

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

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2026 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 *Patients with a pre-operative visual acuity better than 20/40*.
4. 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*.
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:
 - 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 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*.
9. 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*.
10. 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 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

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

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

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:

Reporting Frequency:

This measure is to be submitted each time for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for the patient receiving cataract surgery. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this procedure measure is submitted each time a procedure is performed.

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 between January 1st and September 30th of the performance period. This will allow the post-operative period to occur before third-party intermediaries must submit data to CMS.

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. This measure is procedure based and therefore doesn't allow for the denominator criteria to be conducted via telehealth. It would be appropriate to remove these patients from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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 procedure during the performance period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984, 66987, 66988, 66989, 66991

WITHOUT

Modifier: 55 or 56

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 NOTE:

It would be expected that the planned (target) refraction be assessed and documented within 90 days prior to the denominator eligible 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.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcome measure. As such, no clinical recommendations are included.

REFERENCES:

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

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

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_

Miller KM, Oetting TA, Tweeten JP et al; American Academy of Ophthalmology Preferred Practice Pattern Cataract/Anterior Segment Panel. Cataract in the Adult Eye Preferred Practice Pattern. *Ophthalmology*. 2022;129:P1-P126.

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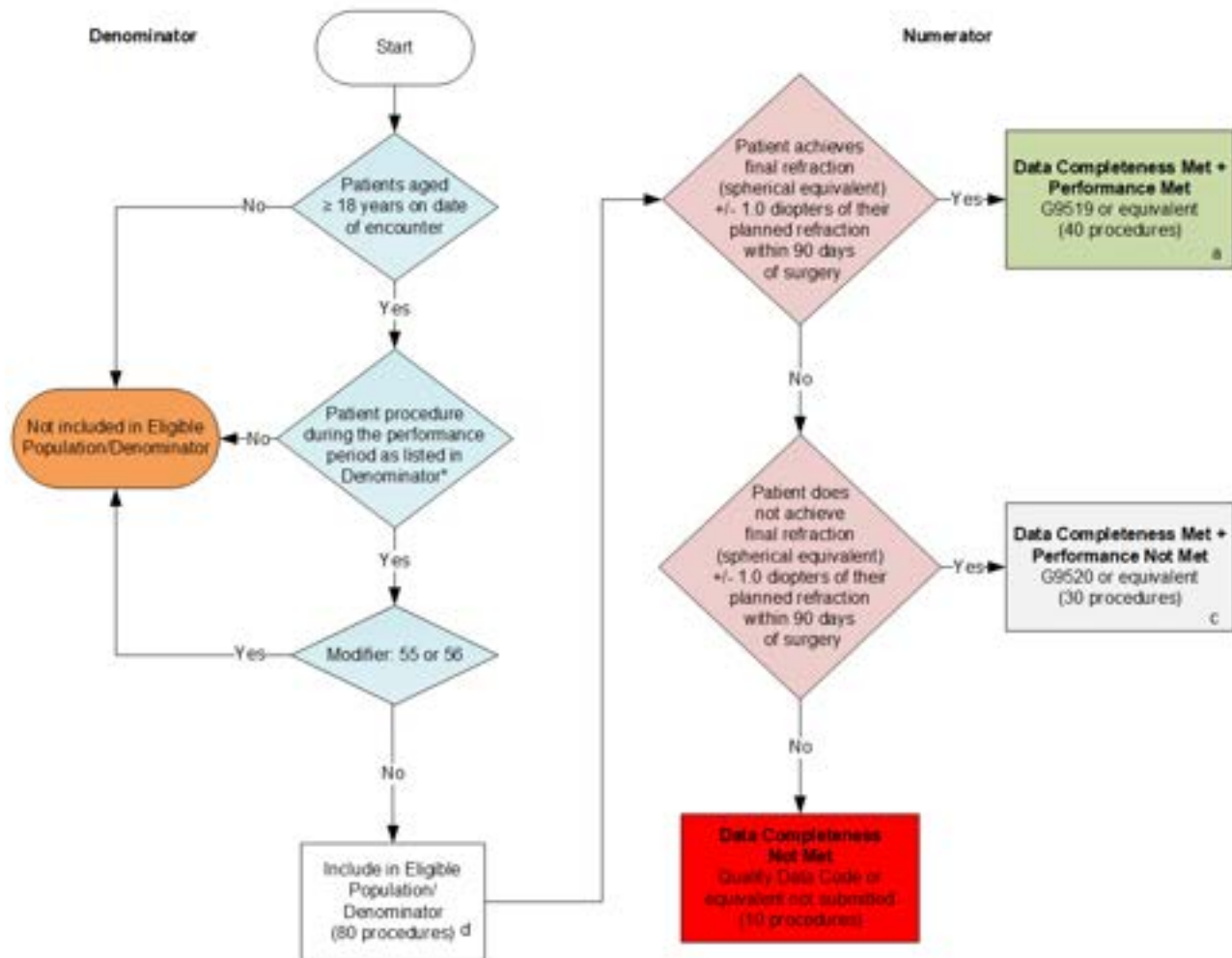
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**2026 Clinical Quality Measure Flow for Quality ID #389:
Cataract Surgery: Difference Between Planned and Final Refraction**

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) = 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

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2026 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 procedure during the performance period as listed in Denominator**.
3. Check *Patient procedure during the performance period as listed in Denominator**:
 - a. If *Patient procedure during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient procedure during the performance period as listed in Denominator** equals Yes, proceed to check *Modifier*.
4. Check *Modifier*:
 - a. If *Modifier: 55 or 56* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Modifier: 55 or 56* equals No, include in *Eligible Population/Denominator*.
5. 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.
6. Start Numerator
7. 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.
8. 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.
9. 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 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

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

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

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:

Reporting Frequency:

This measure is to be submitted for each procedure that is denominator eligible as defined in the denominator criteria.

Intent and Clinician Applicability:

The intent of this measure is to assess that biopsy and excision pathology reports for patients with primary malignant cutaneous melanoma include the pT category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For purposes of MIPS implementation, this procedure measure is submitted each time a procedure is performed during the performance period. 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.

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. This measure is procedure based and therefore doesn't allow for the denominator criteria to be conducted via telehealth. It would be appropriate to remove these patients from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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.

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 procedure during performance period (CPT): 88305

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 updated guidelines for management of primary cutaneous melanoma. In addition to re-affirming the importance of 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.”

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.

REFERENCES:

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](https://www.jaad.org/article/S0190-9622(18)32588-X/fulltext)

Priyadharsini Nagarajan, MD, PhD ; Wonwoo Shon, DO; Klaus J. Busam, MD, David P. Frishberg, MD ; et al.(2025). Protocol for the Examination of Excision Specimens From Patients With Melanoma of the Skin. College of American Pathologists. [Skin.Inv. Melanoma.Res. 1.2.0.0.REL.CAPCP.pdf](#)

Priyadharsini Nagarajan, MD, PhD ; Wonwoo Shon, DO; Klaus J. Busam, MD, David P. Frishberg, MD; et al.(2025). Protocol for the Examination of Biopsy Specimens From Patients With Melanoma of the Skin. College of American Pathologists. [Skin.Inv. Melanoma.Bx. 1.1.0.0.REL.CAPCP.pdf](#)

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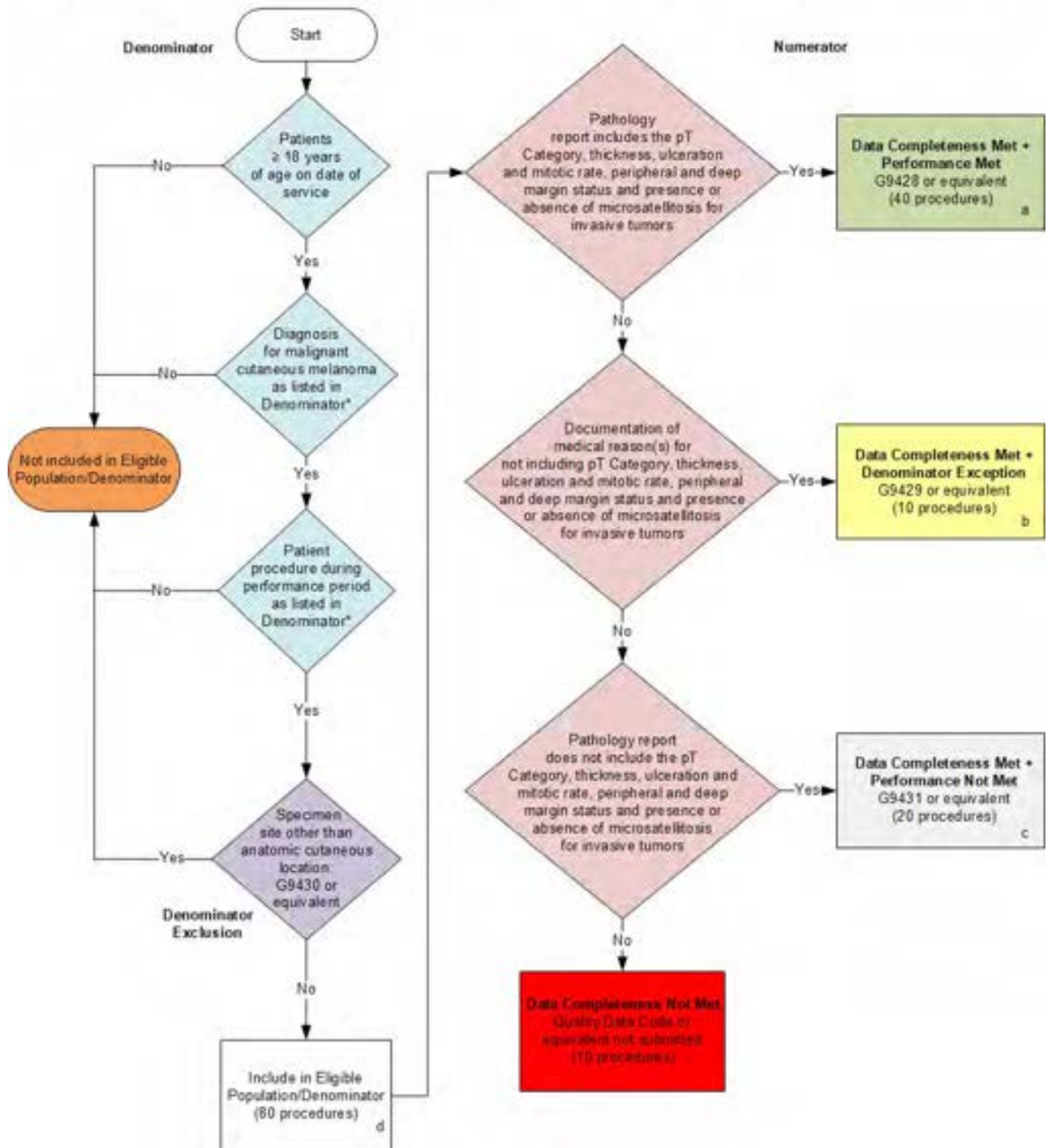
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2026 Clinical Quality Measure Flow for Quality ID #397: Melanoma Reporting

Disclaimer: Refer to measure specification for specific coding and instructions to submit this measure.



SAMPLE CALCULATIONS

Data Completeness=

$$\frac{\text{Performance Met (a=40 procedures)} + \text{Denominator Exception (b=10 procedures)} + \text{Performance Not Met (c=20 procedures)}}{\text{Eligible Population / Denominator (d=80 procedures)}} = \frac{70 \text{ procedures}}{80 \text{ procedures}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a=40 procedures)}}{\text{Data Completeness Numerator (70 procedures) - Denominator Exception (b=10 procedures)}} = \frac{40 \text{ procedures}}{60 \text{ procedures}} = 66.67\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure

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2026 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 Denominator**.
3. Check *Diagnosis for malignant cutaneous melanoma as listed in Denominator**:
 - a. If *Diagnosis for malignant cutaneous melanoma as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Diagnosis for malignant cutaneous melanoma as listed in Denominator** equals Yes, proceed to check *Patient procedure during performance period as listed in Denominator**.
4. Check *Patient procedure during performance period as listed in Denominator**:
 - a. If *Patient procedure during performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient procedure during performance period as listed in Denominator** equals Yes, proceed to check *Specimen site other than anatomic cutaneous location*.
5. 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*.
6. 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.
7. Start Numerator
8. 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*.
9. 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 *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*.
9. 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.
 - c. 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*.
11. Check *Data Completeness Not Met*:
- If *Data Completeness Not Met*, the Quality Data Code 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 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 Exclusion (x equals 0 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

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

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

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:

Reporting Frequency:

This measure is to be submitted each time a biopsy is performed for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients who undergo biopsies with a diagnosis of cutaneous basal cell carcinoma (BCC). It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians providing the pathology services for procedures will submit this measure.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this procedure measure is submitted each time a procedure is performed during the performance period.

To be eligible for this measure, the denominator must be met during the measurement period of 01/01/2026 to 12/24/2026. 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.

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. This measure is procedure based and therefore doesn't allow for the denominator criteria to be conducted via telehealth. It would be appropriate to remove these patients from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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): 88305

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/Dermatopathologist'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..."

REFERENCES:

Kufe, D. W., Pollock, R. E., Weichselbaum, R. R., Bast, R. C., Hait, W. N., Holland, J. F., & Frei, E. (Eds.). (2010). Holland-Frei Cancer Medicine (8th ed.). People's Medical Publishing House

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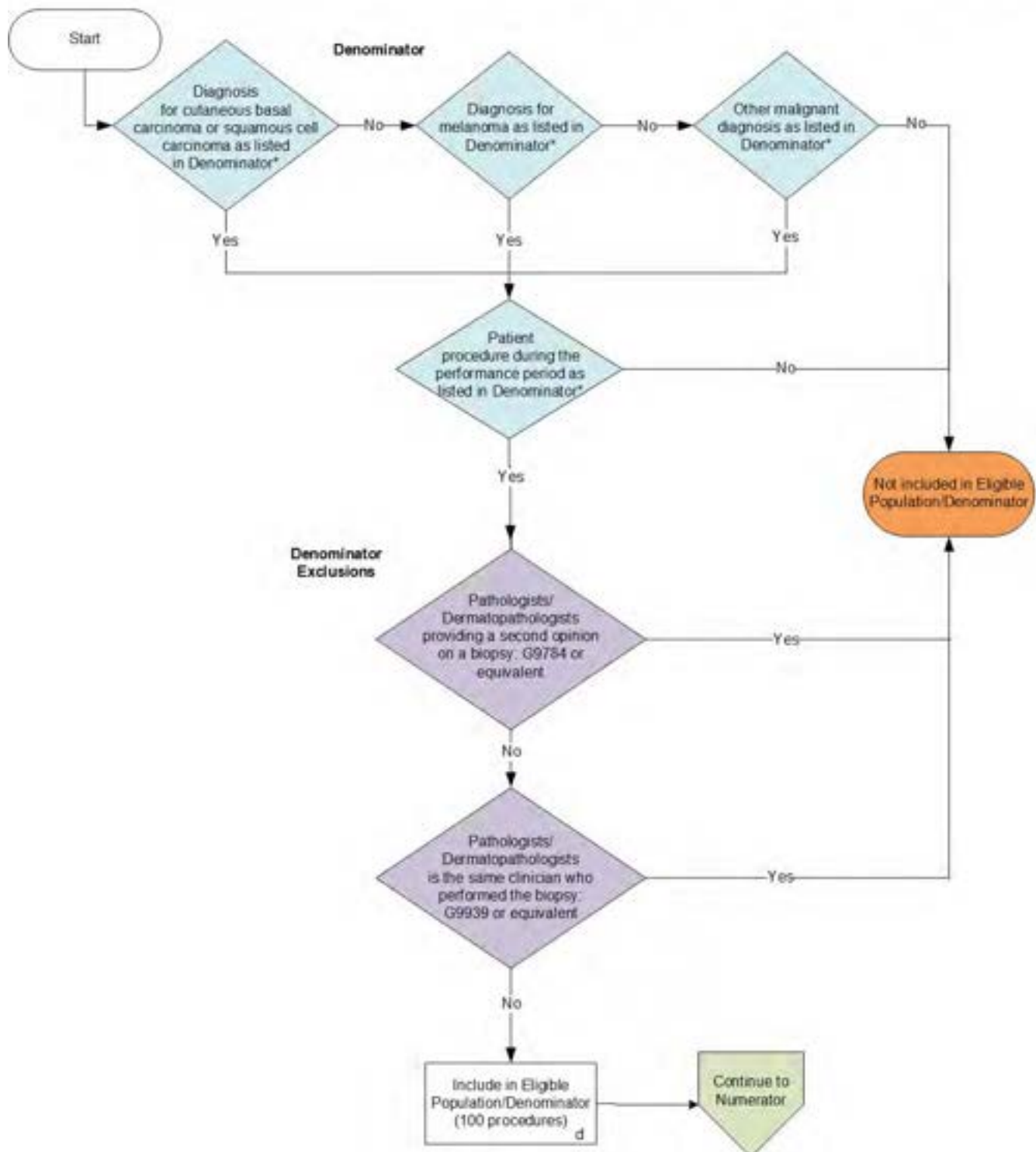
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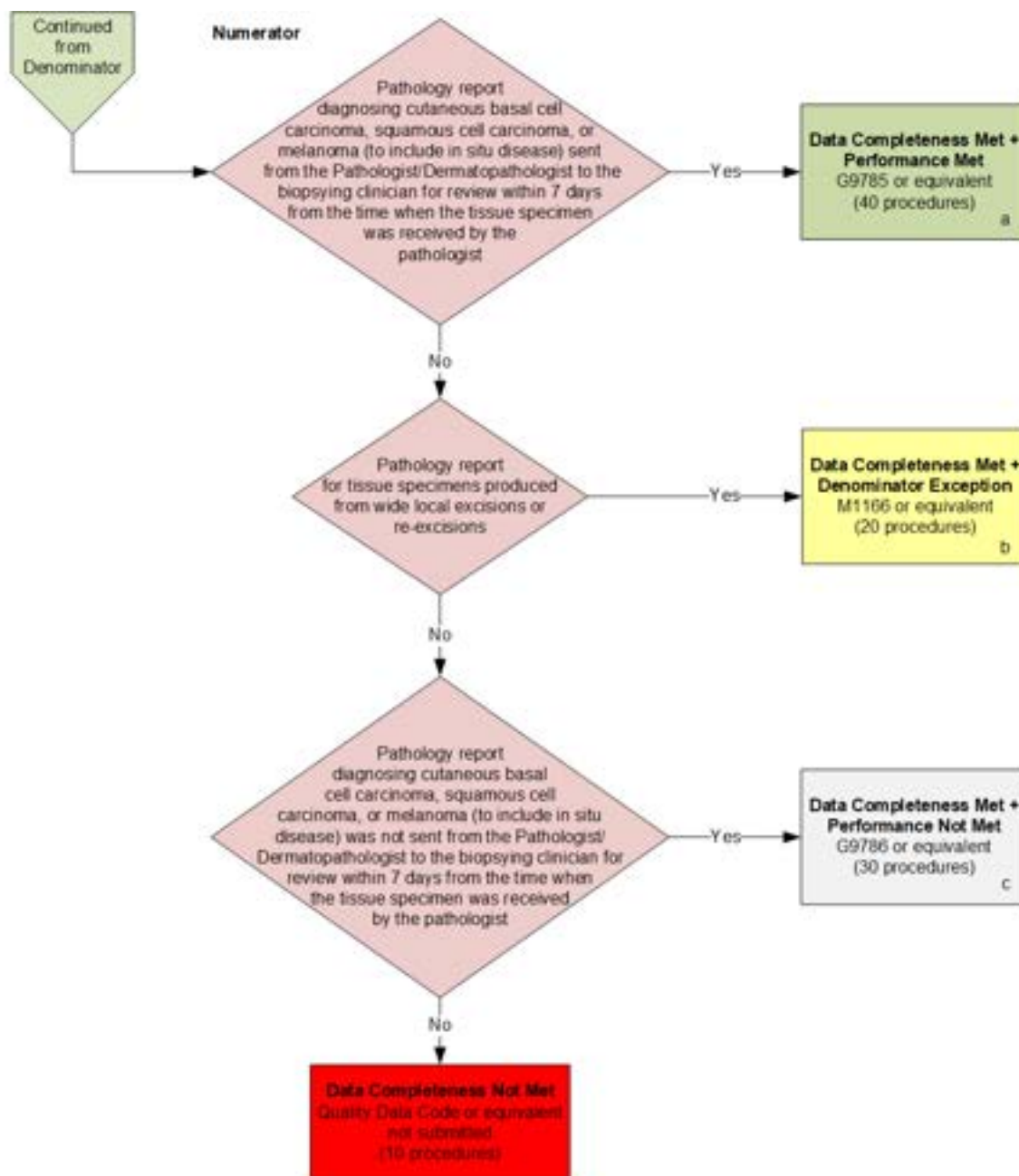
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**2026 Clinical Quality Measure Flow for Quality ID #440:
Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician**

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) = 90 procedures = **90.00%**
Eligible Population / Denominator (d=100 procedures) = 100 procedures

Performance Rate*

Performance Met (a=40 procedures) = 40 procedures = **57.14%**
Data Completeness Numerator (90 procedures) – Denominator Exceptions (b=20 procedures) = 70 procedures

* See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure

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2026 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 as listed in Denominator**.
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 as listed in Denominator**.
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 as listed in Denominator**.
5. Check *Patient procedure during the performance period as listed in Denominator**:
 - a. If *Patient procedure during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient procedure during the performance period as listed in Denominator** equals Yes, proceed to check *Pathologists/Dermatopathologists providing a second opinion on a biopsy*.
6. 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*.
7. 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*.

8. 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 100 procedures in the Sample Calculation.

9. Start Numerator

10. 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*.

11. 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*.

12. 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.

13. 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

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 #499: Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients who had an intravitreal or periocular corticosteroid injection (e.g., triamcinolone, preservative-free triamcinolone, dexamethasone, dexamethasone intravitreal implant, or fluocinolone intravitreal implant) who, within seven (7) weeks following the date of injection, are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP $\leq$ 25 mm Hg for injected eye OR if the IOP was $>$ 25 mm Hg, a plan of care was documented.

INSTRUCTIONS:

Reporting Frequency:

This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients who had an intravitreal or periocular corticosteroid injection. 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 Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient during the performance period. The most advantageous quality data code will be used if the measure is submitted more than once.

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. Patient encounters for this measure conducted via telehealth should be removed from the denominator eligible patient population. Therefore, if the patient meets all denominator criteria but the encounter is conducted via telehealth, it would be appropriate to remove them from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more

information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:

Patients who had an intravitreal or periocular corticosteroid injection (e.g., triamcinolone, preservative-free triamcinolone, dexamethasone, dexamethasone intravitreal implant, or fluocinolone intravitreal implant) with a patient encounter during the performance 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):

All patients regardless of age

AND

Patient encounters during the performance period (CPT): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*

WITHOUT

Encounters conducted via telehealth: M1426

AND

Patients who had an intravitreal or periocular corticosteroid injection (e.g., triamcinolone, preservative-free triamcinolone, dexamethasone, dexamethasone intravitreal implant, or fluocinolone intravitreal implant): M1324

AND NOT

DENOMINATOR EXCLUSION:

Patients with a diagnosis of hypotony: M1326

NUMERATOR:

Number of patients who, within seven (7) weeks following the date of injection, are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP $\leq$ 25 mm Hg for injected eye listed in chart OR if the IOP was $>$ 25 mm Hg, a plan of care was documented.

Definition:

Plan of care – Plan of care includes one of the following: placement on IOP lowering medication (i.e., placement on a new medication, change in frequency or dose of an existing medication, or re-prescribing/renewing an existing medication), order for or performance of a IOP lowering procedure, referral to eye care provider for management of elevated IOP, or return within 4 weeks for IOP re-check.

Numerator Instructions:

For patients who receive more than one injection during the measurement period (12 months), screening only needs to occur once to meet the numerator. Tonometry with documented IOP should occur for the same eye that was injected.

NUMERATOR NOTE:

If the intravitreal or periocular corticosteroid injection occurs from November 12th – December 31st of the performance period and the patient is not able to be seen for follow-up within the performance period, it would be appropriate to report the denominator exception for inadequate time for follow-up.

Numerator Options:

Performance Met:

Patients seen within 7 weeks following the date of injection AND are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP $\leq$ 25 mm Hg for injected eye (M1322)

OR

Performance Met:

Patients seen within 7 weeks following the date of injection AND are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP $>$ 25 mm Hg AND a plan of care was documented (M1323)

OR

Denominator Exception:

Patients who were not seen for reasons documented by clinician for patient or medical reasons (e.g., inadequate time for follow-up, patients who received a prior intravitreal or periocular steroid injection within the last six (6) months and had a subsequent IOP evaluation with IOP $<$ 25mm Hg within seven (7) weeks of treatment) (M1325)

OR

Performance Not Met:

Patients who were not seen within 7 weeks following the date of injection for follow up OR who did not have a documented IOP OR no plan of care documented if the IOP was $>$ 25 mm Hg (M1321)

RATIONALE:

Patients treated with corticosteroid therapy are at increased risk for elevated IOP leading to steroid-induced glaucoma and their quality of life may be negatively impacted due to visual impairments (Breusegem, 2009; Haller, 2011; Iwao, 2007; Jonas, 2003; Phulke, 2017; Skalicky, 2012; Smithen, 2004; Vedantham, 2005).

Several randomized clinical trials and a systematic review identified that IOPs typically peak around 7-9 weeks (Haller, 2010; Kiddee, 2013; Aref, 2015). Ensuring that appropriate monitoring is conducted to detect and treat this complication is important to prevent significant visual morbidity. This measure encourages providers to screen and treat patients identified with an elevated IOP in a timely manner.

CLINICAL RECOMMENDATION STATEMENTS:

While current clinical guidelines do not address the need to assess for elevated IOP following corticosteroid injection, a systematic review completed by Kiddee and colleagues (Kiddee, 2013) identified that 10.9% to 79.0% of these patients will develop clinically significant IOP elevations with the large variation in incidence dependent largely on the specific steroid utilized and dose administered. The timing of IOP elevation also varies based on the type and dose; although, the available literature consistently shows IOP peaking in the 4-8 week range following injection with higher and earlier elevations following intravitreal triamcinolone injections as compared to intravitreal dexamethasone implants. This review recommended that IOP be assessed every two weeks in the first month and monthly for an additional six months at a minimum. Well-designed randomized controlled trials also support initial follow-up of no later than seven weeks. The Standard of Care vs. Corticosteroid for Retinal Vein Occlusion (SCORE) study where pressures peaked within 52.5 days following 4 mg intravitreal triamcinolone acetate injection and the GENEVA study examining the effectiveness of dexamethasone intravitreal injections saw IOP peak within 60 days (Haller, 2010; Aref, 2015). For patients with a diagnosis of glaucoma, these symptoms can occur earlier and we would expect the follow up timeframe would occur sooner such as within the first four weeks following the injection (Vie, 2017).

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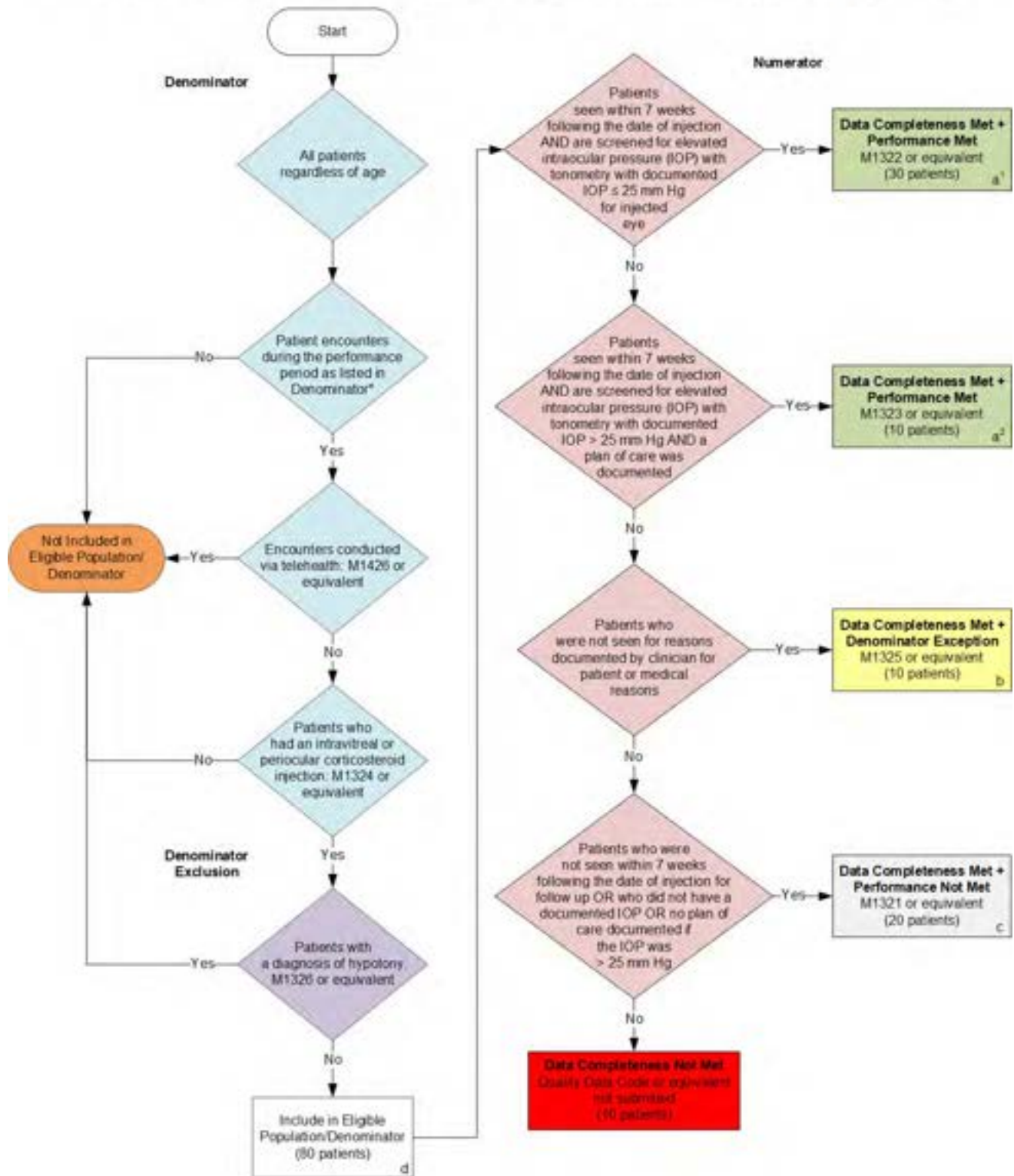
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**2026 Clinical Quality Measure Flow for Quality ID #499:
Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal
or Periocular Steroid Therapy**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.



SAMPLE CALCULATIONS

Data Completeness =

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=40 patients)} + \text{Denominator Exception (b=10 patients)} + \text{Performance Not Met (c=20 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=40 patients)}}{\text{Data Completeness Numerator (70 patients) – Denominator Exception (b=10 patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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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

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2026 Clinical Quality Measure Flow Narrative for Quality ID #499:
Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or
Periocular Steroid Therapy

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

1. Start with Denominator
2. Check *All patients regardless of age*
3. Check *Patient encounters during the performance period as listed in Denominator**:
 - a. If *Patient encounters during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient encounters during the performance period as listed in Denominator** equals Yes, proceed to check *Encounters conducted via telehealth as listed in Denominator**.
4. Check *Encounters conducted via telehealth as listed in Denominator**:
 - a. If *Encounters conducted via telehealth as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Encounters conducted via telehealth as listed in Denominator** equals No, proceed to check *Patients who had an intravitreal or periocular corticosteroid injection*.
5. Check *Patients who had an intravitreal or periocular corticosteroid injection*:
 - a. If *Patients who had an intravitreal or periocular corticosteroid injection* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients who had an intravitreal or periocular corticosteroid injection* equals Yes, proceed to check *Patients with a diagnosis of hypotony*.
6. Check *Patients with a diagnosis of hypotony*:
 - a. If *Patients with a diagnosis of hypotony* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients with a diagnosis of hypotony* equals No, include in *Eligible Population/Denominator*.
7. 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.
8. Start Numerator
9. Check *Patients seen within 7 weeks following the date of injection AND are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP less than or equal to 25 mm Hg for injected eye*:
 - a. If *Patients seen within 7 weeks following the date of injection AND are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP less than or equal to 25 mm Hg for injected eye* 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 a¹ equals 30 patients in the Sample Calculation.
- b. If *Patients seen within 7 weeks following the date of injection AND are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP less than or equal to 25 mm Hg for injected eye* equals No, proceed to check *Patients seen within 7 weeks following the date of injection AND are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP greater than 25 mm Hg AND a plan of care was documented*.
10. Check *Patients seen within 7 weeks following the date of injection AND are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP greater than 25 mm Hg AND a plan of care was documented*:
 - a. If *Patients seen within 7 weeks following the date of injection AND are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP greater than 25 mm Hg AND a plan of care was 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 a² equals 10 patients in the Sample Calculation.
 - b. If *Patients seen within 7 weeks following the date of injection AND are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP greater than 25 mm Hg AND a plan of care was documented* equals No, proceed to check *Patients who were not seen for reasons documented by clinician for patient or medical reasons*.
 11. Check *Patients who were not seen for reasons documented by clinician for patient or medical reasons*:
 - a. If *Patients who were not seen for reasons documented by clinician for patient or medical reasons* 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 patients in the Sample Calculation.
 - b. If *Patients who were not seen for reasons documented by clinician for patient or medical reasons* equals No, proceed to check *Patients who were not seen within 7 weeks following the date of injection for follow up OR who did not have a documented IOP OR no plan of care documented if the IOP was greater than 25 mm Hg*.
 12. Check *Patients who were not seen within 7 weeks following the date of injection for follow up OR who did not have a documented IOP OR no plan of care documented if the IOP was greater than 25 mm Hg*:
 - a. If *Patients who were not seen within 7 weeks following the date of injection for follow up OR who did not have a documented IOP OR no plan of care documented if the IOP was greater than 25 mm Hg* 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 patients in the Sample Calculation.
 - b. If *Patients who were not seen within 7 weeks following the date of injection for follow up OR who did not have a documented IOP OR no plan of care documented if the IOP was greater than 25 mm Hg* 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

Data Completeness equals Performance Met (a^1 plus a^2 equals 40 patients) plus Denominator Exception (b 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^1 plus a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b 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

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 #500: Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients with a diagnosis of acute posterior vitreous detachment (PVD) in either eye who were appropriately evaluated during the initial exam and were re-evaluated no later than 8 weeks.

INSTRUCTIONS:

Reporting Frequency:

This measure is to be submitted once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients with a diagnosis of acute posterior vitreous detachment (PVD). This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions, as defined by the numerator, based on the services provided the measure-specific denominator coding.

Measure Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient during the performance period. The most advantageous quality data code will be used if the measure is submitted more than once.

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. Patient encounters for this measure conducted via telehealth should be removed from the denominator eligible patient population. Therefore, if the patient meets all denominator criteria but the encounter is conducted via telehealth, it would be appropriate to remove them from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:

Patients with a diagnosis of acute PVD in either eye and eligible encounter during performance period.

Definition:

Acute PVD – For the purposes of this measure, acute PVD is defined as a recent onset of 30 days or less. Acute can be documented as new onset vitreous separation or vitreous detachment.

DENOMINATOR NOTE:

A new diagnosis code, that meets the definition of acute PVD, indicates a new occurrence of PVD. If there are multiple occurrences of acute PVD, then the most recent occurrence should be utilized as denominator eligible for the purposes of submitting this measure.

**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 posterior vitreous detachment (ICD-10-CM): H43.811, H43.812, H43.813, H43.819

AND

Acute PVD: M1383

AND

Patient encounters during the performance period (CPT): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*

WITHOUT

Encounters conducted via telehealth: M1426

AND NOT

DENOMINATOR EXCLUSIONS:

Patients with a post-operative encounter of the eye with the acute PVD within 2 weeks before the initial encounter or 8 weeks after initial acute PVD encounter: M1329

OR

Patients with a diagnosis of acute vitreous hemorrhage: M1328

NUMERATOR:

Patients who were appropriately evaluated during the initial exam and were re-evaluated no later than 8 weeks.

Definitions:

Initial exam – To meet performance of the measure, an initial exam must include a vitreous examination AND peripheral dilated examination with documentation of scleral depression of the affected eye or contact lens (e.g., 3-mirror Goldmann) that provides visualization to the ora for 360 degrees OR if the retina cannot be adequately visualized, then ultrasound was performed OR referred to another provider for additional examination (e.g., if retina cannot be visualized and ultrasound is not available).

Re-evaluation exam – To meet performance of the measure, a re-evaluation must occur no later than 8 weeks from initial examination and must include a vitreous examination AND an adequate dilated examination to evaluate the peripheral retina for tears or detachment OR if the retina cannot be adequately visualized, then ultrasound was performed OR referred to another provider for additional examination (e.g., if retina cannot be visualized and ultrasound is not available).

NUMERATOR NOTE:

If the initial exam occurs from November 5th – December 31st of the performance period and the patient is not able to be seen for follow-up within the performance period, it would be appropriate to report the denominator exception for inadequate time for follow-up.

Numerator Options:

Performance Met:

Patients who were appropriately evaluated during the initial exam AND were re-evaluated no later than 8 weeks from initial exam (M1331)

OR

Denominator Exception:

Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up) (M1330)

OR

Performance Not Met:

Patients who were not appropriately evaluated during the initial exam AND/OR who were not re-evaluated within 8 weeks (M1327)

RATIONALE:

Retinal tears, if treated promptly, are less likely to result in detachment (AAO, 2019; ASRS, 2016). Most retinal tears occur in the setting of an acute PVD where patient experience flashes of light and/or new onset of floaters. While the onset of PVD is generally not preventable, prompt examination is critical to identify and treat any associated retinal tears. Prompt treatment will minimize the potential for complications such as retinal detachment and improve a patient's quality of life (AAO, 2019).

CLINICAL RECOMMENDATION STATEMENTS:

This measure is based on clinical recommendations adapted from the AAO Preferred Practice Guidelines (AAO, 2019), which are excerpted below.

The eye examination should include the following elements:

Examination of the vitreous for hemorrhage, detachment, and pigmented cells

Careful examination of the peripheral fundus using scleral depression

There are no symptoms that can reliably distinguish between a PVD with or without an associated retinal break; therefore, a peripheral retinal examination is required. The preferred method of evaluating patients for peripheral vitreoretinal pathology is to use an indirect ophthalmoscope combined with scleral depression. Many patients with retinal tears have blood and pigmented cells in the anterior vitreous. In fully dilated eyes, slit-lamp biomicroscopy with a mirrored contact lens or a condensing lens is an alternative method in fully dilated eyes instead of a scleral depressed indirect examination of the peripheral retina.

Follow-up Evaluation:

The guidelines in Table 3 are recommendations for the timing of re-evaluation in the absence of additional symptoms. Patients with new symptoms or a change in symptoms may require more frequent evaluation. Patients with no positive findings at the initial examination should be seen at the intervals recommended in the Comprehensive Adult Medical Eye Evaluation PPP. All patients with risk factors should be advised to contact their ophthalmologist promptly if new symptoms such as flashes, floaters, peripheral visual field loss, or decreased visual acuity develop.

Type of Lesion

- Symptomatic PVD with no retinal break

Follow-up Interval

- Depending on symptoms, risk factors, and clinical findings, patients may be followed within 2 months, then 6–12 months

REFERENCES:

American Academy of Ophthalmology Retina/Vitreous Preferred Practice Pattern Panel. Preferred Practice Pattern® Guidelines. Posterior Vitreous Detachment, Retinal Breaks, and Lattice Degeneration PPP 2019. San Francisco, CA: American Academy of Ophthalmology; 2019. Available at: www.aao.org/ppp.

American Society of Retina Specialists. Retina health series: Posterior vitreous detachment. Available at: https://www.asrs.org/content/documents/fact_sheet_1_posterior_vitreous_detachment_new.pdf.

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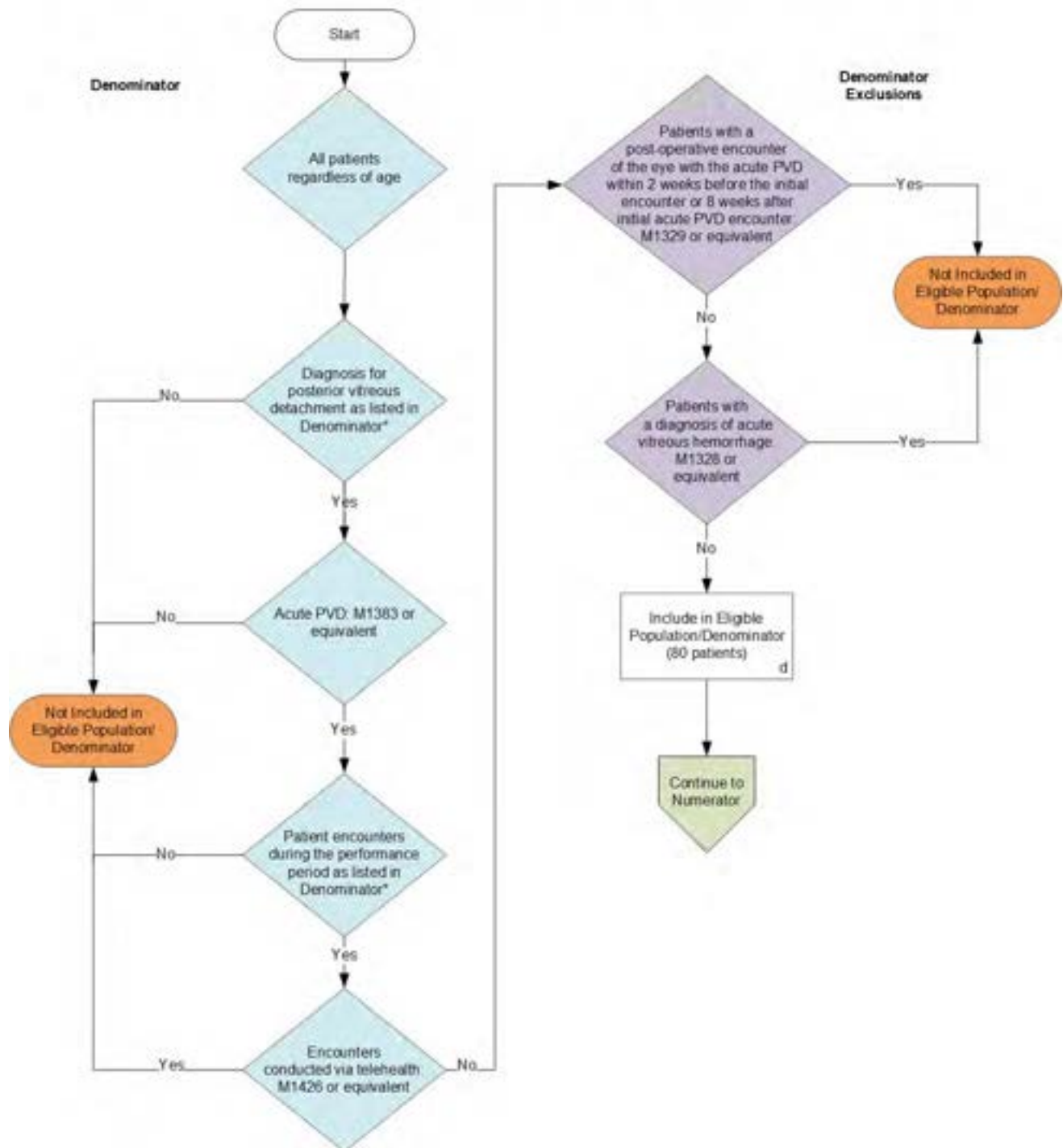
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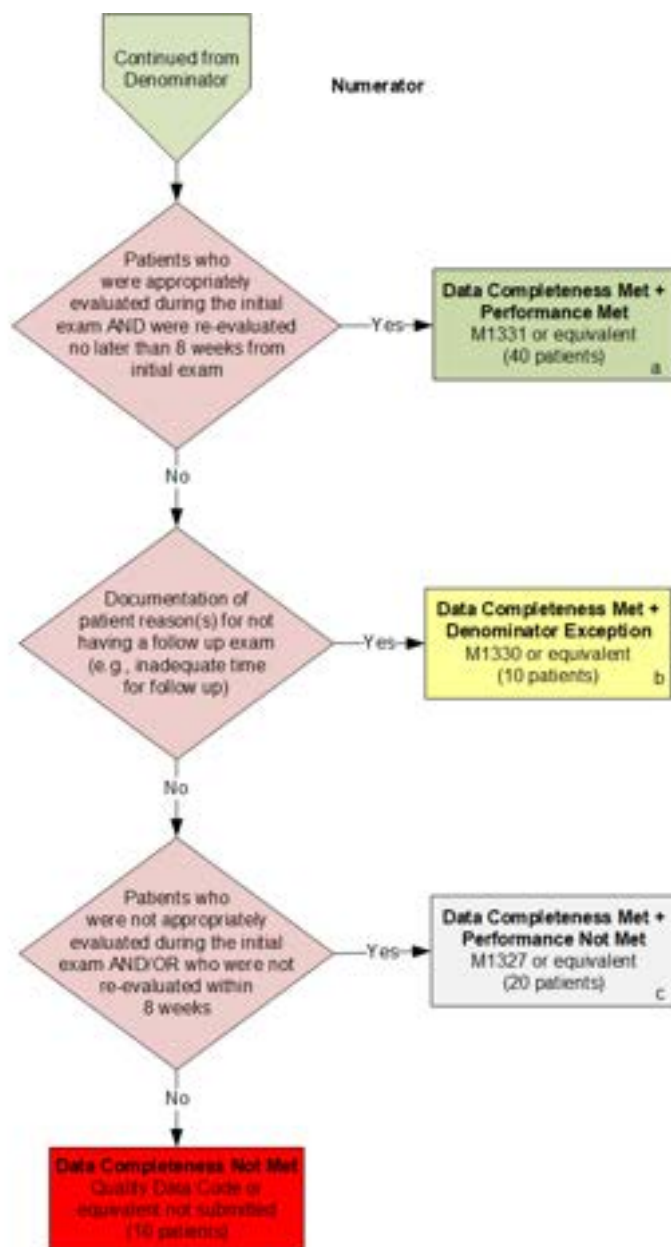
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**2026 Clinical Quality Measure Flow for Quality ID #500:
Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.





SAMPLE CALCULATIONS

Data Completeness =

$$\frac{\text{Performance Met (a=40 patients)} + \text{Denominator Exception (b=10 patients)} + \text{Performance Not Met (c=20 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a=40 patients)}}{\text{Data Completeness Numerator (70 patients) - Denominator Exception (b=10 patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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v10

2026 Clinical Quality Measure Flow Narrative for Quality ID #500:
Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

1. Start with Denominator
2. Check *All patients regardless of age*
3. Check *Diagnosis for posterior vitreous detachment as listed in Denominator**:
 - a. If *Diagnosis for posterior vitreous detachment as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Diagnosis for posterior vitreous detachment as listed in Denominator** equals Yes, proceed to check *Acute PVD*.
4. Check *Acute PVD*:
 - a. If *Acute PVD* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Acute PVD* equals Yes, proceed to check *Patient encounters during the performance period as listed in Denominator**.
5. Check *Patient encounters during the performance period as listed in Denominator**:
 - a. If *Patient encounters during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient encounters during the performance period as listed in Denominator** equals Yes, proceed to check *Encounters conducted via telehealth as listed in Denominator**.
6. Check *Encounters conducted via telehealth as listed in Denominator**:
 - a. If *Encounters conducted via telehealth as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Encounters conducted via telehealth as listed in Denominator** equals No, proceed to check *Patients with a post-operative encounter of the eye with the acute PVD within 2 weeks before the initial encounter or 8 weeks after initial acute PVD encounter*.
7. Check *Patients with a post-operative encounter of the eye with the acute PVD within 2 weeks before the initial encounter or 8 weeks after initial acute PVD encounter*:
 - a. If *Patients with a post-operative encounter of the eye with the acute PVD within 2 weeks before the initial encounter or 8 weeks after initial acute PVD encounter* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients with a post-operative encounter of the eye with the acute PVD within 2 weeks before the initial encounter or 8 weeks after initial acute PVD encounter* equals No, proceed to check *Patients with a diagnosis of acute vitreous hemorrhage*.
8. Check *Patients with a diagnosis of acute vitreous hemorrhage*:
 - a. If *Patients with a diagnosis of acute vitreous hemorrhage* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

- b. If *Patients with a diagnosis of acute vitreous hemorrhage* equals No, include in *Eligible Population/Denominator*.

9. 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.

10. Start Numerator

11. Check *Patients who were appropriately evaluated during the initial exam AND were re-evaluated no later than 8 weeks from the initial exam*:

- a. If *Patients who were appropriately evaluated during the initial exam AND were re-evaluated no later than 8 weeks from the initial exam* 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 *Patients who were appropriately evaluated during the initial exam AND were re-evaluated no later than 8 weeks from the initial exam* equals No, proceed to check *Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)*.

12. Check *Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)*:

- a. If *Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)* 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 patients in the Sample Calculation.
- b. If *Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)* equals No, proceed to check *Patients who were not appropriately evaluated during the initial exam AND/OR who were not re-evaluated within 8 weeks*.

13. Check *Patients who were not appropriately evaluated during the initial exam AND/OR who were not re-evaluated within 8 weeks*:

- a. If *Patients who were not appropriately evaluated during the initial exam AND/OR who were not re-evaluated within 8 weeks* 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 patients in the Sample Calculation.
- b. If *Patients who were not appropriately evaluated during the initial exam AND/OR who were not re-evaluated within 8 weeks* 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 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 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 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

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 #501: Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients with a diagnosis of acute posterior vitreous detachment (PVD) and acute vitreous hemorrhage in either eye who were appropriately evaluated during the initial exam and were re-evaluated no later than 2 weeks.

INSTRUCTIONS:

Reporting Frequency:

This measure is to be submitted once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients with a diagnosis of acute posterior vitreous detachment (PVD) with acute vitreous hemorrhage. 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 Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

Implementation Considerations:

For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient during the performance period. The most advantageous quality data code will be used if the measure is submitted more than once.

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. Patient encounters for this measure conducted via telehealth should be removed from the denominator eligible patient population. Therefore, if the patient meets all denominator criteria but the encounter is conducted via telehealth, it would be appropriate to remove them from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:

Patients with a diagnosis of acute PVD and acute vitreous hemorrhage in either eye and eligible encounter during performance period.

Definition:

Acute PVD – For the purposes of this measure, acute PVD and acute vitreous hemorrhage is defined as recent onset of 30 days or less. For PVD, acute can be documented as new onset vitreous separation or vitreous detachment. Acute vitreous hemorrhage should occur at the same time as PVD and/or have an onset of 30 days or less to ensure vitreous hemorrhage is acute and not chronic.

DENOMINATOR NOTE:

The measure includes any degree of vitreous hemorrhage rather than "meaningful" vitreous hemorrhage since it is difficult to quantify and no criteria exist. If a patient is diagnosed with vitreous hemorrhage, it is assumed that it is meaningful. A new diagnosis code, that meets the definition of acute PVD, indicates a new occurrence of PVD. If there are multiple occurrences of acute PVD, then the most recent occurrence should be utilized as denominator eligible for the purposes of submitting this measure.

**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 PVD (ICD-10-CM): H43.811, H43.812, H43.813, H43.819

AND

Acute PVD: M1337

AND

Diagnosis for vitreous hemorrhage (ICD-10-CM): H43.10, H43.11, H43.12, H43.13

AND

Acute vitreous hemorrhage: M1333

AND

Patient encounters during the performance period (CPT): 92002, 92004, 92012, 92014, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*

WITHOUT

Encounters conducted via telehealth: M1426

AND NOT

DENOMINATOR EXCLUSION:

Patients with a post-operative encounter of the eye with the acute PVD within 2 weeks before the initial encounter or 2 weeks after initial acute PVD encounter: M1334

NUMERATOR:

Patients who were appropriately evaluated during the initial exam and were re-evaluated no later than 2 weeks.

Definitions:

Initial exam – To meet performance of the measure, an initial exam must include a vitreous examination AND peripheral dilated examination with documentation of scleral depression of the affected eye or contact lens (e.g., 3-mirror Goldmann) that provides visualization to the ora for 360 degrees OR if the retina cannot be adequately visualized, then ultrasound was performed OR referred to another provider for additional examination (e.g., if retina cannot be visualized and ultrasound is not available).

Re-evaluation exam – To meet performance of the measure, a re-evaluation must occur no later than 2 weeks from initial examination and must include a vitreous examination AND an adequate dilated examination to evaluate the peripheral retina for tears or detachment OR if the retina cannot be adequately visualized, then ultrasound was performed OR referred to another provider for additional examination (e.g., if retina cannot be

visualized and ultrasound is not available).

NUMERATOR NOTE:

If the initial exam occurs from December 17th – December 31st of the performance period and the patient is not able to be seen for follow-up within the performance period, it would be appropriate to report the denominator exception for inadequate time for follow-up.

Numerator Options:

Performance Met:

Patients who were appropriately evaluated during the initial exam AND were re-evaluated no later than 2 weeks (M1336)

OR

Denominator Exception:

Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up) (M1335)

OR

Performance Not Met:

Patients who were not appropriately evaluated during the initial exam AND/OR who were not re-evaluated within 2 weeks (M1332)

RATIONALE:

Retinal tears, if treated promptly, are less likely to result in detachment (AAO, 2019, ASRS, 2016). Pigmented cells and hemorrhage in the setting of an acute PVD are associated with an increased risk of retinal tears, and these findings necessitate close follow-up examination to identify and treat any associated retinal tears. Prompt treatment will minimize the potential for complications such as retinal detachment and improve a patient's quality of life (AAO, 2014).

CLINICAL RECOMMENDATION STATEMENTS:

This measure is based on clinical recommendations adapted from the AAO Preferred Practice Guidelines (AAO, 2019), which are excerpted below.

The eye examination should include the following elements:

Examination of the vitreous for hemorrhage, detachment, and pigmented cells

Careful examination of the peripheral fundus using scleral depression

There are no symptoms that can reliably distinguish between a PVD with or without an associated retinal break; therefore, a peripheral retinal examination is required. The preferred method of evaluating patients for peripheral vitreoretinal pathology is to use an indirect ophthalmoscope combined with scleral depression. Many patients with retinal tears have blood and pigmented cells in the anterior vitreous. In fully dilated eyes, slit-lamp biomicroscopy with a mirrored contact lens or a condensing lens is an alternative method in fully dilated eyes instead of a scleral depressed indirect examination of the peripheral retina.

A spontaneous vitreous hemorrhage can be the presenting sign of PVD or may occur during the evolution of the PVD. Two-thirds of patients who present with associated vitreous hemorrhage were found to have at least one break. In this subgroup, one-third had more than one break and approximately 88% of the breaks occurred in the superior quadrants. If media opacity or patient cooperation precludes an adequate examination of the peripheral retina, B- scan ultrasonography should be performed to search for retinal tears, RRD, mass lesions, or other causes of vitreous hemorrhage. Bilateral patching and/or elevation of the head while sleeping may be used when attempting to clear the vitreous hemorrhage. If no abnormalities are found, frequent follow-up examinations are recommended (i.e., every 1–2 weeks initially). Wide-field color photography can detect some peripheral retinal breaks but does not replace careful ophthalmoscopy and may be useful in patients not able to tolerate the exam.

Even if the vitreous hemorrhage is sufficiently dense to obscure the posterior pole, the peripheral retina frequently can be examined using indirect ophthalmoscopy and scleral depression. Patients who present with vitreous hemorrhage sufficient to obscure all retinal details and have a negative B-scan ultrasonographic evaluation should be followed closely. When a retinal tear is suspected, repeat ultrasonographic examination should be performed within 1 to 2 weeks of the initial evaluation.

REFERENCES:

American Academy of Ophthalmology Retina/Vitreous Preferred Practice Pattern Panel. Preferred Practice Pattern® Guidelines. Posterior Vitreous Detachment, Retinal Breaks, and Lattice Degeneration PPP 2019. San Francisco, CA: American Academy of Ophthalmology; 2019. Available at: www.aao.org/ppp.

American Society of Retina Specialists. Retina health series: Posterior vitreous detachment. Available at: https://www.asrs.org/content/documents/fact_sheet_1_posterior_vitreous_detachment_new.pdf.

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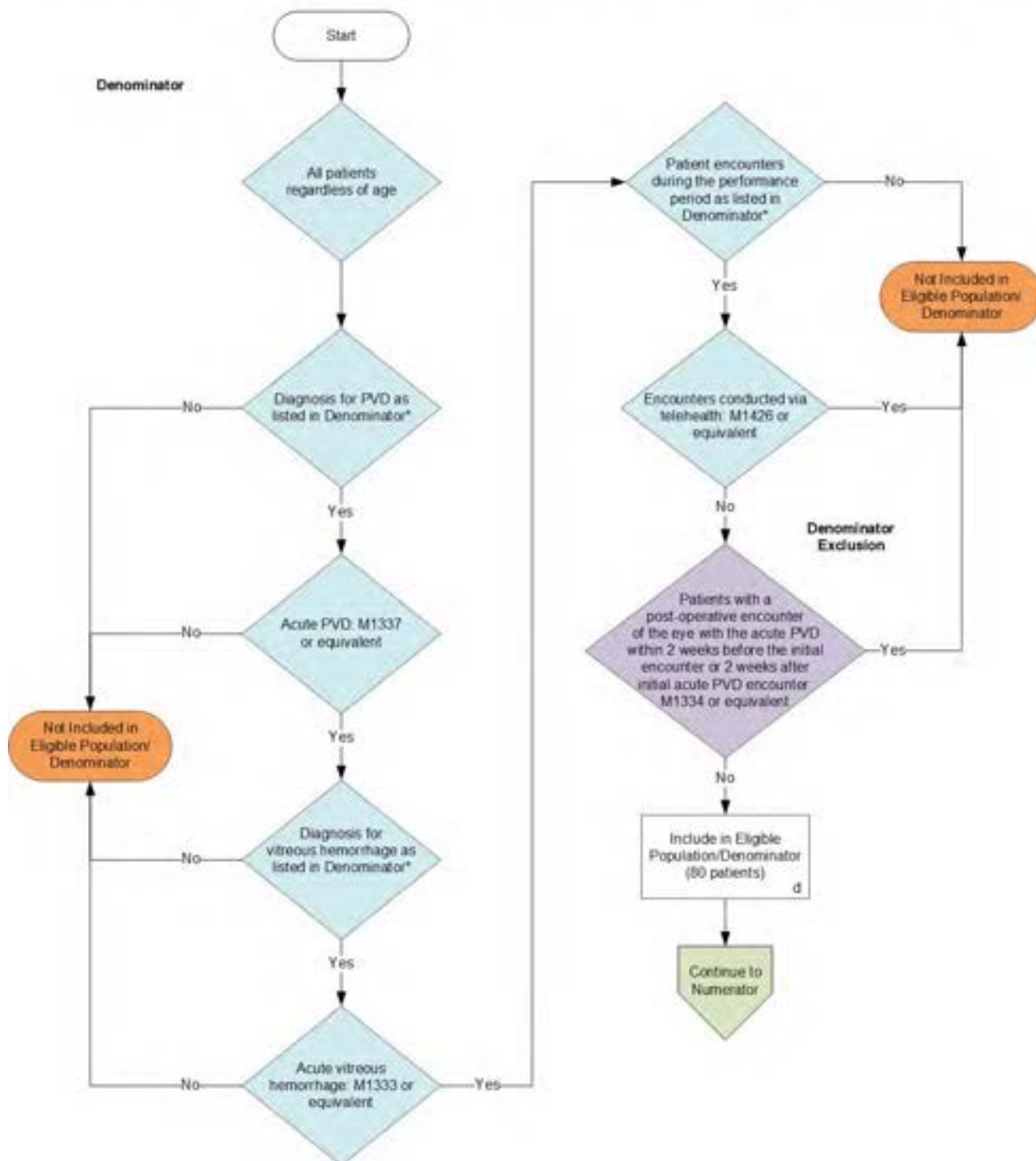
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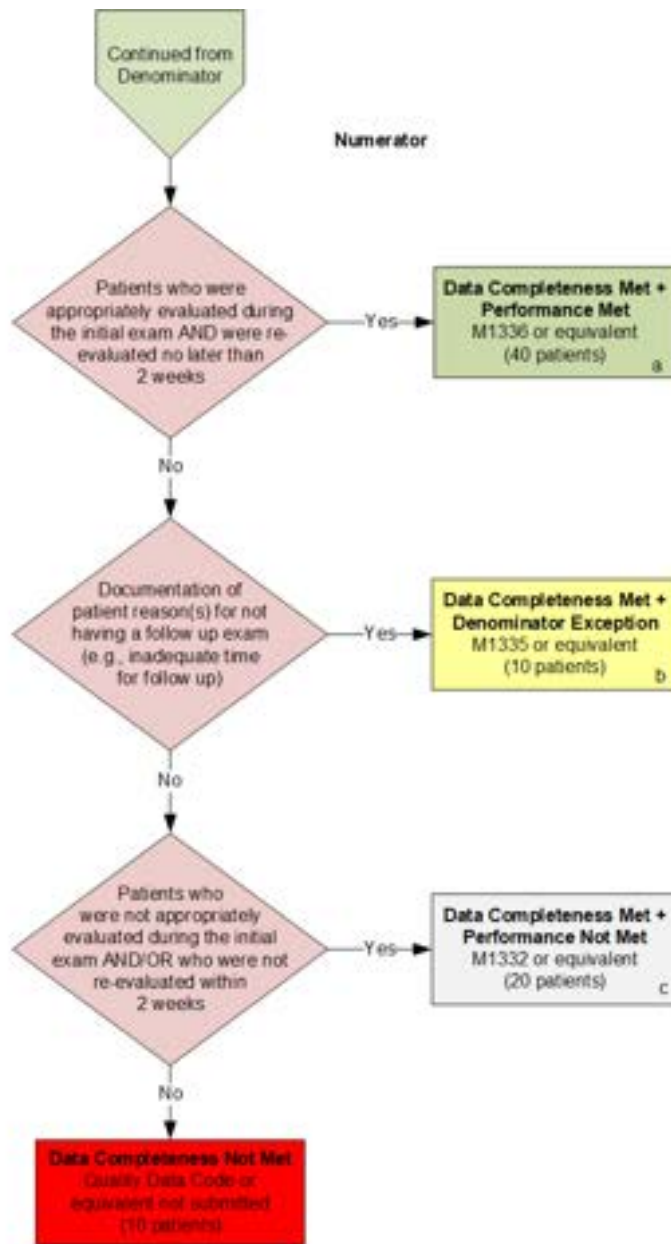
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**2026 Clinical Quality Measure Flow for Quality ID #501:
Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate
Examination and Follow-up**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.





SAMPLE CALCULATIONS

Data Completeness =

$$\frac{\text{Performance Met (a=40 patients)} + \text{Denominator Exception (b=10 patients)} + \text{Performance Not Met (c=20 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate =

$$\frac{\text{Performance Met (a=40 patients)}}{\text{Data Completeness Numerator (70 patients) - Denominator Exception (b=10 patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.
 NOTE: Submission Frequency: Patient-Process

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2026 Clinical Quality Measure Flow Narrative for Quality ID #501:
Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination
and Follow-up

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

1. Start with Denominator
2. Check *All patients regardless of age.*
3. Check *Diagnosis for PVD as listed in Denominator**:
 - a. If *Diagnosis for PVD as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Diagnosis for PVD as listed in Denominator** equals Yes, proceed to check *Acute PVD*.
4. Check *Acute PVD*:
 - a. If *Acute PVD* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Acute PVD* equals Yes, proceed to check *Diagnosis for vitreous hemorrhage as listed in Denominator**.
5. Check *Diagnosis for vitreous hemorrhage as listed in Denominator**:
 - a. If *Diagnosis for vitreous hemorrhage as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Diagnosis for vitreous hemorrhage as listed in Denominator** equals Yes, proceed to check *Acute vitreous hemorrhage*.
6. Check *Acute vitreous hemorrhage*:
 - a. If *Acute vitreous hemorrhage* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Acute vitreous hemorrhage* equals Yes, proceed to check *Patient encounters during the performance period as listed in Denominator**.
7. Check *Patient encounters during the performance period as listed in Denominator**:
 - a. If *Patient encounters during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient encounters during the performance period as listed in Denominator** equals Yes, proceed to check *Encounters conducted via telehealth as listed in Denominator**.
8. Check *Encounters conducted via telehealth as listed in Denominator**:
 - a. If *Encounters conducted via telehealth as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Encounters conducted via telehealth as listed in Denominator** equals No, proceed to check

Patients with a post-operative encounter of the eye with the acute PVD within 2 weeks before the initial encounter or 2 weeks after initial acute PVD encounter.

9. Check *Patients with a post-operative encounter of the eye with the acute PVD within 2 weeks before the initial encounter or 2 weeks after initial acute PVD encounter*:
 - a. If *Patients with a post-operative encounter of the eye with the acute PVD within 2 weeks before the initial encounter or 2 weeks after initial acute PVD encounter* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients with a post-operative encounter of the eye with the acute PVD within 2 weeks before the initial encounter or 2 weeks after initial acute PVD encounter* 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 80 patients in the Sample Calculation.
11. Start Numerator
12. Check *Patients who were appropriately evaluated during the initial exam AND were re-evaluated no later than 2 weeks*.
 - a. If *Patients who were appropriately evaluated during the initial exam AND were re-evaluated no later than 2 weeks* 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 *Patients who were appropriately evaluated during the initial exam AND were re-evaluated no later than 2 weeks* equals No, proceed to check *Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)*.
13. Check *Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)*:
 - a. If *Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)* equals Yes, include in *Data Completeness Met and Denominator Exception*.
 - *Data Completeness Met and Denominator Exception* is represented as Denominator Exception in the Sample Calculation listed at the end of this document. Letter b equals 10 patients in the Sample Calculation.
 - b. If *Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)* equals No, proceed to check *Patients who were not appropriately evaluated during the initial exam AND/OR who were not re-evaluated within 2 weeks*.
14. Check *Patients who were not appropriately evaluated during the initial exam AND/OR who were not re-evaluated within 2 weeks*:
 - a. If *Patients who were not appropriately evaluated during the initial exam AND/OR who were not re-*

evaluated within 2 weeks equals Yes, include in Data Completeness Met and Performance Not Met.

- *Data Completeness Met and Performance Not Met* is represented as Performance Not Met in the Sample Calculation listed at the end of this document. Letter c equals 20 patients in the Sample Calculation.

- b. If *Patients who were not appropriately evaluated during the initial exam AND/OR who were not re-evaluated within 2 weeks* equals No, proceed to check *Data Completeness Not Met*.

15. 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 Denominator Exception (b 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 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

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 #509: Melanoma: Tracking and Evaluation of Recurrence

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:

Process – High Priority

- *INVERSE MEASURE (CRITERIA 2): LOWER SCORE – BETTER*

DESCRIPTION:

Percentage of patients who had an excisional surgery for melanoma or melanoma in situ with initial American Joint Committee on Cancer (AJCC) staging of 0, I, or II, in the past 5 years in which the operating clinician examines and/or diagnoses the patient for recurrence of melanoma.

INSTRUCTIONS:

Reporting Frequency:

This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients with a diagnosis of melanoma. 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 intent of this measure is to ensure that patients who had an excisional surgery for melanoma or melanoma in situ in the past 5 years with an initial AJCC staging of 0, I, OR II have a follow up exam for melanoma recurrence. The exam for recurrence can be completed by any provider as long as it is documented in the medical record by the excising clinician that the exam was performed.

Measure Strata and Performance Rates:

This measure contains two strata defined by two submission criteria.

This measure produces two performance rates.

There are 2 Submission Criteria for this measure:

- 1) All patients that the clinician has performed a type of excisional surgery for melanoma or melanoma in situ in the past 5 years with an initial AJCC staging of 0, I, or II.

AND

- 2) Documentation by the clinician who performed the surgery that an exam for recurrence of melanoma was performed on the patient within the performance period.

This measure will be calculated with 2 performance rates:

- 1) Documentation by the clinician who performed the surgery that an exam for recurrence of melanoma was performed on the patient within the performance period.
- 2) All patients that were diagnosed with a recurrent melanoma in the current performance period.

For accountability reporting in the CMS MIPS program, the rate for submission criteria 1 is used for performance.

Implementation Considerations:

For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient for the performance period. The most advantageous quality data code will be used if the measure is submitted more than once.

Performance rate 2 is an inverse measure which means 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.

Telehealth:

NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. Patient encounters for this measure conducted via telehealth should be removed from the denominator eligible patient population. Therefore, if the patient meets all denominator criteria but the encounter is conducted via telehealth, it would be appropriate to remove them from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

ALL SUBMISSION CRITERIA: ALL PATIENTS WHO HAVE HAD EXCISIONAL SURGERY FOR MELANOMA OR MELANOMA IN SITU IN THE PAST 5 YEARS WITH AN INITIAL AJCC STAGING OF 0, I, OR II

DENOMINATOR (CRITERIA 1 & 2):

All patients that the clinician has performed a type of excisional surgery for melanoma or melanoma in situ in the past 5 years with an initial AJCC staging of 0, I, or II

Definitions:

Patients with an excisional surgery (denominator criteria M1386) – see Reference Coding

DENOMINATOR NOTE:

The past five year timeframe for an encounter begins at the start of the performance period.

**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 and older on the date of the encounter

AND

Diagnosis for Melanoma or Melanoma in situ on the date of the encounter (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, D03.20, D03.121, D03.122, 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

Patients with an excisional surgery for melanoma or melanoma in situ in the past 5 years with an initial AJCC Staging of 0, I, or II at the start of the performance period: M1386

AND

Patient encounters during the performance period (CPT): 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*

WITHOUT

Encounters conducted via telehealth: M1426

AND NOT

DENOMINATOR EXCLUSION:

Patients who died during the performance period: M1387

Reference Coding:

Denominator Criteria for Excisional Surgery [M1386] is defined by the following coding only: 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646, 17311, 17312, 17313, 17314, 17315

NUMERATOR (CRITERIA 1):

Documentation by the clinician who performed the surgery that an exam for recurrence of melanoma was performed on the patient within the performance period.

Numerator Instructions:

Inverse Measure – Which means 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.

Lost to Follow-up – For purposes of this measure, in addition to those patients that the clinician is unable to locate for follow-up after documentation of attempt, lost to follow-up includes documentation of patients who relocated outside of the geographic area, transferred to a new clinician, or who had changes in insurance and are unable to follow-up.

Numerator Options:

Performance Met:

Patients with documentation of an exam performed for recurrence of melanoma (M1388)

OR

Denominator Exception:

Documentation of patient reasons for no examination i.e., refusal of examination OR lost to follow-up (documentation must include information that the clinician was unable to reach the patient by phone, mail or secure electronic mail – at least one method must be documented) (M1392)

OR

Performance Not Met:

Patients who do not have a documented exam performed for recurrence of melanoma or no documentation within the performance period (M1390)

NUMERATOR (CRITERIA 2):

All patients that were diagnosed with a recurrent melanoma in the current performance period.

Definitions:

Recurrent – For purposes of this measure, recurrence is local recurrence of where the anatomical location(s) of the excised lesion or Mohs surgery occurred for ALL qualifying excisions identified in the denominator. Other locations should not be counted for this measure.

Reported score – AJCC staging 0, I, or II

Numerator Instructions:

Lost to Follow-up – For purposes of this measure, in addition to those patients that the clinician is unable to locate for follow-up after documentation of attempt, lost to follow-up includes documentation of patients who relocated outside of the geographic area, transferred to a new clinician, or who had changes in insurance and are unable to follow-up.

Numerator Options:

Performance Not Met:

Patients who were not diagnosed with recurrent melanoma during the current performance period (M1393)

OR

Denominator Exception:

Documentation of patient reasons for no examination, i.e., refusal of examination OR lost to follow-up (documentation must include information that the clinician was unable to reach the patient by phone, mail or secure electronic mail – at least one method must be documented) (M1392)

OR

Performance Met:

All patients who were diagnosed with recurrent melanoma during the current performance period (M1391)

RATIONALE:

Melanoma recurrence is an outcome that needs precise evaluation. This measure will allow for the development of a system in which melanomas can accurately be tracked so that we can truly understand the effectiveness of care. The literature describes a lack of a standard for follow-up, tracking, and evaluating melanoma in early-stage disease. This measure will evaluate the frequency of recurrence along with the type of recurrence (local, in transit, LN, systemic) that occurs after an excisional procedure.

It is also recognized that there may be a lack of communication between the excising clinician and the clinician who is following the patient longitudinally. This measure is also an initiative to drive a care-collaborative network that encourages communication about the recurrence status of melanoma patients.

CLINICAL RECOMMENDATION STATEMENTS:

1. For common follow-up recommendations for all patients: "Follow up schedule is influenced by risk of recurrence and new primary melanoma, which depends on patient/family history of melanoma, mole count, and/or presence of atypical moles/dysplastic nevi." (NCCN Melanoma: Cutaneous, 2025)
2. Patterns of Recurrence: "For patients who present with stage I-II melanoma and who are rendered free of disease after initial treatment, recurrences are distributed as follows: approximately 15% to 20% are local or in transit" (NCCN Melanoma: Cutaneous, 2025)
3. Timing of recurrence: "Data from several studies suggest that the time it takes for the risk of recurrence to reach its low plateau depends on the stage of disease at first presentation. In a retrospective study of patients who initially presented with stage I melanoma (N = 1568), 80% of the 293 recurrences developed within the first 3 years, but some recurrences (<8%) were detected 5 to 10 years after the initial treatment. A prospective study found that for patients with stage I or II at initial presentation, the risk of recurrence reached a low level by 4.4 years after initial diagnosis" (NCCN Melanoma: Cutaneous, 2025)

REFERENCES:

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) Melanoma: cutaneous. National Comprehensive Cancer Network; 2025.

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2026 Clinical Quality Measure Flow for Quality ID #509: Melanoma: Tracking and Evaluation of Recurrence Multiple Performance Rates

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

ACCOUNTABILITY REPORTING IN THE CMS MIPS PROGRAM: SAMPLE CALCULATIONS

Overall Data Completeness (Submission Criteria 1) =

$$\frac{\text{Performance Met (a)=40 patients} + \text{Denominator Exception (b)=10 patients} + \text{Performance Not Met (c)=20 patients}}{\text{Eligible Population / Denominator (d)=80 patients}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Overall Performance Rate (Submission Criteria 1)=

$$\frac{\text{Performance Met (a)=40 patients}}{\text{Data Completeness Numerator (70 patients) - Denominator Exception (b)=10 patients}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

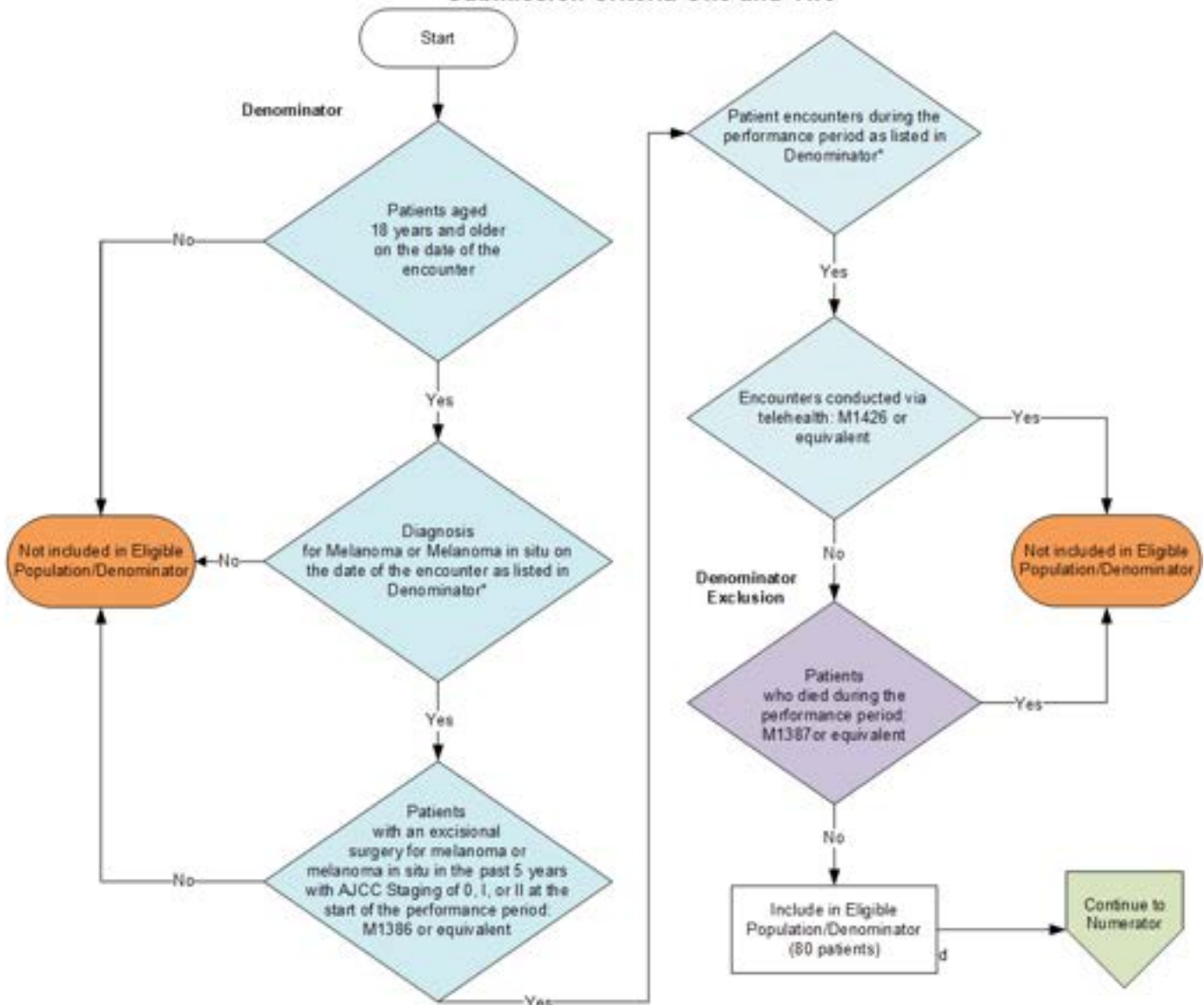
*See the posted measure specifications for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

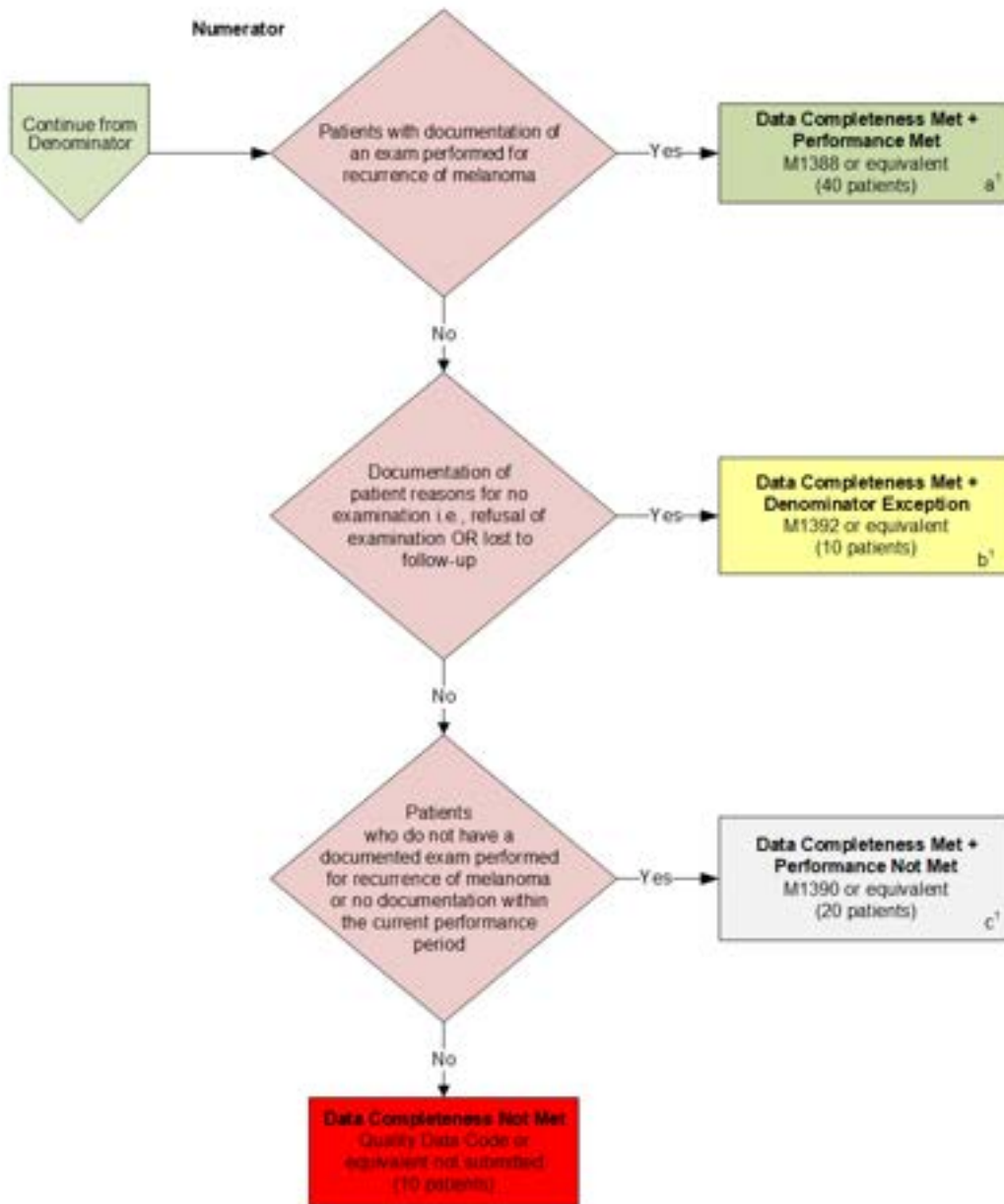
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Submission Criteria One and Two



Submission Criteria One



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=

$$\frac{\text{Performance Met (a}^1\text{=40 patients)} + \text{Denominator Exception (b}^1\text{=10 patients)} + \text{Performance Not Met (c}^1\text{=20 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a}^1\text{=40 patients)}}{\text{Data Completeness Numerator (70 patients) - Denominator Exception (b}^1\text{=10 patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

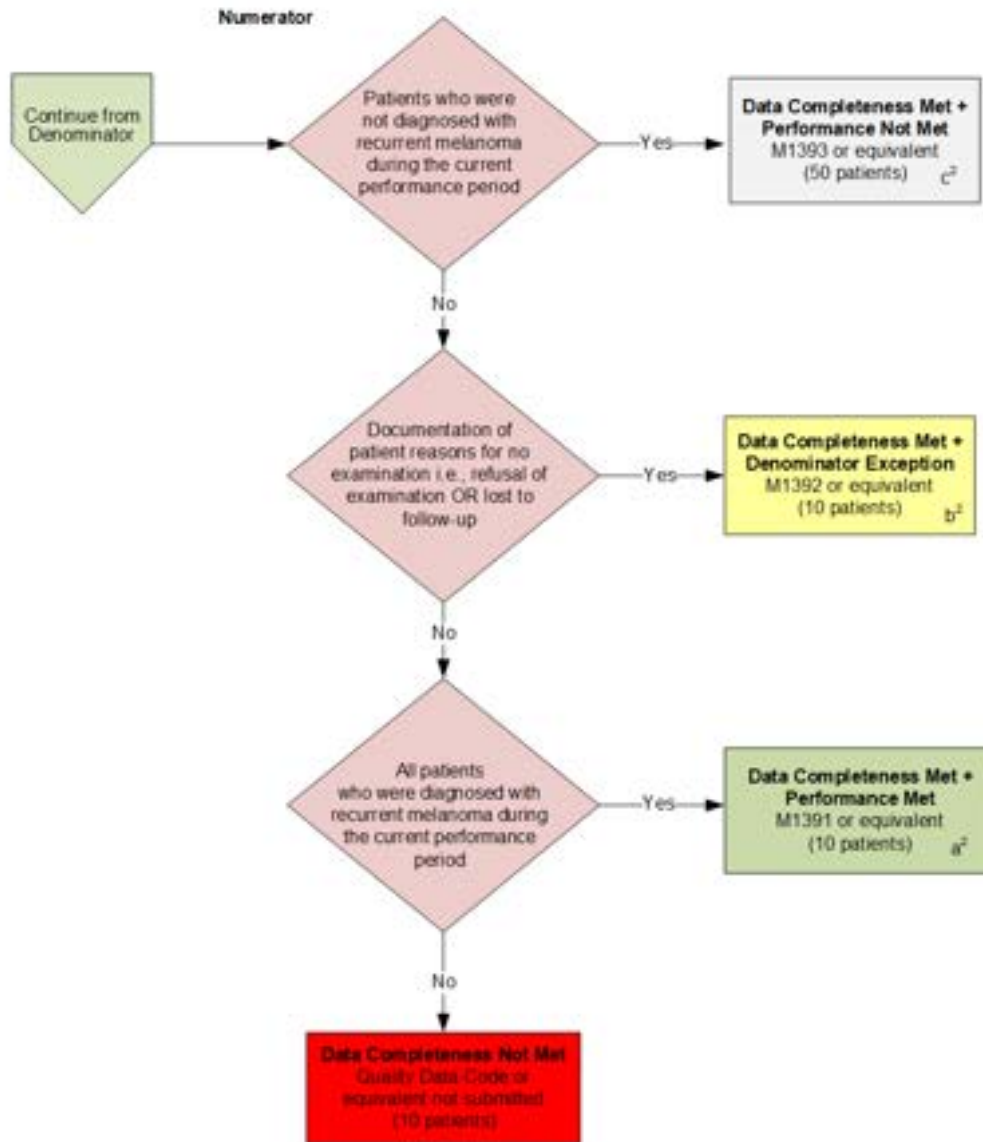
*See the posted measure specifications for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

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Submission Criteria Two
INVERSE MEASURE: LOWER SCORE – BETTER**



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness=

Performance Met (a²=10 patients) + Denominator Exception (b²=10 patients) + Performance Not Met (c²=50 patients) = 70 patients = 87.50%
 Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a²=10 patients) = 10 patients = 16.67%
 Data Completeness Numerator (70 patients) – Denominator Exception (b²=10 patients) = 60 patients

*See the posted measure specifications for specific coding and instructions to submit this measure.

**A lower calculated performance rate for this submission criteria indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Process

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2026 Clinical Quality Measure Flow Narrative for Quality ID #509:

Melanoma: Tracking and Evaluation of Recurrence

Multiple Performance Rates

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure

Accountability Reporting in the CMS MIPS Program: Sample Calculations

Overall Data Completeness (Submission Criteria 1) Performance Met (a1 equals 40 patients) plus Denominator Exceptions (b1 equals 10 patients) plus Performance Not Met (c1 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.

Overall Performance Rate (Submission Criteria 1) Performance Met (a1 equals 40 patients) divided by Data Completeness Numerator (equals 70 patients) minus Denominator Exceptions (b1 equals 80 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

Submission Criteria One and Two:

1. Start with Denominator:
2. Check *Patients aged 18 years and older on date of the encounter*.
 - a. If *Patients aged 18 years and older on date of the encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients aged 18 years and older on date of the encounter* equals Yes, proceed to check *Diagnosis for Melanoma or Melanoma in situ as listed in Denominator**.
3. Check *Diagnosis for Melanoma or Melanoma in situ as listed in Denominator**
 - a. If *Diagnosis for Melanoma or Melanoma in situ as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Diagnosis for Melanoma or Melanoma in situ as listed in Denominator** equals Yes, proceed to check *Patients with an excisional surgery for melanoma or melanoma in situ in the past 5 years with an initial AJCC Staging of 0, I, or II at the start of the performance period*.
4. Check *Patients with an excisional surgery for melanoma or melanoma in situ in the past 5 years with an initial AJCC Staging of 0, I, or II at the start of the performance period*.
 - a. If *Patients with an excisional surgery for melanoma or melanoma in situ in the past 5 years with an initial AJCC Staging of 0, I, or II at the start of the performance period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients with an excisional surgery for melanoma or melanoma in situ in the past 5 years with an initial AJCC Staging of 0, I, or II at the start of the performance period* equals Yes, proceed to check *Patient encounters during the performance period as listed in Denominator**

5. Check *Patient encounters during the performance period as listed in Denominator**.
 - a. If *Patient encounters during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient encounters during the performance period as listed in Denominator** equals Yes, proceed to check *Encounters conducted via telehealth*.
6. Check *Encounters conducted via telehealth*
 - a. If *Encounters conducted via telehealth* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Encounters conducted via telehealth* equals No, proceed to *Patients who died during the performance period* include in *Eligible Population/Denominator*.
7. Check *Patients who died during the performance period*.
 - a. If *Patients who died during the performance period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients who died during the performance 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 equals 80 episodes in the Sample Calculation.
9. Start Numerator (SUBMISSION CRITERIA ONE):
10. Check *Patients with documentation of an exam performed for recurrence of melanoma*.
 - a. If *Patients with documentation of an exam performed for recurrence of melanoma* 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 a¹ equals 40 patients in the Sample Calculation
 - b. If *Patients with documentation of an exam performed for recurrence of melanoma* equals No, proceed to check *Documentation of patient reasons for no examination i.e., refusal of examination OR lost to follow-up*.
11. Check *Documentation of patient reasons for no examination i.e., refusal of examination OR lost to follow-up*.
 - a. If *Documentation of patient reasons for no examination i.e., refusal of examination OR lost to follow-up* 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 b¹ equals 10 patients in the Sample Calculation.

- b. If *Documentation of patient reasons for no examination i.e., refusal of examination OR lost to follow-up* equals No, proceed to check *Patients who do not have a documented exam performed for recurrence of melanoma or no documentation within the performance period*.

12. Check *Patients who do not have a documented exam performed for recurrence of melanoma or no documentation within the performance period*.

- a. If *Patients who do not have a documented exam performed for recurrence of melanoma or no documentation within the performance period* 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 c¹ equals 20 patients in the Sample Calculation.

If *Patients who do not have a documented exam performed for recurrence of melanoma or no documentation within the performance 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 Not Met (a¹ equals 40 patients) plus Denominator Exception (b¹ equals 10 patients) plus Performance Met (c¹ 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 (a¹ equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b¹ equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specifications 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.

1. Start Numerator (SUBMISSION CRITERIA TWO):
2. Check *Patients who were not diagnosed with recurrent melanoma during the current performance period*.
 - a. If *Patients who were not diagnosed with recurrent melanoma during the current performance period* 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 c² equals 20 patients in the Sample Calculation.

If Patients who were not diagnosed with recurrent melanoma during the current performance period equals No, proceed to check Documentation of patient reasons for no examination i.e., refusal of examination OR lost to follow-up.

3. Check *Documentation of patient reasons for no examination i.e., refusal of examination OR lost to follow-up.*

- a. If *Documentation of patient reasons for no examination i.e., refusal of examination OR lost to follow-up* 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 b2 equals 10 patients in the Sample Calculation.
- b. If *Documentation of patient reasons for no examination i.e., refusal of examination OR lost to follow-up* equals No, proceed to check *Patients who were not diagnosed with recurrent melanoma during the current performance period*.

4. Check *All patients who were diagnosed with recurrent melanoma during the current performance period*.

- a. If *All patients who were diagnosed with recurrent melanoma during the current performance period* 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 a2 equals 40 patients in the Sample Calculation
- b. If *All patients who were diagnosed with recurrent melanoma during the current performance period* equals No, proceed to check *Data Completeness Not Met*.

5. 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 Not Met (c2 equals 20 patients) plus Denominator Exception (b2 equals 10 patients) plus Performance Met (a2 equals 40 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 (a2 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b2 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specifications 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 #513: Patient Reported Falls and Plan of Care

2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients (or caregivers as appropriate) with an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke who reported a fall occurred and those that fell had a plan of care for falls documented at every visit.

INSTRUCTIONS:

Reporting Frequency:

This measure is to be submitted at each visit for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients with an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke who reported a fall. 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 Strata and Performance Rates:

This measure contains two strata defined by two submission criteria.

This measure produces two performance rates.

There are 2 Submission Criteria for this measure:

- 1) Patients with an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke.

AND

- 2) Patients with an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke who report (or caregiver as appropriate) a fall occurred since last visit.

Submission Criteria 1 ensures the full patient population is being assessed and reporting requirements are met.

This measure will be calculated with 2 performance rates:

- 1) Patients with a diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke who were assessed for at each visit during the performance period
- 2) Patients with a diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke who report a fall occurred since the last visit AND who have a plan of care for falls

For accountability reporting in the CMS MIPS program, the rate for Submission Criteria 2 is used for performance. For the purposes of data completeness, Submission Criteria 1 will be used.

Implementation Considerations:

For the purposes of MIPS implementation, this visit measure is submitted each time a patient has a denominator eligible encounter during the performance period.

Telehealth:

TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient

encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

SUBMISSION CRITERIA 1: PATIENTS WITH AN ACTIVE DIAGNOSIS OF A MOVEMENT DISORDER, MULTIPLE SCLEROSIS, A NEUROMUSCULAR DISORDER, DEMENTIA, OR STROKE

DENOMINATOR (CRITERIA 1):

Patients with an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke.

Definition:

Active – Active diagnosis means the diagnosis has to be coded or billed for on the date of service, not just a diagnosis on the historical problem list.

Denominator Criteria 1(Eligible Cases):

Active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke (ICD-10-CM): A52.17, A81.00, A81.01, A81.89, E08.40, E08.42, E09.40, E09.42, E10.40, E10.42, E11.40, E11.42, E13.40, E13.42, F01.50, F02.80, E83.01, F02.81, F03.90, F03.91, F05, F06.8, F10.27, G10, G11.0, G11.1, G11.2, G11.3, G11.8, G11.9, G12.1, G12.20, G12.21, G12.24, G12.29, G12.9, G13.0, G13.1, G13.2, G13.8, G20, G23, G24.01, G24.02, G24.09, G24.1, G24.2, G24.8, G24.9, G25.2, G25.3, G25.4, G25.5, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G31.85, G31.89, G94G31.84, G32.81, G35, G60.0, G60.2, G60.3, G60.8, G60.9, G62.0, G62.1, G62.2, G62.89, G62.9, G63, G65.2, G70.00, G70.01, G70.2, G70.80, G70.81, G71.00, G71.01, G71.02, G71.09, G71.11, G71.2, G71.3, G72.41, G73.1, G73.3, G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9, G90.3, I63.10, I63.111, I63.112, I63.113, I63.119, I63.12, I63.131, I63.132, I63.133, I63.139, I63.19, I63.40, I63.411, I63.412, I63.413, I63.419, I63.421, I63.422, I63.423, I63.429, I63.431, I63.432, I63.433, I63.439, I63.441, I63.442, I63.443, I63.449, I63.49, I69.010, I69.011, I69.012, I69.014, I69.015, I69.018, I69.019, I69.193, I69.893, I69.993, M33.20, M33.21, M33.22, M33.29, I69.093, M62.59, R25, R25.2, R27.0, R29.6, R41.3, W19.XXXA, W19.XXXD, W19.XXXS, G35A, G35B, G35B0, G35B1, G35B2, G35C, G35C0, G35C1, G35C2, G35D, QA0, QA001, QA0010, QA00101, QA00102, QA00109, QA0011, QA0012, QA00131, QA00139, QA00141, QA00142, QA00149, QA00151, QA00159

AND

Patient encounters during the performance period (CPT): 99421, 99422, 99423, 99241, 99242, 99243, 99244, 99245, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99441, 99442, 99443, 99421, 99422, 99423, 99241, 99242, 99243, 99244, 99245, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99441, 99442, 99443, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016

NUMERATOR (CRITERIA 1):

Patients (or caregivers as appropriate) that reported a fall occurred since the last visit.

Definitions:

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 paralysis, epileptic seizure, overwhelming external force, or overwhelming environmental hazards.

NUMERATOR NOTE:

This submission criteria will be used to determine data completeness for MIPS, ensuring patients are being screened for falls at each visit. Numerator data from this submission criteria will not be used in the final performance calculation as it is assessing for incidence only.

Numerator Options:

Performance Met:

Patients who did not report a fall (M1492)

OR

Denominator Exception:

Documentation of falls not performed due to medical reasons (e.g., syncope, Vertigo and related disorders, restless leg syndrome, Tourette syndrome/tic disorder, back pain, Concussion/mild traumatic brain injury (mTBI), cervical dystonia, or epilepsy) (M1493)

OR

Performance Not Met:

Patients that reported a fall since the last visit (M1494)

AND

SUBMISSION CRITERIA 2: PATIENTS WITH AN ACTIVE DIAGNOSIS OF A MOVEMENT DISORDER, MULTIPLE SCLEROSIS, A NEUROMUSCULAR DISORDER, DEMENTIA, OR STROKE WHO REPORT (OR CAREGIVER AS APPROPRIATE) A FALL OCCURRED SINCE LAST VISIT

DENOMINATOR (CRITERIA 2):

Patients with an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke who report (or caregiver as appropriate) a fall occurred since last visit.

Definition:

Active – Active diagnosis means the diagnosis has to be coded or billed for on the date of service, not just a diagnosis on the historical problem list.

Denominator Criteria 2(Eligible Cases):

Active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke since last visit (ICD-10-CM): A52.17, A81.00, A81.01, A81.89, E08.40, E08.42, E09.40, E09.42, E10.40, E10.42, E11.40, E11.42, E13.40, E13.42, F01.50, F02.80, E83.01, F02.81, F03.90, F03.91, F05, F06.8, F10.27, G10, G11.0, G11.1, G11.2, G11.3, G11.8, G11.9, G12.1, G12.20, G12.21, G12.24, G12.29, G12.9, G13.0, G13.1, G13.2, G13.8, G20, G23, G24.01, G24.02, G24.09, G24.1, G24.2, G24.8, G24.9, G25.2, G25.3, G25.4, G25.5, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G31.85, G31.89, G94G31.84, G32.81, G35, G60.0, G60.2, G60.3, G60.8, G60.9, G62.0, G62.1, G62.2, G62.89, G62.9, G63, G65.2, G70.00, G70.01, G70.2, G70.80, G70.81, G71.00, G71.01, G71.02, G71.09, G71.11, G71.2, G71.3, G72.41, G73.1, G73.3, G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9, G90.3, I63.10, I63.111, I63.112, I63.113, I63.119, I63.12, I63.131, I63.132, I63.133, I63.139, I63.19, I63.40, I63.411, I63.412, I63.413, I63.419, I63.421, I63.422, I63.423, I63.429, I63.431, I63.432, I63.433, I63.439, I63.441, I63.442, I63.443, I63.449, I63.49, I69.010, I69.011, I69.012, I69.014, I69.015, I69.018, I69.019, I69.193, I69.893, I69.993, M33.20, M33.21, M33.22, M33.29, I69.093, M62.59, R25, R25.2, R27.0, R29.6, R41.3, W19.XXXA, W19.XXXD, W19.XXXS, G35A, G35B, G35B0, G35B1, G35B2, G35C, G35C0, G35C1, G35C2, G35D, QA0., QA001, QA0010, QA00101, QA00102, QA00109, QA0011, QA0012, QA00131, QA00139, QA00141, QA00142, QA00149, QA00151, QA00159

AND

Patient encounters during the performance period (CPT): 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 99422, 99423, 99241, 99242, 99243, 99244, 99245, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99441, 99442, 99443, 99421, 99422, 99423, 99241, 99242, 99243, 99244, 99245, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99421, 99441, 99442, 99443

NUMERATOR (CRITERIA 2):

Patients who had a falls plan of care documented at every visit.

Definition:

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 paralysis, epileptic seizure, overwhelming external force, or overwhelming environmental hazards.

Plan of care – a plan of care must include the following: Balance, strength, or gait training OR Referral to physical or occupational therapy OR Home safety evaluation.

Numerator Options:

Performance Met:

Patients that reported a fall occurred who had a plan of care for falls documented OR patients that did not report a fall (M1495)

OR

Denominator Exception:

Documentation of falls not performed due to medical reasons (e.g., syncope, Vertigo and related disorders, restless leg syndrome, Tourette syndrome/tic disorder, back pain, Concussion/mild traumatic brain injury (mTBI), cervical dystonia, or epilepsy) (M1497)

OR

Performance Not Met:

Patients that had a fall who did not have a plan of care for falls documented OR do not have documentation of being assessed for falls (M1496)

RATIONALE:

Many studies have been conducted on the rate of falls for common neurological conditions. All of them indicate that falls are an issue for neurology patients with symptomology that affects movement and balance. Falls and the fear of falling can impact quality of life and should be addressed for populations most at risk for falling.

In people age 65 years and older, falls are one of the leading causes of death. However, patients with neurological conditions are often younger and are at an increased risk for falls due to disease symptomology. 127,456,106 non-fatal falls were recorded from 2001-2015. For those that were hospitalized due to the fall, the cost is approximately \$39,000 per patient.

The U.S. Preventive Services Task Force updated their recommendations for fall prevention in community-dwelling older adults. There are many intervention recommendations for patients 65 years and older.

CLINICAL RECOMMENDATION STATEMENTS:

- The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls (B recommendation)
- The USPSTF recommends that clinicians selectively offer multifactorial interventions to prevent falls to community-dwelling adults 65 years or older who are at increased risk for falls. Existing evidence indicates that the overall net benefit of routinely offering multifactorial interventions to prevent falls is small. When determining whether this service is appropriate for an individual, patients and clinicians should consider the balance of benefits and harms based on the circumstances of prior falls, presence of comorbid medical conditions, and the patient's values and preferences (C recommendation)
- The USPSTF recommends against vitamin D supplementation to prevent falls in community dwelling adults 65

years or older (D recommendation)

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- Borges Sde M, Radanovic M, Forlenza OV. Fear of falling and falls in older adults with mild cognitive impairment and Alzheimer's disease. *Neuropsychol Dev Cogn B Aging Neuropsychol Cogn* 2015; 22:312-21.
- Ansai JH, Andrade LP, Nakagawa TH, Rebelatto JR. Performances on the timed up and go test and subtasks between fallers and non-fallers in older adults with cognitive impairment. *Arq Neurosiquitr* 2018; 76:381-386.
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- US Preventive Services Task Force. Interventions to Prevent Falls in Community-Dwelling Older Adults. *JAMA* 2018; 319:1696-1704.
- Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. Available at: <https://wisqars.cdc.gov/>

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2026 Clinical Quality Measure Flow for Quality ID #513: Patient Reported Falls and Plan of Care

Multiple Performance Rates

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

ACCOUNTABILITY REPORTING IN THE CMS MIPS PROGRAM: SAMPLE CALCULATIONS

Overall Data Completeness (Submission Criteria 1)*=

$$\frac{\text{Performance Met (a}^1=40 \text{ visits)} + \text{Denominator Exception (b}^1=10 \text{ visits)} + \text{Performance Not Met (c}^1=20 \text{ visits)}}{\text{Eligible Population / Denominator (d}^1=80 \text{ visits)}} = \frac{70 \text{ visits}}{80 \text{ visits}} = 87.50\%$$

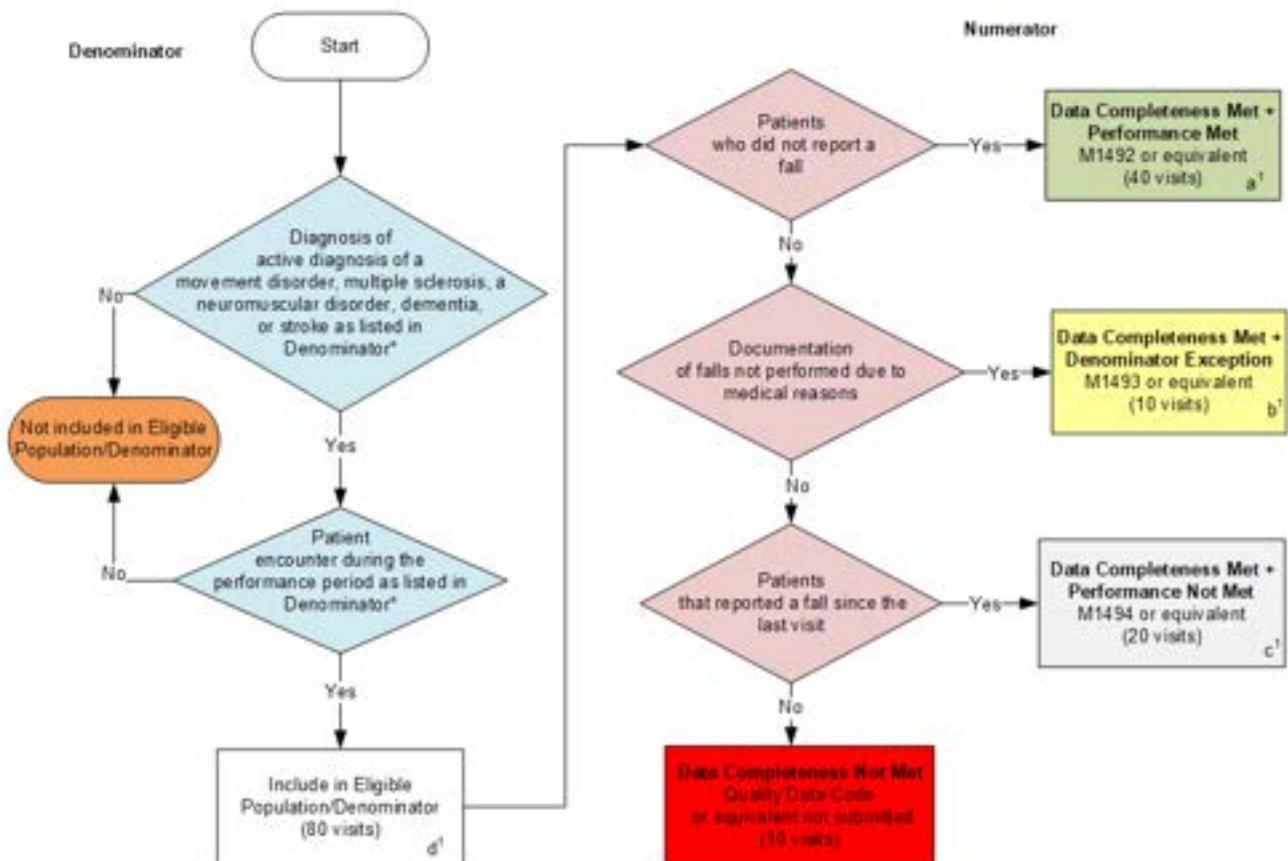
Overall Performance Rate (Submission Criteria 2)*=

$$\frac{\text{Performance Met (a}^1=40 \text{ visits)}}{\text{Data Completeness Numerator (70 visits) - Denominator Exception (b}^1=10 \text{ visits)}} = \frac{40 \text{ visits}}{60 \text{ visits}} = 66.67\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Visit

Submission Criteria One



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=

$$\frac{\text{Performance Met (a}^1=40 \text{ visits)} + \text{Denominator Exception (b}^1=10 \text{ visits)} + \text{Performance Not Met (c}^1=20 \text{ visits)}}{\text{Eligible Population / Denominator (d}^1=80 \text{ visits)}} = \frac{70 \text{ visits}}{80 \text{ visits}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a}^1=40 \text{ visits)}}{\text{Data Completeness Numerator (70 visits) - Denominator Exception (b}^1=10 \text{ visits)}} = \frac{40 \text{ visits}}{60 \text{ visits}} = 66.67\%$$

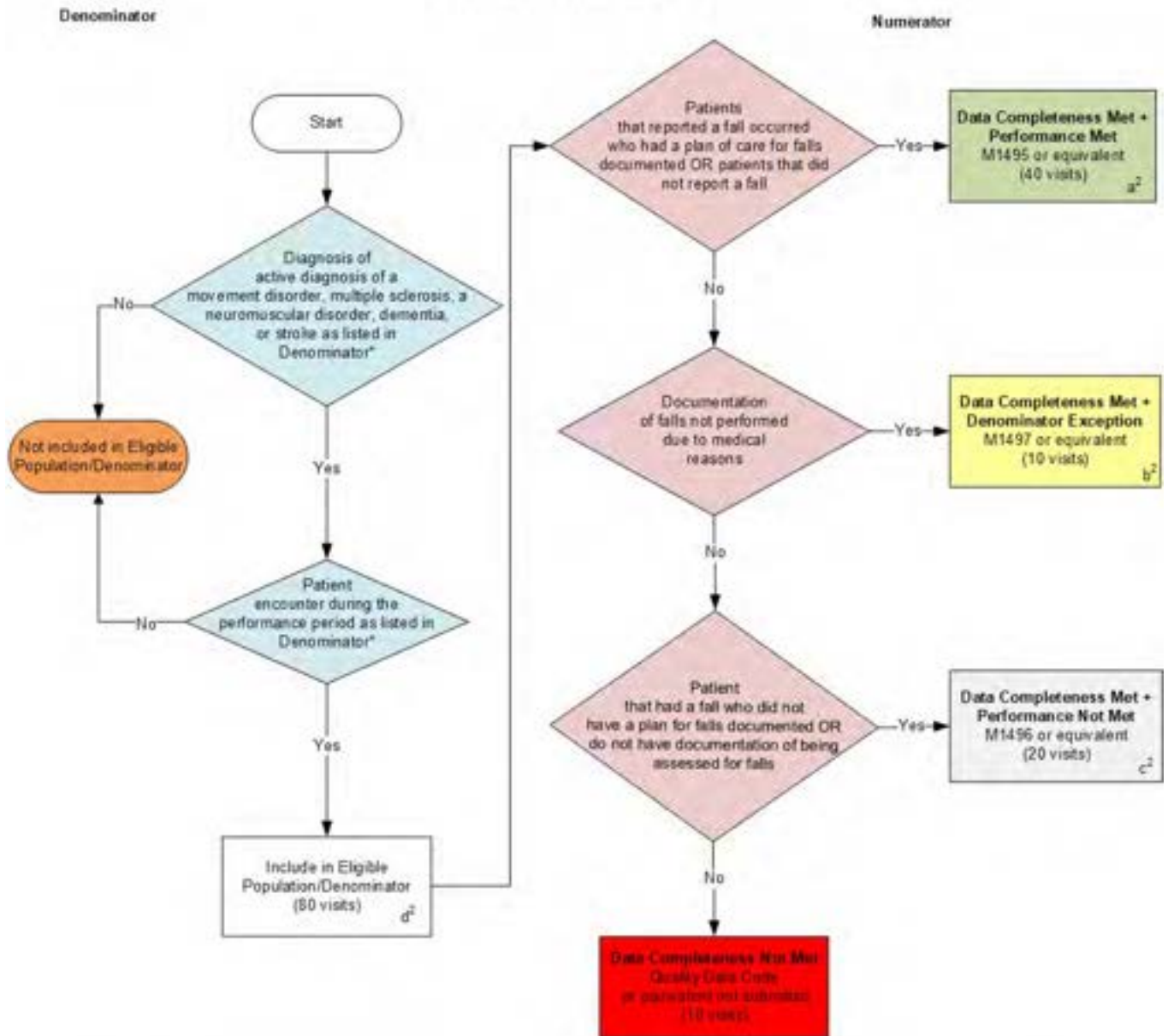
*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Visit

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v10

Submission Criteria Two



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness =
 Performance Met ($a^2=40$ visits) + Denominator Exception ($b^2=10$ visits) + Performance Not Met ($c^2=20$ visits) = 70 visits = 87.50%
 Eligible Population / Denominator ($d^2=80$ visits) = 80 visits

Performance Rate =
 Performance Met ($a^2=40$ visits) = 40 visits = 66.67%
 Data Completeness Numerator (70 visits) - Denominator Exception ($b^2=10$) = 60 visits

*See the posted measure specification for specific coding and instructions to submit this measure.
 NOTE: Submission Frequency: Visit

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 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.
 v10

2026 Clinical Quality Measure Flow Narrative for Quality ID #513:
Patient Reported Falls and Plan of Care
Multiple Performance Rates

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure

Accountability Reporting in the CMS MIPS Program: Sample Calculations

Overall Data Completeness (Submission Criteria 1) Performance Met (a¹ equals 40 patients) plus Denominator Exceptions (b¹ equals 10 patients) plus Performance Not Met (c¹ equals 20 patients) divided by Eligible Population/Denominator (d¹ equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Overall Performance Rate (Submission Criteria 2) Performance Met (a² equals 40 patients) divided by Data Completeness Numerator (b² equals 10 patients) minus Denominator Exceptions (b² 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: Visit

Submission Criteria One:

1. Start with Denominator
2. Check *Diagnosis of active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke as listed in Denominator**.
 - a. If *Diagnosis of active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke as listed in Denominator** equals No, do not include in *Eligible Population/ Denominator*. Stop processing.
 - b. If *Diagnosis of active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke as listed in Denominator** equals, Yes, proceed to check *Patient encounters during the performance period as listed in Denominator**
3. Check *Patient encounters during the performance period as listed in Denominator**.
 - a. If *Patient encounters during the performance period as listed in Denominator* equals No, do not include in *Eligible Population/ Denominator*. Stop processing.
 - b. If *Patient encounters 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 d¹ equals 80 patients in the Sample Calculation.
5. Start Numerator
6. Check *Patients who did not report a fall*.
 - a. If *Patients who did not report a fall* equals Yes, include in *Data Completeness 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 a¹ equals 40 patients in the Sample Calculation.
- b. If *Patients who did not report a fall* equals No, proceed to *Documentation of falls not performed due to medical reasons*.
- 7. Check *Documentation of falls not performed due to medical reasons*.
 - a. If *Documentation of falls not performed due to medical reasons* equals Yes, then 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 b¹ equals 10 patients in the Sample Calculation.
 - b. If *Documentation of falls not performed due to medical reasons* equals No, then proceed to *Patients that reported a fall since the last visit*.
- 8. Check *Patients that reported a fall since the last visit*.
 - a. If *Patients that reported a fall since the last visit* equals Yes, then 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 c¹ equals 20 patients in the Sample Calculation.
 - b. If *Patients that reported a fall since the last visit* equals no, then include in *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 (a¹ equals 40 patients) plus Denominator Exceptions (b¹ equals 10 patients) plus Performance Not Met (c¹ equals 20 patients) divided by Eligible Population/Denominator (d¹ equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a¹ equals 40 patients) divided by Data Completeness Numerator (equals 70 patients) minus Denominator Exceptions (b¹ 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: 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.

Submission Criteria Two:

1. Start with Denominator
2. Check *Active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke since last visit as listed in Denominator**.
 - a. If *Active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke since last visit as listed in Denominator** equals No, do not include in *Eligible Population/ Denominator*. Stop processing.
 - b. If *Active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke since last visit as listed in Denominator** equals Yes, proceed to check *Patient encounters during the performance period as listed in Denominator**
3. Check *Patient encounters during the performance period as listed in Denominator**.
 - a. If *Patient encounters during the performance period as listed in Denominator* equals No, do not include in *Eligible Population/ Denominator*. Stop processing.
 - b. If *Patient encounters 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 d² equals 80 patients in the Sample Calculation.
5. Start Numerator
6. Check *Patients that reported a fall occurred who had a plan of care for falls documented OR patients that did not report a fall*.
 - a. If *Patients that reported a fall occurred who had a plan of care for falls documented OR patients that did not report a fall* equals Yes, then 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 a² equals 40 patients in the Sample Calculation.
 - b. If *Patients that reported a fall occurred who had a plan of care for falls documented OR patients that did not report a fall* equals No, proceed to *Documentation of falls not performed due to medical reasons*.
7. Check *Documentation of falls not performed due to medical reasons*.
 - a. If *Documentation of falls not performed due to medical reasons* 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 b² equals 10 patients in the Sample Calculation.
 - b. If *Documentation of falls not performed due to medical reasons* equals No, proceed to

Patients that had a fall who did not have a plan of care for falls documented OR do not have documentation of being assessed for falls.

8. Check *Patients that had a fall who did not have a plan of care for falls documented OR do not have documentation of being assessed for falls.*

a. If *Patients that had a fall who did not have a plan of care for falls documented OR do not have documentation of being assessed for falls* 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 c² equals 20 patients in the Sample Calculation.

b. If *Patients that had a fall who did not have a plan of care for falls documented OR do not have documentation of being assessed for falls* 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 (a² equals 40 patients) plus Denominator Exceptions (b² equals 10 patients) plus Performance Not Met (c² equals 20 patients) divided by Eligible Population/Denominator (d² equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a² equals 40 patients) divided by Data Completeness Numerator (b² equals 10 patients) minus Denominator Exceptions (b² 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: 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.

eCQM Title	Diabetes: Glycemic Status Assessment Greater Than 9%		
CMS ID	122	eCQM Version Number	14.0.000
CBE Number	Not Applicable	GUID	f2986519-5a4e-4149-a8f2-af0a1dc7f6bc
Measurement Period	January 1, 2026 through December 31, 2026		
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 a glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) > 9.0% during the measurement period 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 endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of the measure or specification. 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 may be used for internal, noncommercial purposes (e.g., use by healthcare providers in connection with their practices) without obtaining approval from NCQA. All other uses, including a commercial use (including but not limited to vendors using or embedding the measures and specifications into any product or service to calculate measure results for customers for any purpose), must be approved by NCQA and are subject to a license at the discretion of NCQA. (C) 2012-2025 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.		
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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	Intermediate Outcome		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Diabetes is the seventh leading cause of death in the United States (Centers for Disease Control and Prevention [CDC], 2022a). In 2019, diabetes affected more than 37 million Americans (11.3% of the U.S. population) and killed more than 87,000 people (American Diabetes Association [ADA], 2022a). 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, 2022a). 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, 2022b). 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% increase from the estimated \$245 billion spent on diabetes in 2012 (ADA, 2018). Controlling A1c blood levels helps reduce the risk of microvascular complications (eye, kidney and nerve diseases) (ADA, 2022b). American Diabetes Association (2023): - Assess glycemic status (A1C or other glycemic measurement such as time in range or glucose management indicator) at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control). (Level of evidence: E) - An A1C goal for many nonpregnant adults of <7% (53 mmol/mol) without significant hypoglycemia is appropriate. (Level of evidence: A)		
Clinical Recommendation Statement	- On the basis of health care professional 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: B) - Less stringent A1C goals (such as <8% [64 mmol/mol]) may be appropriate for patients with limited life expectancy or where the harms of treatment are greater than the benefits. Health care professionals should consider deintensification of therapy if appropriate to reduce the risk of hypoglycemia in patients with inappropriate stringent A1C targets. (Level of evidence: B) - Standardized, single-page glucose reports from continuous glucose monitoring (CGM) devices with visual cues, such as the ambulatory glucose profile, should be considered as a standard summary for all CGM devices. Level of evidence: E		
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. (2022a). Statistics About Diabetes. Retrieved from https://diabetes.org/about-us/statistics/about-diabetes'
Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. (2022a). What is Diabetes? Retrieved from https://www.cdc.gov/diabetes/basics/diabetes.html'
Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. (2022b). Diabetes Report Card 2021. US Dept of Health and Human Services. Retrieved from https://archive.cdc.gov/www_cdc_gov/diabetes/library/reports/reportcard.html'
Reference	Reference Text: 'ElSayed, N.A., Aleppo, G., Ardoda, V.R., Bannuru, R.B., Brown, F.M., Bruemmer, D.,...Staton, R.C., American Diabetes Association (ADA). (2022). 6. Glycemic Targets: Standards of Care in Diabetes—2023. Diabetes Care 2023,46(Supplement_1):S97–S110. https://doi.org/10.2337/dc23-S006'
Definition	None If the glycemic status assessment (HbA1c or GMI) is in the medical record, the test can be used to determine numerator compliance. Glycemic status assessment (HbA1c or GMI) must be reported as a percentage (%).
Guidance	If multiple glycemic status assessments were recorded for a single date, use the lowest result. 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 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.
Denominator Exclusions	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 diagnosis 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 glycemic status assessment (HbA1c or GMI) (performed during the measurement period) is >9.0% or is missing, or was not performed during the measurement period
Numerator Exclusions	None
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"] DiabetesDiagnosis
where DiabetesDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
)
```

▲ Denominator

"Initial Population"

▲ Denominator Exclusions

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

▲ Numerator

"Has Most Recent Glycemic Status Assessment Without Result"
or "Has Most Recent Elevated Glycemic Status Assessment"
or "Has No Record Of Glycemic Status Assessment"

▲ Numerator Exclusions

None

▲ Denominator Exceptions

None

▲ Stratification

None

Definitions

▲ AIFrailTCF.Has Advanced Illness in Year Before or During Measurement Period

```
exists ( ["Diagnosis": "Advanced Illness"] AdvancedIllnessDiagnosis
  where AdvancedIllnessDiagnosis.prevalencePeriod starts during day of Interval[start of "Measurement Period" - 1 year, end of "Measurement Period"]
)
```

▲ AIFrailTCF.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 day of "Measurement Period"
)
or exists ( ["Encounter, Performed": "Frailty Encounter"] FrailtyEncounter
  where FrailtyEncounter.relevantPeriod overlaps day of "Measurement Period"
)
or exists ( ["Symptom": "Frailty Symptom"] FrailtySymptom
  where FrailtySymptom.prevalencePeriod overlaps day of "Measurement Period"
)
```

▲ AIFrailTCF.Has Dementia Medications in Year Before or During Measurement Period

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

▲ AIFrailTCF.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 day of
  end of "Measurement Period"
  sort by
  end of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)asc
)) LastHousingStatus
  where LastHousingStatus.result ~ "Lives in nursing home (finding)"
) is not null
```

▲ AIFrailTCF.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 Advanced Illness in Year Before or During Measurement Period"
or "Has Dementia Medications in Year Before or During Measurement Period"
)
)
```

▲ Denominator

"Initial Population"

▲ Denominator Exclusions

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

▲ Glycemic Status Assessment

```
( ["Laboratory Test, Performed": "HbA1c Laboratory Test"]
union ["Laboratory Test, Performed": "Glucose management indicator"] ) GlycemicStatus
where Global."LatestOf" ( GlycemicStatus.relevantDatetime, GlycemicStatus.relevantPeriod ) during day of "Measurement Period"
```

▲ Has Most Recent Elevated Glycemic Status Assessment

"Lowest Glycemic Status Assessment Reading on Most Recent Day".result > 9 '%'

▲ Has Most Recent Glycemic Status Assessment Without Result

"Lowest Glycemic Status Assessment Reading on Most Recent Day" is not null
and "Lowest Glycemic Status Assessment Reading on Most Recent Day".result is null

▲ Has No Record Of Glycemic Status Assessment

not exists "Glycemic Status Assessment"

▲ 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 day of "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 day of "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 day of "Measurement Period"
)
or exists ( ["Diagnosis": "Hospice Diagnosis"] HospiceCareDiagnosis
  where HospiceCareDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
)
```

▲ Initial Population

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

▲ Lowest Glycemic Status Assessment Reading on Most Recent Day

```
First("Glycemic Status Assessment" QualifyingGlycemicStatus
  where Global."LatestOf"(QualifyingGlycemicStatus.relevantDatetime, QualifyingGlycemicStatus.relevantPeriod) same day as "Most Recent Glycemic Status Date"
  sort by(result as Quantity)
)
```

▲ Most Recent Glycemic Status Date

```
Last(("Glycemic Status Assessment" QualifyingGlycemicStatus
  return date from start of Global."NormalizeInterval"(QualifyingGlycemicStatus.relevantDatetime, QualifyingGlycemicStatus.relevantPeriod))
QualifyingGlycemicStatusDays
  sort asc
)
```

▲ Numerator

"Has Most Recent Glycemic Status Assessment Without Result"
or "Has Most Recent Elevated Glycemic Status Assessment"
or "Has No Record Of Glycemic Status Assessment"

▲ PalliativeCare.Has 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 day of "Measurement Period"
)
or exists ( ["Diagnosis": "Palliative Care Diagnosis"] PalliativeDiagnosis
  where PalliativeDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
)
or exists ( ["Encounter, Performed": "Palliative Care Encounter"] PalliativeEncounter
  where PalliativeEncounter.relevantPeriod overlaps day of "Measurement Period"
)
or exists ( ["Intervention, Performed": "Palliative Care Intervention"] PalliativeIntervention
  where Global."NormalizeInterval" ( PalliativeIntervention.relevantDatetime, PalliativeIntervention.relevantPeriod ) overlaps day of "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 Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

["Patient Characteristic Sex": "Federal 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 "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")
- code "Glucose management indicator" ("LOINC Code (97506-0)")
- code "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)")
- code "Housing status" ("LOINC Code (71802-3)")
- code "Lives in 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 "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 "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- 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 Diagnosis" (2.16.840.1.113883.3.464.1003.1165)
- 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 "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "Palliative Care Diagnosis" (2.16.840.1.113883.3.464.1003.1167)
- 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 Type" (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: Advanced Illness" using "Advanced Illness" (2.16.840.1.113883.3.464.1003.110.12.1082)"
- "Diagnosis: Diabetes" using "Diabetes" (2.16.840.1.113883.3.464.1003.103.12.1001)"
- "Diagnosis: Frailty Diagnosis" using "Frailty Diagnosis" (2.16.840.1.113883.3.464.1003.113.12.1074)"
- "Diagnosis: Hospice Diagnosis" using "Hospice Diagnosis" (2.16.840.1.113883.3.464.1003.1165)"
- "Diagnosis: Palliative Care Diagnosis" using "Palliative Care Diagnosis" (2.16.840.1.113883.3.464.1003.1167)"
- "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: 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: Nutrition Services" using "Nutrition Services (2.16.840.1.113883.3.464.1003.1006)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "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: Glucose management indicator" using "Glucose management indicator (LOINC Code 97506-0)"
- "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 Type" using "Payer Type (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: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"
- "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 Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

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

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation		
CMS ID	143	eCQM Version Number	14.0.000
CBE Number	0086e	GUID	db9d9f09-6b6a-4749-a8b2-8c1fdb018823
Measurement Period	January 1, 2026 through December 31, 2026		
Measure Steward	American Academy of Ophthalmology		
Measure Developer	American Academy of Ophthalmology		
Measure Developer	American Medical Association (AMA)		
Endorsed By	CMS Consensus Based Entity		
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 during the measurement period		
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	Due to technical limitations, registered trademarks are indicated by (R) or [R].		
	Proportion		
	Process		
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 (Gedde et al., 2021). 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.		
	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 (Gedde et al., 2021)		
Clinical Recommendation Statement	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) (Gedde et al., 2021).		
	Higher score indicates better quality		
	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/archophth.124.12.1754'		
	Reference Type: CITATION		
Improvement Notation	Higher score indicates better quality		
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'		
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'		

	Reference Type: CITATION
Reference	Reference Text: 'Gedde, S. J., Vinod, K., Wright, M. M., Muir, K. W., Lind, J. T., Chen, P. P., Li, T., Mansberger, S. L., & American Academy of Ophthalmology Preferred Practice Pattern Glaucoma Panel (2021). Primary Open-Angle Glaucoma Preferred Practice Pattern(R). Ophthalmology, 128(1), P71–P150. https://doi.org/10.1016/j.ophtha.2020.10.022 '
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 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 during the measurement period
Numerator Exclusions	None
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 day of
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 day of 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 day of 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 day of
EncounterWithPOAG.relevantPeriod
where OpticDiscExamPerformed.result is not null

▲ Primary Open Angle Glaucoma Encounter

"Qualifying Encounter During Day of Measurement Period" ValidQualifyingEncounter
with ["Diagnosis": "Primary Open Angle Glaucoma"] POAGDiagnosis
such that POAGDiagnosis.prevalencePeriod overlaps day of ValidQualifyingEncounter.relevantPeriod

▲ Qualifying Encounter During Day of 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 day of "Measurement Period"
and QualifyingEncounter.class !~ "virtual"

▲ SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

["Patient Characteristic Sex": "Federal 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 "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- 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 "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 Type" (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 Type" using "Payer Type (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: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"

Supplemental Data Elements

▲ SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

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

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care		
CMS ID	142	eCQM Version Number	14.0.000
CBE Number	Not Applicable	GUID	53d6d7c3-43fb-4d24-8099-17e74c022c05
Measurement Period	January 1, 2026 through December 31, 2026		
Measure Steward	American Academy of Ophthalmology		
Measure Developer	American Academy of Ophthalmology		
Measure Developer	American Medical Association (AMA)		
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 during the measurement period		
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Measure Type	Proportion		
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 et al., 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 or endocrinologist for appropriate management of their systemic condition and should communicate examination results to the physician managing the patient's ongoing diabetes care (Lim et al., 2025).		
	A goal is to achieve 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 DR and the need for optimal metabolic control (Lim et al., 2025).		
	Establishing a close partnership between the ophthalmologist and the primary care physician is an important step to ensure optimal patient care. Furthermore, it is important to help educate patients with diabetes as well as their primary care physician about the ophthalmologic implications of controlling blood glucose (as monitored by HbA1c) to as near to normal as is safely possible (Lim et al., 2025).		
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: 'Lim, J.I., Kim, S.J., Bailey, S.T., Kovach, J.L., Vemulakonda, G.A., Ying, G., Flaxel, C.J. and the American Academy of Ophthalmology Preferred Practice Pattern Retina/Vitreous Committee (2025). Diabetic Retinopathy Preferred Practice Pattern. Ophthalmology. 2025 in press. doi: 10.1016/j.ophtha.2024.12.020.'		
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. (2016). Impact of physician communication on diabetic eye examination adherence: Results from a Retrospective Cohort Analysis. Retina.;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 clinician will record laterality in the patient medical record, as quality care and clinical documentation should include laterality.
Guidance	The communication of results, including the level of severity of diabetic retinopathy and presence or absence of macular edema to the primary care physician providing ongoing care of a patient's diabetes should be completed soon after the dilated exam is performed. Eligible clinicians reporting on this measure should note that all data for the measurement period is to be submitted by the deadline established by CMS. Therefore, eligible clinicians who see patients towards the end of the measurement 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 during the measurement period
Denominator	Equals Initial Population who had a dilated macular or fundus exam performed during the measurement period
Denominator Exclusions	None
Numerator	Patients with documentation, at least once within the measurement period, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care
Numerator Exclusions	None
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.

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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 Day of Measurement Period" ValidQualifyingEncounter
with ["Diagnosis": "Diabetic Retinopathy"] DiabeticRetinopathy
such that DiabeticRetinopathy.prevalencePeriod overlaps day of 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
and LevelOfSeverityCommunicated.sentDatetime during day of "Measurement Period"

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
and MacularEdemaAbsentCommunicated.sentDatetime during day of "Measurement Period"

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
and MacularEdemaPresentCommunicated.sentDatetime during day of "Measurement Period"

Macular Exam Performed

["Diagnostic Study, Performed": "Macular Exam"] MacularExam
with "Diabetic Retinopathy Encounter" EncounterDiabeticRetinopathy
such that Global."NormalizeInterval" (MacularExam.relevantDatetime, MacularExam.relevantPeriod) during day of 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 day of 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 day of 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 day of 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 Day of 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 day of "Measurement Period"
and QualifyingEncounter.class != "virtual"

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

["Patient Characteristic Sex": "Federal 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 "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- 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 "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 Type" (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 Type" using "Payer Type (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: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"

Supplemental Data Elements

▲ SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

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

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	Diabetes: Eye Exam		
CMS ID	131	eCQM Version Number	14.0.000
CBE Number	Not Applicable	GUID	d90bdab4-b9d2-4329-9993-5c34e2c0dc66
Measurement Period	January 1, 2026 through December 31, 2026		
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 in the 12 months prior to the measurement period 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 endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of the measure or specification. 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 may be used for internal, noncommercial purposes (e.g., use by healthcare providers in connection with their practices) without obtaining approval from NCQA. All other uses, including a commercial use (including but not limited to vendors using or embedding the measures and specifications into any product or service to calculate measure results for customers for any purpose), must be approved by NCQA and are subject to a license at the discretion of NCQA. (C) 2012-2025 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.		
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Disclaimer	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	Diabetes is the eighth leading cause of death in the United States. In 2021, diabetes affected more than 38 million Americans (11.6 percent of the U.S. population) and killed more than 103,000 people (American Diabetes Association [ADA], 2024). Diabetes is a long-lasting disease marked by high blood glucose levels, resulting from the body's inability to produce or use insulin properly (Centers for Disease Control and Prevention [CDC], 2022a). 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, 2022b). In 2022, diabetes cost the U.S. an estimated \$413 billion: \$307 billion in direct medical costs and \$106 billion in reduced productivity. The direct medical cost of diabetes increased by 7% between 2017 and 2022 (Parker et al., 2022). Diabetes is the leading cause of new cases of blindness among adults aged 18–64 years (CDC, 2024). Diabetic retinopathy is progressive damage to the small blood vessels in the retina that may result in loss of vision. Approximately 4.1 million adults are affected by diabetic retinopathy (CDC, 2020). American Diabetes Association (2024): - 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 exams 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 Professional Practice Committee. 12. Retinopathy, neuropathy, and foot care: Standards of Care in Diabetes—2024. Diabetes Care 2024;47(Suppl. 1):S231–S243'
	Reference Type: CITATION
Reference	Reference Text: 'American Diabetes Association. (2024). Statistics About Diabetes. Retrieved from https://diabetes.org/about-diabetes/statistics/about-diabetes'
	Reference Type: CITATION
Reference	Reference Text: 'Centers for Disease Control and Prevention. (2020). 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. (2022a). What is Diabetes? Retrieved from https://www.cdc.gov/diabetes/basics/diabetes.html'
	Reference Type: CITATION
Reference	Reference Text: 'Centers for Disease Control and Prevention. (2022b). National Diabetes Statistics Report, 2021. US Dept of Health and Human Services. Retrieved from https://www.cdc.gov/diabetes/library/reports/reportcard.html'
	Reference Type: Citation
Reference	Reference Text: 'Centers for Disease Control and Prevention. (2024). National Diabetes Statistics Report. Retrieved from https://www.cdc.gov/diabetes/php/data-research/index.html'
	Reference Type: CITATION
Reference	Reference Text: 'Parker E, Lin J, Mahoney T, et al. Economic Costs of Diabetes in the U.S. in 2022. Diabetes Care. 2024;47(1):26-43. doi:10.2337/dci23-0085'
Definition	None
	The eye exam must be performed by an ophthalmologist or optometrist, or there must be evidence that fundus photography results were analyzed by a system that provides an autonomous artificial intelligence (AI) calculation.
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
	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 with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: - Advanced illness diagnosis during the measurement period or the year prior - OR taking dementia medications during the measurement period or the year prior
Denominator Exclusions	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 receiving palliative care for any part of the measurement period.
	Exclude patients who have bilateral absence of eyes any time during the patient's history through the end of the measurement period.
	Patients with an eye screening for diabetic retinal disease. This includes patients with diabetes who had one of the following: - 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 - 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 - An autonomous eye exam in the measurement period - A retinal exam finding with a retinopathy severity level in any part of the measurement period - A retinal exam finding with no retinopathy severity level in the year prior to the measurement period
Numerator	
Numerator Exclusions	None
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

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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"] DiabetesDx
where DiabetesDx.prevalencePeriod overlaps day of "Measurement Period"
)

```

▲ Denominator

"Initial Population"

▲ Denominator Exclusions

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

▲ Numerator

("Diabetic Retinopathy Overlapping Measurement Period"
and ("Retinal Exam in Measurement Period")
)
or (not ("Diabetic Retinopathy Overlapping Measurement Period")
and ("Retinal Exam in Measurement Period or Year Prior")
)
or "Autonomous Eye Exam in Measurement Period"
or "Retinal Exam Finding with Retinopathy Severity Level in Measurement Period"
or "Retinal Exam Finding with No Retinopathy Severity Level in Year Prior"

▲ Numerator Exclusions

None

▲ Denominator Exceptions

None

▲ Stratification

None

Definitions

▲ AIFrailTCF.Has Advanced Illness in Year Before or During Measurement Period

exists (["Diagnosis": "Advanced Illness"] AdvancedIllnessDiagnosis
where AdvancedIllnessDiagnosis.prevalencePeriod starts during day of Interval[start of "Measurement Period" - 1 year, end of "Measurement Period"]
)

▲ AIFrailTCF.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 day of "Measurement Period"
)
or exists (["Encounter, Performed": "Frailty Encounter"] FrailtyEncounter
where FrailtyEncounter.relevantPeriod overlaps day of "Measurement Period"
)
or exists (["Symptom": "Frailty Symptom"] FrailtySymptom
where FrailtySymptom.prevalencePeriod overlaps day of "Measurement Period"
)

▲ AIFrailTCF.Has Dementia Medications in Year Before or During Measurement Period

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

▲ AIFrailTCF.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 day of
end of "Measurement Period"
sort by
end of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)asc
) LastHousingStatus
where LastHousingStatus.result ~ "Lives in nursing home (finding)"
) is not null

▲ AIFrailTCF.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 Advanced Illness in Year Before or During Measurement Period"
or "Has Dementia Medications in Year Before or During Measurement Period"
)
)

▲ Autonomous Eye Exam in Measurement Period

exists ["Physical Exam, Performed": "Eye Diabetic retinopathy screening Autonomous artificial intelligence"] AutonomousEyeExam
where AutonomousEyeExam.result in "Autonomous Eye Exam Result or Finding"
and Global."NormalizeInterval" (AutonomousEyeExam.relevantDatetime, AutonomousEyeExam.relevantPeriod) during day of "Measurement Period"

▲ Bilateral Absence of Eyes

exists (["Diagnosis": "Anophthalmos of bilateral eyes (disorder)"] BilateralAbsenceEyes
 where BilateralAbsenceEyes.prevalencePeriod starts on or before day of 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."Has Palliative Care in the Measurement Period"
 or "Bilateral Absence of Eyes"

Diabetic Retinopathy Overlapping Measurement Period

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

Has Left Eye No Retinopathy in Year Prior

exists (["Physical Exam, Performed": "Left eye Diabetic retinopathy severity level by Ophthalmoscopy"] LeftEyeNoRetinopathy
 where LeftEyeNoRetinopathy.result ~ "No apparent retinopathy"
 and Global."NormalizeInterval" (LeftEyeNoRetinopathy.relevantDatetime, LeftEyeNoRetinopathy.relevantPeriod) during day of Interval[start of "Measurement Period" - 1 year, end of "Measurement Period" - 1 year])

Has Left Eye Retinopathy

exists (["Physical Exam, Performed": "Left eye Diabetic retinopathy severity level by Ophthalmoscopy"] LeftEyeRetinopathy
 where LeftEyeRetinopathy.result in "Diabetic Retinopathy Severity Level"
 and Global."NormalizeInterval" (LeftEyeRetinopathy.relevantDatetime, LeftEyeRetinopathy.relevantPeriod) during day of "Measurement Period"

Has Right Eye No Retinopathy in Year Prior

exists (["Physical Exam, Performed": "Right eye Diabetic retinopathy severity level by Ophthalmoscopy"] RightEyeNoRetinopathy
 where RightEyeNoRetinopathy.result ~ "No apparent retinopathy"
 and Global."NormalizeInterval" (RightEyeNoRetinopathy.relevantDatetime, RightEyeNoRetinopathy.relevantPeriod) during day of Interval[start of "Measurement Period" - 1 year, end of "Measurement Period" - 1 year])

Has Right Eye Retinopathy

exists (["Physical Exam, Performed": "Right eye Diabetic retinopathy severity level by Ophthalmoscopy"] RightEyeRetinopathy
 where RightEyeRetinopathy.result in "Diabetic Retinopathy Severity Level"
 and Global."NormalizeInterval" (RightEyeRetinopathy.relevantDatetime, RightEyeRetinopathy.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 day of "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 day of "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 day of "Measurement Period"
)
 or exists (["Diagnosis": "Hospice Diagnosis"] HospiceCareDiagnosis
 where HospiceCareDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
)

Initial Population

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

Numerator

("Diabetic Retinopathy Overlapping Measurement Period"
 and ("Retinal Exam in Measurement Period")
)
 or (not ("Diabetic Retinopathy Overlapping Measurement Period")
 and ("Retinal Exam in Measurement Period or Year Prior")
)
 or "Autonomous Eye Exam in Measurement Period"
 or "Retinal Exam Finding with Retinopathy Severity Level in Measurement Period"
 or "Retinal Exam Finding with No Retinopathy Severity Level in Year Prior"

PalliativeCare.Has 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 day of "Measurement Period"
)
 or exists (["Diagnosis": "Palliative Care Diagnosis"] PalliativeDiagnosis
 where PalliativeDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
)
 or exists (["Encounter, Performed": "Palliative Care Encounter"] PalliativeEncounter
 where PalliativeEncounter.relevantPeriod overlaps day of "Measurement Period"

```
)
or exists ( ["Intervention, Performed": "Palliative Care Intervention"] PalliativeIntervention
  where Global."NormalizeInterval" ( PalliativeIntervention.relevantDatetime, PalliativeIntervention.relevantPeriod ) overlaps day of "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 Finding with No Retinopathy Severity Level in Year Prior

```
( "Has Left Eye No Retinopathy in Year Prior" and "Has Right Eye No Retinopathy in Year Prior" )
```

Retinal Exam Finding with Retinopathy Severity Level in Measurement Period

```
( "Has Left Eye Retinopathy" and "Has Right Eye Retinopathy" )
or ( "Has Left Eye Retinopathy" and "Has Right Eye No Retinopathy in Year Prior" )
or ( "Has Right Eye Retinopathy" and "Has Left Eye No Retinopathy in Year Prior" )
```

Retinal Exam in Measurement Period

```
exists ["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

```
exists ["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 Type"]
```

SDE Race

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

SDE Sex

```
["Patient Characteristic Sex": "Federal 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 "Anophthalmos of bilateral eyes (disorder)" ("SNOMEDCT Code (15665641000119103)")
- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Eye Diabetic retinopathy screening Autonomous artificial intelligence" ("LOINC Code (105914-6)")
- 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 "Left eye Diabetic retinopathy severity level by Ophthalmoscopy" ("LOINC Code (71490-7)")
- code "Lives in nursing home (finding)" ("SNOMEDCT Code (160734000)")
- code "Medical equipment used" ("LOINC Code (98181-1)")
- code "No apparent retinopathy" ("LOINC Code (LA18643-9)")
- code "Right eye Diabetic retinopathy severity level by Ophthalmoscopy" ("LOINC Code (71491-5)")
- code "Yes (qualifier value)" ("SNOMEDCT Code (373066001)")
- 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 "Autonomous Eye Exam Result or Finding" (2.16.840.1.113883.3.464.1004.2616)
- 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 "Diabetic Retinopathy Severity Level" (2.16.840.1.113883.3.464.1003.1266)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- 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 Diagnosis" (2.16.840.1.113883.3.464.1003.1165)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Palliative Care Diagnosis" (2.16.840.1.113883.3.464.1003.1167)
- 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 Type" (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: Advanced Illness" using "Advanced Illness (2.16.840.1.113883.3.464.1003.110.12.1082)"
- "Diagnosis: Anophthalmos of bilateral eyes (disorder)" using "Anophthalmos of bilateral eyes (disorder) (SNOMEDCT Code 15665641000119103)"
- "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: Frailty Diagnosis" using "Frailty Diagnosis (2.16.840.1.113883.3.464.1003.113.12.1074)"
- "Diagnosis: Hospice Diagnosis" using "Hospice Diagnosis (2.16.840.1.113883.3.464.1003.1165)"
- "Diagnosis: Palliative Care Diagnosis" using "Palliative Care Diagnosis (2.16.840.1.113883.3.464.1003.1167)"
- "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: 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: 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: 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 Type" using "Payer Type (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: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"
- "Physical Exam, Performed: Eye Diabetic retinopathy screening Autonomous artificial intelligence" using "Eye Diabetic retinopathy screening Autonomous artificial intelligence (LOINC Code 105914-6)"
- "Physical Exam, Performed: Left eye Diabetic retinopathy severity level by Ophthalmoscopy" using "Left eye Diabetic retinopathy severity level by Ophthalmoscopy (LOINC Code 71490-7)"
- "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)"
- "Physical Exam, Performed: Right eye Diabetic retinopathy severity level by Ophthalmoscopy" using "Right eye Diabetic retinopathy severity level by Ophthalmoscopy (LOINC Code 71491-5)"
- "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 Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

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

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	Documentation of Current Medications in the Medical Record		
CMS ID	68	eCQM Version Number	15.0.000
CBE Number	Not Applicable	GUID	9a032d9c-3d9b-11e1-8634-00237d5bf174
Measurement Period	January 1, 2026 through December 31, 2026		
Measure Steward	Centers for Medicare & Medicaid Services (CMS)		
Measure Developer	American Institutes for Research (AIR)		
Endorsed By	None		
Description	Percentage of visits for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter This electronic clinical quality measure (Measure) and related data specifications are owned and stewarded by the Centers for Medicare & Medicaid Services (CMS). CMS contracted (Contract # 75FCMC18D0027/ Task Order #: 75FCMC24F0144) with the American Institutes for Research (AIR) to develop this electronic measure. AIR is not responsible for any use of the Measure. AIR makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and AIR has no liability to anyone who relies on such measures or specifications.		
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. AIR 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 2004-2024 American Medical Association. LOINC(R) copyright 2004-2024 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2024 International Health Terminology Standards Development Organisation. 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.		
Disclaimer	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	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, & Gonzales, 2011). Other vulnerable groups include individuals who are chronically ill or disabled (Nabhanizadeh, Oppewal, Boot, & Maes-Festen, 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) admitted to the emergency room. Of 80 patients included in the study, the home medications were reordered for 65% of patients on their admission. Of the 65%, 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). 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). 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 electronic health record (EHR) documentation with an overall risk ratio (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 2023 Ambulatory Health Care National Patient Safety Goals guide clinicians to maintain and communicate accurate patient medication information (2023). Specifically, the section NPSG.03.06.01 "Maintain and communicate accurate patient medication information" states the following: "Obtain and/or update information on the medications the patient is currently taking. This information is documented in a list or other format that is useful to those who manage medication. Compare the medication information the patient brought to the organization with the medications ordered for the patient by the organization in order to identify and resolve discrepancies." The Joint Commission's 2023 Hospital National Patient Safety Goals also addressed documenting current medications (2023). Specifically, the section NPSG.03.06.01 "Maintain and communicate accurate patient information" states the following: "Obtain information on the medications the patient is currently taking when they are admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications." 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 Type: CITATION
Reference	Reference Text: 'American Medical Association. (2007). The physician's role in medication reconciliation: Issues, strategies, and safety principles. http://www.doctutor.es/wp-content/uploads/2013/09/med-rec-monograph.pdf .'
	Reference Type: CITATION
Reference	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. <i>European Journal of Public Health</i> , 26(1), 60-64. https://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. <i>Journal of Applied Research in Intellectual Disabilities</i> , 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. <i>Quality and Safety in Health Care</i> , 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. https://www.cdc.gov/nchs/data/hsr/2018/038.pdf '
	Reference Type: CITATION
Reference	Reference Text: 'National Quality Forum. (2010). Safe practices for better healthcare - 2010 update. https://www.qualityforum.org/publications/2010/04/safe_practices_for_better_healthcare_%E2%80%932010_update.aspx '
	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. <i>Journal of Young Pharmacists</i> , 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). <i>American Journal of Health-System Pharmacy</i> , 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. <i>Health Services Research</i> , 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. <i>The Joint Commission Journal on Quality and Patient Safety</i> , 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. <i>The Annals of Pharmacotherapy</i> , 45(7-8), 977-989. http://doi.org/10.1345/aph.1P627 '
	Reference Type: CITATION
Reference	Reference Text: 'The Joint Commission. (2023). Ambulatory Health Care: 2023 National Patient Safety Goals. https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2023/npsg_chapter_ahc_jul2023.pdf '
	Reference Type: CITATION
Reference	Reference Text: 'The Joint Commission. (2023). Hospital: 2023 National Patient Safety Goals. https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2023/npsg_chapter_hap_jul2023.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. <i>Journal for Healthcare Quality</i> , 32(5), 12-21. http://doi.org/10.1111/j.1945-1474.2010.00097.x '
	Current Medications: Medications the patient is presently taking including all prescriptions, over-the-counter products, herbals, vitamins, minerals, dietary (nutritional) supplements, and cannabis/cannabidiol (CBD) products with each medication's name, dosage, frequency and administered route.
Definition	Encounter to Document Medications: An encounter performed during the measurement period where medications should be reviewed.
	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 eligible 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 on the day of the encounter.
	This list must include all known prescriptions, over-the-counter products, herbals, vitamins, minerals, dietary (nutritional) supplements, cannabis/cannabidiol (CBD) 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
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	None
Denominator Exceptions	Documentation of an acute health crisis where time is of the essence and delay of 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

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Population Criteria

Initial Population

"Qualifying Encounter During Day of Measurement Period" QualifyingEncounter

Denominator

"Initial Population"

Denominator Exclusions

None

Numerator

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

Numerator Exclusions

None

Denominator Exceptions

"Qualifying Encounter During Day of 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 day of QualifyingEncounter.relevantPeriod
and MedicationsNotDocumented.negationRationale = "Acute health crisis (finding)"

Stratification

None

Definitions

Denominator

"Initial Population"

Denominator Exceptions

"Qualifying Encounter During Day of 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 day of QualifyingEncounter.relevantPeriod
and MedicationsNotDocumented.negationRationale = "Acute health crisis (finding)"

Initial Population

"Qualifying Encounter During Day of Measurement Period" QualifyingEncounter

Numerator

"Qualifying Encounter During Day of Measurement Period" QualifyingEncounter
with (["Procedure, Performed": "Documentation of current medications (procedure)"]
union ["Intervention, Performed": "Documentation of current medications (procedure)"]) MedicationsDocumented

such that Global."EarliestOf" (MedicationsDocumented.relevantDatetime, MedicationsDocumented.relevantPeriod) during day of QualifyingEncounter.relevantPeriod and Global."HasEnd" (Global."NormalizeInterval" (MedicationsDocumented.relevantDatetime, MedicationsDocumented.relevantPeriod))

Qualifying Encounter During Day of Measurement Period

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

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer Type"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

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

Functions

Global.Earliest(period Interval<DateTime>)

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

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

Earliest(NormalizeInterval(pointInTime, period))

Global.HasEnd(period Interval<DateTime>)

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

Global.HasStart(period Interval<DateTime>)

```
not ( start of period is null
  or start of period = minimum DateTime
)
```

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 "Acute health crisis (finding)" ("SNOMEDCT Code (705016005)")
- 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 "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- valueset "Payer Type" (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 Type" using "Payer Type (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: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"
- "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 Type"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

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

Risk Adjustment Variables

None

Measure Set	CLINICAL QUALITY MEASURE SET

eCQM Title	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery		
CMS ID	133	eCQM Version Number	14.0.000
CBE Number	0565e	GUID	39e0424a-1727-4629-89e2-c46c2fbb3f5f
Measurement Period	January 1, 2026 through December 31, 2026		
Measure Steward	American Academy of Ophthalmology		
Measure Developer	American Academy of Ophthalmology		
Measure Developer	American Medical Association (AMA)		
Endorsed By	CMS Consensus Based Entity		
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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	Due to technical limitations, registered trademarks are indicated by (R) or [R].		
	Proportion		
	Outcome		
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 (Miller et al., 2022), 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 Food and Drug Administration 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.		
Clinical Recommendation Statement	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. 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 Type: CITATION
Reference	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 Type: CITATION
Reference	Reference Text: 'Lim, J.I., Kim, S.J., Bailey, S.T., Kovach, J.L., Vemulakonda, G.A., Ying, G., Flaxel, C.J. and the American Academy of Ophthalmology Preferred Practice Pattern Retina/Vitreous Committee (2025). Diabetic Retinopathy Preferred Practice Pattern. Ophthalmology. 2025 in press. doi: 10.1016/j.ophtha.2024.12.020.' , Reference Type: CITATION
Reference	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 Type: CITATION
Reference	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/archophth.1995.01100100093037' Reference Type: CITATION
Reference	Reference Text: 'National Eye Institute. (2019). Cataract data and statistics. https://nei.nih.gov/eyedata/cataract' Reference Type: CITATION
Reference	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 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 measurement 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.
Guidance	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 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 performed between January and September of the measurement period for patients 18 years and older
Denominator	Equals Initial Population Cataract surgeries in patients with significant ocular conditions impacting the visual outcome of surgery
Denominator Exclusions	Significant ocular conditions include: amblyopia, burn confined to eye and adnexa, cataracts secondary to ocular disorders, congenital cataract, mature or hypermature cataract, posterior polar cataract, central corneal ulcer, certain types of iridocyclitis, choroidal degenerations, choroidal detachment, choroidal hemorrhage and rupture, cloudy cornea, corneal edema, disorders of cornea including corneal opacity, degeneration of macula and posterior pole, degenerative disorders of globe, diabetic macular edema, diabetic retinopathy disorders of optic chiasm, disorders of visual cortex, disseminated chorioretinitis and disseminated retinochoroiditis, focal chorioretinitis and focal retinochoroiditis, glaucoma, hereditary dystrophies (choroidal, corneal, retinal), hypotony of eye, injury to optic nerve and pathways, macular scare of posterior polar, morgagnian cataract, nystagmus and other irregular eye movements, open wound of eyeball, optic atrophy, optic neuritis, pathologic myopia, posterior lenticonus, prior penetrating keratoplasty, purulent endophthalmitis, retinal detachment with retinal defect, retinal vascular occlusion, retrolental fibroplasias, scleritis, separation of retinal layers, traumatic cataract, uveitis, vascular disorders of iris and ciliary body, and visual field defects
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	None
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

"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 Surgeries in Patients with Significant Ocular Conditions Impacting the Visual Outcome of Surgery"

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 Surgeries in Patients with Significant Ocular Conditions Impacting the Visual Outcome of Surgery

"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": "Disorders of Cornea Including Corneal Opacity"]
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 and 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 day of Global."NormalizeInterval" (CataractSurgeryPerformed.relevantDatetime,
CataractSurgeryPerformed.relevantPeriod)

Cataract Surgery Between January and September of Measurement Period

["Procedure, Performed": "Cataract Surgery"] CataractSurgeryProcedure
where Global."NormalizeInterval" (CataractSurgeryProcedure.relevantDatetime, CataractSurgeryProcedure.relevantPeriod) during day of "Measurement Period"
and Global."NormalizeInterval" (CataractSurgeryProcedure.relevantDatetime, CataractSurgeryProcedure.relevantPeriod) starts 92 days or more before day of end of
"Measurement Period"

Denominator

"Initial Population"

Denominator Exclusions

"Cataract Surgeries in Patients with Significant Ocular Conditions Impacting the Visual Outcome of Surgery"

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 Type"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "Federal 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 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 "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 "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 "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 Cornea Including Corneal Opacity" (2.16.840.1.113883.3.526.3.1419)
- 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 "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- 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 and 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 "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 Type" (2.16.840.1.114222.4.11.3591)
- valueset "Posterior Lenticulus" (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 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: Cataract Secondary to Ocular Disorders" using "Cataract Secondary to Ocular Disorders (2.16.840.1.113883.3.526.3.1410)"
- "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: 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 Cornea Including Corneal Opacity" using "Disorders of Cornea Including Corneal Opacity (2.16.840.1.113883.3.526.3.1419)"
- "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 Associated with Congenital Anomalies and Dystrophies and Systemic Syndromes" using "Glaucoma Associated with Congenital Anomalies and Dystrophies and Systemic Syndromes (2.16.840.1.113883.3.526.3.1461)"
- "Diagnosis: Glaucoma" using "Glaucoma (2.16.840.1.113883.3.526.3.1423)"
- "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 Lenticulus" using "Posterior Lenticulus (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 Type" using "Payer Type (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: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"
- "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 Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

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

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		
CMS ID	138	eCQM Version Number	14.0.000
CBE Number	Not Applicable	GUID	e35791df-5b25-41bb-b260-673337bc44a8
Measurement Period	January 1, 2026 through December 31, 2026		
Measure Steward	National Committee for Quality Assurance		
Measure Developer	National Committee for Quality Assurance		
Measure Developer	American Medical Association (AMA)		
Endorsed By	None		
Description	Percentage of patients aged 12 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: - Percentage of patients aged 12 years and older who were screened for tobacco use one or more times during the measurement period - Percentage of patients aged 12 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 - Percentage of patients aged 12 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 This Physician Performance Measure (Measure) and related data specifications are owned by the National Committee for Quality Assurance (NCQA). NCQA is not responsible for any use of the Measure. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of the measure or specification. 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 may be used for internal, noncommercial purposes (e.g., use by healthcare providers in connection with their practices) without obtaining approval from NCQA. All other uses, including a commercial use (including but not limited to vendors using or embedding the measures and specifications into any product or service to calculate measure results for customers for any purpose), must be approved by NCQA and are subject to a license at the discretion of NCQA. The Physician Consortium for Performance Improvement's (PCPI) and American Medical Association's (AMA) significant past efforts and contributions to the development and updating of the measure are acknowledged. (C) 2012-2025 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.		
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Disclaimer	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	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 U.S. 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). The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to		

	prevent initiation of tobacco use among school-aged children and adolescents (Grade B Statement) (U.S. Preventive Services Task Force, 2020). The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care--feasible interventions for the cessation of tobacco use among school-aged children and adolescents (Grade I Statement) (U.S. Preventive Services Task Force, 2020). 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).
Improvement Notation	Higher score indicates better quality Reference Type: CITATION
Reference	Reference Text: 'US Department of Health and Human Services. (2008). 6, Evidence and Recommendations. Treating Tobacco Use and Dependence: 2008 Update. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK63943/' Reference Type: CITATION
Reference	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' Reference Type: CITATION
Reference	Reference Text: 'US Preventive Services Task Force. (2020). Primary Care Interventions for Prevention and Cessation of Tobacco Use in Children and Adolescents. US Preventive Services Task Force Recommendation Statement. JAMA, 2020;323(16):1590-1598. doi:10.1001/jama.2020.4679' 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 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).
Definition	
Guidance	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 12 years and older seen for at least two visits or at least one preventive visit during the measurement period
	Population 1: Equals Initial Population.
Denominator	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
	Population 1: Patients who were screened for tobacco use at least once during the measurement period.
Numerator	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	None
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

Population Criteria 1

Initial Population

```
AgeInYearsAt(date from start of "Measurement Period") >= 12
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") >= 12
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") >= 12
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 day of "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 day of "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 day of "Measurement Period"
  )
  or exists ( ["Diagnosis": "Hospice Diagnosis"] HospiceCareDiagnosis
    where HospiceCareDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
  )

```

4 Initial Population

```

AgeInYearsAt(date from start of "Measurement Period") >= 12
and ( Count("Qualifying Visit During Measurement Period") >= 2
  or exists "Preventive Visit During Measurement Period"
)

```

4 Most Recent Tobacco Use Screening Indicates Tobacco Non User

```

( Last(["Assessment, Performed": "Tobacco Use Screening"] TobaccoUseScreening
  where Global."NormalizeInterval"(TobaccoUseScreening.relevantDatetime, TobaccoUseScreening.relevantPeriod) during day of "Measurement Period"
  sort by start of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)
) ) MostRecentTobaccoUseScreening
where MostRecentTobaccoUseScreening.result in "Tobacco Non User"

```

4 Most Recent Tobacco Use Screening Indicates Tobacco User

```

( Last(["Assessment, Performed": "Tobacco Use Screening"] TobaccoUseScreening
  where Global."NormalizeInterval"(TobaccoUseScreening.relevantDatetime, TobaccoUseScreening.relevantPeriod) during day of "Measurement Period"
  sort by start of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)
) ) MostRecentTobaccoUseScreening
where MostRecentTobaccoUseScreening.result in "Tobacco User"

```

4 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

```

4 Numerator 2

```

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

```

4 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"
  )
)

```

4 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 Initial Office Visit, 18 and Up"]
union ["Encounter, Performed": "Preventive Care, Established Office Visit, 0 to 17"]
union ["Encounter, Performed": "Preventive Care Services, Initial Office Visit, 0 to 17"]
union ["Encounter, Performed": "Preventive Care Services Group Counseling"]
union ["Encounter, Performed": "Preventive Care Services Individual Counseling"]
union ["Encounter, Performed": "Unlisted preventive medicine service"]
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"] ) PreventiveEncounter
where PreventiveEncounter.relevantPeriod during day of "Measurement Period"

```

4 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": "Virtual Encounter"] ) OfficeBasedEncounter
where OfficeBasedEncounter.relevantPeriod during day of "Measurement Period"

```

4 SDE Ethnicity

```

["Patient Characteristic Ethnicity": "Ethnicity"]

```

4 SDE Payer

```

["Patient Characteristic Payer": "Payer Type"]

```

4 SDE Race

```

["Patient Characteristic Race": "Race"]

```

4 SDE Sex

```

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

```

4 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"]
)
```

4 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

4 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 "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- 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 Diagnosis" (2.16.840.1.113883.3.464.1003.1165)
- 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 "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Payer Type" (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 "Preventive Care Services, Initial Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1022)
- valueset "Preventive Care, Established Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1024)
- 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)
- valueset "Virtual Encounter" (2.16.840.1.113883.3.464.1003.101.12.1089)

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: Hospice Diagnosis" using "Hospice Diagnosis (2.16.840.1.113883.3.464.1003.1165)"
- "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: 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: 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, 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)"
- "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)"
- "Encounter, Performed: Virtual Encounter" using "Virtual Encounter (2.16.840.1.113883.3.464.1003.101.12.1089)"
- "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 Type" using "Payer Type (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: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"

Supplemental Data Elements

▲ SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

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

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	Controlling High Blood Pressure		
CMS ID	165	eCQM Version Number	14.0.000
CBE Number	Not Applicable	GUID	abdc37cc-bac6-4156-9b91-d1be2c8b7268
Measurement Period	January 1, 2026 through December 31, 2026		
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 (<140/90 mmHg) during the measurement period 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 endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of the measure or specification. 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 may be used for internal, noncommercial purposes (e.g., use by healthcare providers in connection with their practices) without obtaining approval from NCQA. All other uses, including a commercial use (including but not limited to vendors using or embedding the measures and specifications into any product or service to calculate measure results for customers for any purpose), must be approved by NCQA and are subject to a license at the discretion of NCQA. (C) 2012-2025 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.		
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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	Intermediate 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], 2023). 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). In an analysis of adults with hypertension in National Health and Nutrition Examination Survey (NHANES), the estimated age-adjusted proportion with controlled blood pressure (BP) increased from 31.8 percent in 1999 to 53.8 percent in 2014. However, that proportion declined to 43.7 percent in 2017 to 2018 (Tsao et al., 2022). HBP increases risks of heart disease and stroke which are two of the leading causes of death in the US (CDC, 2023). 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, 2021). The National Center for Health Statistics reported that in 2020 there were over 670,000 deaths with HBP as a primary or contributing cause (CDC, 2022). Between 2009 and 2019 the number of deaths due to HBP rose by 65.3 percent (Tsao et al., 2022). 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). Age-adjusted death rates attributable to HBP in 2019 were more than twice as high in non-Hispanic Black males (56.7 percent) when compared to rates for non-Hispanic White males (25.7 percent) (Tsao et al., 2022). HBP costs the U.S. approximately 131 billion dollars each year, averaged over 12 years from 2003 to 2014 (Kirkland et al., 2018). A study on cost-effectiveness on treating hypertension found that controlling HBP in patients with cardiovascular disease and systolic blood pressures (SBP) of >= 160 mmHg could be effective and cost-saving (Moran et al., 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 mmHg compared to a SBP goal of <140 mmHg 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.		

	U.S. Preventive Services Task Force (USPSTF) (2021): - The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment. This is a grade A recommendation. American College of Cardiology/American Heart Association (2017): - For adults with confirmed hypertension and known cardiovascular disease (CVD) or 10-year atherosclerotic cardiovascular disease (ASCVD) event risk of 10 percent 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 Academy of Family Physicians (2022): - Treat adults who have hypertension to a standard blood pressure target (less than 140/90 mm Hg) to reduce the risk of all-cause and cardiovascular mortality (strong recommendation; high-quality evidence). Treating to a lower blood pressure target (less than 135/85 mm Hg) does not provide additional benefit at preventing mortality; however, a lower blood pressure target could be considered based on patient preferences and values. (Grade: strong recommendation, Quality of evidence: high) - Consider treating adults who have hypertension to a lower blood pressure target (less than 135/85 mm Hg) to reduce risk of myocardial infarction (weak recommendation; moderate-quality evidence). Although treatment to a standard blood pressure target (less than 140/90 mm Hg) reduced the risk of myocardial infarction, there was a small additional benefit observed with a lower blood pressure target. There was no observed additional benefit in preventing stroke with the lower blood pressure target. (Grade: weak recommendation, Quality of evidence: low) American Diabetes Association (2022): - For individuals with diabetes and hypertension at higher cardiovascular risk (existing atherosclerotic cardiovascular disease or 10-year atherosclerotic cardiovascular disease risk ≥ 15 percent), a blood pressure target of $<130/80$ mmHg may be appropriate, if it can be safely attained (Level of evidence: B) - For individuals with diabetes and hypertension at lower risk for cardiovascular disease (10-year atherosclerotic cardiovascular disease risk <15 percent), treat to a blood pressure target of $<140/90$ mmHg (Level of evidence: A)
Clinical Recommendation Statement	
Improvement Notation	Higher score indicates better quality Reference Type: CITATION
Reference	Reference Text: 'American Diabetes Association. (2022). 10. Cardiovascular disease and risk management: Standards of medical care in diabetes—2022. Diabetes Care 2022, 44(Suppl. 1), S144-S175. https://doi.org/10.2337/dc22-S010' Reference Type: CITATION
Reference	Reference Text: 'Centers for Disease Control and Prevention. (2021). Team-based care for high blood pressure. Retrieved from https://www.cdc.gov/policy/polaris/healthtopics/highbloodpressure/tbctool.html' Reference Type: CITATION
Reference	Reference Text: 'Centers for Disease Control and Prevention. (2023). 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. (2022). About Multiple Cause of Death, 1999–2020. CDC WONDER Online Database website. Atlanta, GA: Centers for Disease Control and Prevention. 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;311(5):507-520. doi: 10.1001/jama.2013.284427' Reference Type: CITATION
Reference	Reference Text: 'Kirkland, E. B., Heincelman, M., Bishu, K. G., Schumann, S. O., Schreiner, A., Axon, R. N.,...Moran, W. P. (2018). Trends in Healthcare Expenditures Among US Adults With Hypertension: National Estimates, 2003–2014. Journal of the American Heart Association, 7(11), e008731. https://doi.org/10.1161/JAHA.118.008731' 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/NEJMs1406751. [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: 'Tsao, C. W., Aday, A. W., Almarazooq, Z. I., Alonso, A., Beaton, A. Z., Bittencourt, M. S.,...Kissela, B. M. (2022). Heart Disease and Stroke Statistics—2022 Update: A Report From the American Heart Association. Circulation, 145(8), e153–e639. https://doi.org/10.1161/CIR.0000000000001052' Reference Type: CITATION
Reference	Reference Type: CITATION

	Reference Text: 'U.S. Preventive Services Task Force. Screening for hypertension in adults: U.S. Preventive Services Task Force reaffirmation recommendation statement. JAMA, 325(16), 1650. Retrieved from https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertension-in-adults-screening' 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). 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA 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. Hypertension. 71(6). https://doi.org/10.1161/HYP.0000000000000065' Reference Type: CITATION
Reference	Reference Text: 'Coles, S., Fisher, L., Lin, K. W., Lyon, C., Vosooney, A. A., & Bird, M. D. (2022). Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP. American family physician, 106(6). Retrieved from https://www.aafp.org/pubs/afp/issues/2022/1200/practice-guidelines-aafp-hypertension-full-guideline.html'
Definition	None In reference to the numerator element, only blood pressure readings performed by a clinician or an automated blood pressure monitor or 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 an automated blood pressure monitor or device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the automated blood pressure monitor or 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.
Guidance	Do not include BP readings taken during an acute inpatient stay or an emergency department (ED) visit. 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 during the measurement period 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 Exclude patients who are in hospice care for any part of the measurement period.
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 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 diagnosis 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 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 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	None
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, 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")
or exists ("End Stage Renal Disease Procedures")
or exists ("End Stage Renal Disease Encounter")
or AIFrailTCF."Is Age 66 to 80 with Advanced Illness and Frailty or Is Age 81 or Older with Frailty"
or AIFrailTCF."Is Age 66 or Older Living Long Term in a Nursing Home"
or PalliativeCare."Has 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": "Virtual Encounter"]
union ["Encounter, Performed": "Telephone Visits"]) ValidEncounter
where ValidEncounter.relevantPeriod during day of "Measurement Period"

▲ AIFrailTCF.Has Advanced Illness in Year Before or During Measurement Period

exists (["Diagnosis": "Advanced Illness"] AdvancedIllnessDiagnosis
where AdvancedIllnessDiagnosis.prevalencePeriod starts during day of Interval[start of "Measurement Period" - 1 year, end of "Measurement Period"]
)

▲ AIFrailTCF.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 day of "Measurement Period"
)
or exists (["Encounter, Performed": "Frailty Encounter"] FrailtyEncounter
where FrailtyEncounter.relevantPeriod overlaps day of "Measurement Period"
)
or exists (["Symptom": "Frailty Symptom"] FrailtySymptom
where FrailtySymptom.prevalencePeriod overlaps day of "Measurement Period"
)

▲ AIFrailTCF.Has Dementia Medications in Year Before or During Measurement Period

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

▲ AIFrailTCF.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 day of
end of "Measurement Period"
sort by
end of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)asc
)) LastHousingStatus
where LastHousingStatus.result ~ "Lives in nursing home (finding)"
) is not null

▲ AIFrailTCF.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 Advanced Illness in Year Before or During Measurement Period"
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"
)

```

▲ 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" )
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."Has 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 day of "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 day of "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 day of "Measurement Period"
)
or exists ( ["Diagnosis": "Hospice Diagnosis"] HospiceCareDiagnosis
  where HospiceCareDiagnosis.prevalencePeriod overlaps day of "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.Has 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 day of "Measurement Period"
)
or exists (["Diagnosis": "Palliative Care Diagnosis"] PalliativeDiagnosis
where PalliativeDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
)
or exists (["Encounter, Performed": "Palliative Care Encounter"] PalliativeEncounter
where PalliativeEncounter.relevantPeriod overlaps day of "Measurement Period"
)
or exists (["Intervention, Performed": "Palliative Care Intervention"] PalliativeIntervention
where Global."NormalizeInterval" (PalliativeIntervention.relevantDatetime, PalliativeIntervention.relevantPeriod) overlaps day of "Measurement Period"
)

▲ Pregnancy or Renal Diagnosis

(["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 Evaluation and Management 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 Evaluation and Management 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 Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

["Patient Characteristic Sex": "Federal 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 "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 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 "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 Evaluation and Management 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 "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- 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 Diagnosis" (2.16.840.1.113883.3.464.1003.1165)
- 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 "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "Palliative Care Diagnosis" (2.16.840.1.113883.3.464.1003.1167)
- 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 Type" (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)
- valueset "Virtual Encounter" (2.16.840.1.113883.3.464.1003.101.12.1089)

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: Advanced Illness" using "Advanced Illness (2.16.840.1.113883.3.464.1003.110.12.1082)"
- "Diagnosis: Chronic Kidney Disease, Stage 5" using "Chronic Kidney Disease, Stage 5 (2.16.840.1.113883.3.526.3.1002)"
- "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: Hospice Diagnosis" using "Hospice Diagnosis (2.16.840.1.113883.3.464.1003.1165)"
- "Diagnosis: Kidney Transplant Recipient" using "Kidney Transplant Recipient (2.16.840.1.113883.3.464.1003.109.12.1029)"
- "Diagnosis: Palliative Care Diagnosis" using "Palliative Care Diagnosis (2.16.840.1.113883.3.464.1003.1167)"
- "Diagnosis: Pregnancy" using "Pregnancy (2.16.840.1.113883.3.526.3.378)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Emergency Department Evaluation and Management Visit" using "Emergency Department Evaluation and Management 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: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "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)"
- "Encounter, Performed: Virtual Encounter" using "Virtual Encounter (2.16.840.1.113883.3.464.1003.101.12.1089)"
- "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 Type" using "Payer Type (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: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"
- "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 Type"]

▲ **SDE Race**

["Patient Characteristic Race": "Race"]

▲ **SDE Sex**

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

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	Use of High-Risk Medications in Older Adults		
CMS ID	156	eCQM Version Number	14.0.000
CBE Number	Not Applicable	GUID	a3837ff8-1abc-4ba9-800e-fd4e7953adbd
Measurement Period	January 1, 2026 through December 31, 2026		
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). This Physician Performance Measure (Measure) and related data specifications are owned and stewarded by the Centers for Medicare & Medicaid Services (CMS). CMS contracted (Contract HHSM-500-2011-00079C) with the National Committee for Quality Assurance (NCQA) to develop this electronic measure. NCQA is not responsible for any use of the Measure. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of the measure or specification. 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. 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) codes, descriptions and other data are copyright 2025. American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Applicable FARS/DFARS restrictions apply to government use. The measure specifications contain coding from LOINC(R) (https://loinc.org). The LOINC table, LOINC codes, LOINC panels and form file, LOINC linguistic variants file, LOINC/RSNA Radiology Playbook, and LOINC/IEEE Medical Device Code Mapping Table are copyright 2004-2025 Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee, and are available at no cost under the license at https://loinc.org/kb/license/. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2024 International Health Terminology Standards Development Organisation. ICD-10 copyright 2025 World Health Organization. All Rights Reserved. The Measure uses RxNorm, a standardized nomenclature and coding for clinical drugs and drug delivery devices, which is made publicly available courtesy of the U.S. National Library of Medicine (NLM), National Institutes of Health, Department of Health and Human Services. NLM is not responsible for the Measure and does not endorse or recommend this or any other product. "HL7" is the registered trademark of Health Level Seven International. 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.		
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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 (PIM) 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 & Paauw, 2017). Long-term use of benzodiazepines in older adults has been associated with increased risk of dementia (Zhong, Wang, Zhang, & Zhao, 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). Among Medicare beneficiaries it is estimated that the prevalence of PIM use was 77% among long-stay nursing home residents (defined as >101 consecutive days in a nursing home). The most common PIMs were benzodiazepines, antipsychotics, and insulin (Riester et al., 2023). 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 (2023). The criteria were developed through key clinical expert		

	consensus processes by Beers in 1997, Zhan in 2001, Fick et al. in 2003, 2012, 2015, and 2019 and, most recently the American Geriatrics Society Beers Criteria Update Expert Panel in 2023. 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 Type: CITATION
Reference	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 Type: CITATION
Reference	Reference Text: 'Fick, D. M., Semla, T., Beizer, J., et al. (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: 'Fick, D., Semla, T., Beizer, J., et al. (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: 'Fu, A. Z., Jiang, J. Z., Reeves, J. H., Fincham, J. E., Liu, G. G., & Perri, M. (2007). Potentially Inappropriate Medication Use and Healthcare Expenditures in the US Community-Dwelling Elderly. Medical Care, 45(5), 472-476. Retrieved from http://www.jstor.org/stable/40221449' 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., & Paauw, 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, & 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, & 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 Type: CITATION

	Reference Text: 'Zhong, G., Wang, Y., Zhang, Y., & Zhao, Y. (2015). Association between benzodiazepine use and dementia: a meta-analysis. PLoS One, 10(5).' Reference Type: CITATION
Reference	Reference Text: 'Fick, D. M., Semla, T. P., Steinman, M., et al. (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.' Reference Type: CITATION
Reference	Reference Text: 'Riester, M. R., Goyal, P., Steinman, M. A., et al. (2023). Prevalence of Potentially Inappropriate Medication Prescribing in US Nursing Homes, 2013–2017. Journal of General Internal Medicine, 38(6), 1563-1566.' Reference Type: CITATION
Reference	Reference Text: 'The 2023 American Geriatrics Society Beers Criteria Update Expert Panel. (2023). American Geriatrics Society 2023 updated AGS Beers Criteria for potentially inappropriate medication use in older adults. Journal of the American Geriatrics Society, 71(7), 2052-2081.'
Definition	Index Prescription Start Date (IPSD). The start date of the earliest prescription ordered for a high-risk medication during the measurement period. A high-risk medication is identified by any one of the following: - A prescription for medications classified as high risk at any dose and for any duration. - A prescription for medications classified as high risk at any dose with greater than a 90 day supply. - 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. 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.
Guidance	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. - At least two orders of high-risk medications from the same drug class. - At least two orders of high-risk medications from the same drug class with summed days supply greater than 90 days. - 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 except for appropriate diagnoses. - Patients with two or more antipsychotic prescriptions ordered on different days, and who did not 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. - Patients with two or more benzodiazepine prescriptions ordered on different days, and who did not 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. Total rate (the sum of the two previous numerators, deduplicated).
Numerator Exclusions	None
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

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."Has 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."Has Palliative Care in the Measurement Period"

⚡ Numerator

("More than One Antipsychotic Order"
and (not exists ((["Diagnosis": "Schizophrenia"]
union ["Diagnosis": "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 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"]
)
)
)

⚡ Numerator Exclusions

None

⚡ 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."Has Palliative Care in the Measurement Period"

⚡ Numerator

"Numerator 2"
or ("Numerator 1"
and not "Numerator 2"
)

⚡ Numerator Exclusions

None

⚡ Denominator Exceptions

None

⚡ Stratification

None

Definitions

⚡ Antipsychotic Index Prescription Start Date

```
First(["Medication, Order": "Potentially Harmful Antipsychotics for Older Adults"] AntipsychoticMedication
where AntipsychoticMedication.authorDatetime during "Measurement Period"
return AntipsychoticMedication.authorDatetime
sort asc
)
```

⚡ Benzodiazepine Index Prescription Start Date

```
First(["Medication, Order": "Potentially Harmful Benzodiazepines for Older Adults"] BenzodiazepineMedication
where BenzodiazepineMedication.authorDatetime during "Measurement Period"
return BenzodiazepineMedication.authorDatetime
sort asc
)
```

⚡ Denominator

"Initial Population"

⚡ Denominator Exclusions

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

⚡ High Risk Medications with Average Daily Dose Criteria

```
exists ( "More Than One Order"(["Medication, Order": "Digoxin Medications"] DigoxinOrdered
where "Average Daily Dose"(DigoxinOrdered) > 0.125 'mg/d'
)
or exists ( "More Than One Order"(["Medication, Order": "Doxepin Medications"] 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 day of "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 day of "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 day of "Measurement Period"
)
or exists ( ["Diagnosis": "Hospice Diagnosis"] HospiceCareDiagnosis
where HospiceCareDiagnosis.prevalencePeriod overlaps day of "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": "Potentially Harmful Antipsychotics for Older Adults"]))

⚡ More than One Benzodiazepine Order

exists ("More Than One Order"(["Medication, Order": "Potentially Harmful Benzodiazepines for Older Adults"]))

⚡ 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"
and ( not exists ( ( ["Diagnosis": "Schizophrenia"]
union ["Diagnosis": "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 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"]
)
)
)

```

4 Numerator 3

```

"Numerator 2"
or ( "Numerator 1"
and not "Numerator 2"
)

```

4 PalliativeCare.Has 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 day of "Measurement Period"
)
or exists ( ["Diagnosis": "Palliative Care Diagnosis"] PalliativeDiagnosis
where PalliativeDiagnosis.prevalencePeriod overlaps day of "Measurement Period"
)
or exists ( ["Encounter, Performed": "Palliative Care Encounter"] PalliativeEncounter
where PalliativeEncounter.relevantPeriod overlaps day of "Measurement Period"
)
or exists ( ["Intervention, Performed": "Palliative Care Intervention"] PalliativeIntervention
where Global."NormalizeInterval" ( PalliativeIntervention.relevantDatetime, PalliativeIntervention.relevantPeriod ) overlaps day of "Measurement Period"
)

```

4 Qualifying Encounters

```

( ["Encounter, Performed": "Office Visit"]
union ["Encounter, Performed": "Ophthalmological 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": "Virtual Encounter"]
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"] ) ValidEncounters
where ValidEncounters.relevantPeriod during "Measurement Period"

```

4 Same High Risk Medications Ordered on Different Days

```

"More Than One Order"(["Medication, Order": "Potentially Harmful Antihistamines for Older Adults"])
union "More Than One Order"(["Medication, Order": "Potentially Harmful Antiparkinsonian Agents for Older Adults"])
union "More Than One Order"(["Medication, Order": "Potentially Harmful Gastrointestinal Antispasmodics for Older Adults"])
union "More Than One Order"(["Medication, Order": "Dipyridamole Medications"])
union "More Than One Order"(["Medication, Order": "Guanfacine Medications"])
union "More Than One Order"(["Medication, Order": "Nifedipine Medications"])
union "More Than One Order"(["Medication, Order": "Potentially Harmful Antidepressants for Older Adults"])
union "More Than One Order"(["Medication, Order": "Potentially Harmful Barbiturates for Older Adults"])
union "More Than One Order"(["Medication, Order": "ergoloid mesylates, USP 1 MG Oral Tablet"])
union "More Than One Order"(["Medication, Order": "Meprobamate Medications"])
union "More Than One Order"(["Medication, Order": "Potentially Harmful Estrogens for Older Adults"])
union "More Than One Order"(["Medication, Order": "Potentially Harmful Sulfonylureas for Older Adults"])
union "More Than One Order"(["Medication, Order": "Desiccated Thyroid Medications"])
union "More Than One Order"(["Medication, Order": "Potentially Harmful Nonbenzodiazepine Hypnotics for Older Adults"])
union "More Than One Order"(["Medication, Order": "Potentially Harmful Skeletal Muscle Relaxants for Older Adults"])
union "More Than One Order"(["Medication, Order": "Potentially Harmful Pain Medications for Older Adults"])
union "More Than One Order"(["Medication, Order": "Megestrol Medications"])
union "More Than One Order"(["Medication, Order": "Meperidine Medications"])

```

4 SDE Ethnicity

```

["Patient Characteristic Ethnicity": "Ethnicity"]

```

4 SDE Payer

```

["Patient Characteristic Payer": "Payer Type"]

```

4 SDE Race

```

["Patient Characteristic Race": "Race"]

```

4 SDE Sex

```

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

```

4 Two High Risk Medications with Prolonged Duration

```

Sum(("More Than One Order"(["Medication, Order": "Potentially Harmful Antiinfectives for Older Adults"]))) 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

4 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 0.33
when Frequency ~ "Every forty eight hours (qualifier value)" then 0.5
when Frequency ~ "Every eight to twelve hours (qualifier value)" then 3.0
when Frequency ~ "Every six to eight hours (qualifier value)" then 4.0
when Frequency ~ "Every three to four hours (qualifier value)" then 8.0
when Frequency ~ "Every three to six hours (qualifier value)" then 8.0
when Frequency ~ "Every two to four hours (qualifier value)" then 12.0
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 ~ "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 0.25 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 10 MG Oral Capsule" then 10 'mg'
when Strength ~ "doxepin 10 MG/ML Oral Solution" then 10 'mg/mL'
when Strength ~ "doxepin 25 MG Oral Capsule" then 25 'mg'
when Strength ~ "doxepin 50 MG Oral Capsule" then 50 'mg'
when Strength ~ "doxepin 75 MG Oral Capsule" then 75 'mg'
when Strength ~ "doxepin 100 MG Oral Capsule" then 100 'mg'
when Strength ~ "doxepin 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"
)
or ( date from OrderMedication1.authorDatetime ~ date from OrderMedication2.authorDatetime
and OrderMedication1.authorDatetime during "Measurement Period"
and date from start of OrderMedication1.relevantPeriod !~ date from start of OrderMedication2.relevantPeriod
and start of OrderMedication1.relevantPeriod during "Measurement Period"
and start of OrderMedication2.relevantPeriod 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 0.25 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 10 MG Oral Capsule" ("RXNORM Code (1000048)")
- code "doxepin 10 MG/ML Oral Solution" ("RXNORM Code (1000054)")
- code "doxepin 100 MG Oral Capsule" ("RXNORM Code (1000058)")
- code "doxepin 150 MG Oral Capsule" ("RXNORM Code (1000064)")
- code "doxepin 25 MG Oral Capsule" ("RXNORM Code (1000070)")
- code "doxepin 3 MG Oral Tablet" ("RXNORM Code (966787)")
- code "doxepin 50 MG Oral Capsule" ("RXNORM Code (1000076)")
- code "doxepin 6 MG Oral Tablet" ("RXNORM Code (966793)")
- code "doxepin 75 MG Oral Capsule" ("RXNORM Code (1000097)")
- code "ergoloid mesylates, USP 1 MG Oral Tablet" ("RXNORM Code (318179)")
- 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" ("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 "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 "Benzodiazepine Withdrawal" (2.16.840.1.113883.3.464.1003.105.12.1208)
- valueset "Bipolar Disorder" (2.16.840.1.113883.3.67.1.101.1.128)
- valueset "Care Services in Long Term Residential Facility" (2.16.840.1.113883.3.464.1003.101.12.1014)
- valueset "Desiccated Thyroid Medications" (2.16.840.1.113883.3.464.1003.1060)
- valueset "Digoxin Medications" (2.16.840.1.113883.3.464.1003.1065)
- valueset "Dipyridamole Medications" (2.16.840.1.113883.3.464.1003.1051)
- valueset "Discharge Services Nursing Facility" (2.16.840.1.113883.3.464.1003.101.12.1013)
- valueset "Doxepin Medications" (2.16.840.1.113883.3.464.1003.1067)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- valueset "Generalized Anxiety Disorder" (2.16.840.1.113883.3.464.1003.105.12.1210)
- valueset "Guanfacine Medications" (2.16.840.1.113883.3.464.1003.196.11.1252)
- 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 Diagnosis" (2.16.840.1.113883.3.464.1003.1165)
- valueset "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)
- valueset "Megestrol Medications" (2.16.840.1.113883.3.464.1003.1247)
- valueset "Meperidine Medications" (2.16.840.1.113883.3.464.1003.1248)
- valueset "Meprobamate Medications" (2.16.840.1.113883.3.464.1003.1057)
- valueset "Nifedipine Medications" (2.16.840.1.113883.3.464.1003.1053)
- 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 "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Palliative Care Diagnosis" (2.16.840.1.113883.3.464.1003.1167)
- 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 Type" (2.16.840.1.114222.4.11.3591)
- valueset "Potentially Harmful Antidepressants for Older Adults" (2.16.840.1.113883.3.464.1003.1054)
- valueset "Potentially Harmful Antihistamines for Older Adults" (2.16.840.1.113883.3.464.1003.1043)
- valueset "Potentially Harmful Antiinfectives for Older Adults" (2.16.840.1.113883.3.464.1003.196.12.1481)
- valueset "Potentially Harmful Antiparkinsonian Agents for Older Adults" (2.16.840.1.113883.3.464.1003.1049)
- valueset "Potentially Harmful Antipsychotics for Older Adults" (2.16.840.1.113883.3.464.1003.196.12.1523)
- valueset "Potentially Harmful Barbiturates for Older Adults" (2.16.840.1.113883.3.464.1003.1055)
- valueset "Potentially Harmful Benzodiazepines for Older Adults" (2.16.840.1.113883.3.464.1003.196.12.1522)
- valueset "Potentially Harmful Estrogens for Older Adults" (2.16.840.1.113883.3.464.1003.1058)
- valueset "Potentially Harmful Gastrointestinal Antispasmodics for Older Adults" (2.16.840.1.113883.3.464.1003.1050)
- valueset "Potentially Harmful Nonbenzodiazepine Hypnotics for Older Adults" (2.16.840.1.113883.3.464.1003.196.12.1480)
- valueset "Potentially Harmful Pain Medications for Older Adults" (2.16.840.1.113883.3.464.1003.1063)
- valueset "Potentially Harmful Skeletal Muscle Relaxants for Older Adults" (2.16.840.1.113883.3.464.1003.1062)
- valueset "Potentially Harmful Sulfonyleureas for Older Adults" (2.16.840.1.113883.3.464.1003.1059)
- 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 "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)
- valueset "Virtual Encounter" (2.16.840.1.113883.3.464.1003.101.12.1089)

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" (2.16.840.1.113883.3.67.1.101.1.128)
- "Diagnosis: Generalized Anxiety Disorder" using "Generalized Anxiety Disorder" (2.16.840.1.113883.3.464.1003.105.12.1210)
- "Diagnosis: Hospice Diagnosis" using "Hospice Diagnosis" (2.16.840.1.113883.3.464.1003.1165)
- "Diagnosis: Palliative Care Diagnosis" using "Palliative Care Diagnosis" (2.16.840.1.113883.3.464.1003.1167)
- "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" 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 (CPT Code 99211)"
- "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: 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)"
- "Encounter, Performed: Virtual Encounter" using "Virtual Encounter (2.16.840.1.113883.3.464.1003.101.12.1089)"
- "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: Desiccated Thyroid Medications" using "Desiccated Thyroid Medications (2.16.840.1.113883.3.464.1003.1060)"
- "Medication, Order: Digoxin Medications" using "Digoxin Medications (2.16.840.1.113883.3.464.1003.1065)"
- "Medication, Order: Dipyrindamole Medications" using "Dipyrindamole Medications (2.16.840.1.113883.3.464.1003.1051)"
- "Medication, Order: Doxepin Medications" using "Doxepin Medications (2.16.840.1.113883.3.464.1003.1067)"
- "Medication, Order: ergoloid mesylates, USP 1 MG Oral Tablet" using "ergoloid mesylates, USP 1 MG Oral Tablet (RXNORM Code 318179)"
- "Medication, Order: Guanfacine Medications" using "Guanfacine Medications (2.16.840.1.113883.3.464.1003.196.11.1252)"
- "Medication, Order: Megestrol Medications" using "Megestrol Medications (2.16.840.1.113883.3.464.1003.1247)"
- "Medication, Order: Meperidine Medications" using "Meperidine Medications (2.16.840.1.113883.3.464.1003.1248)"
- "Medication, Order: Meprobamate Medications" using "Meprobamate Medications (2.16.840.1.113883.3.464.1003.1057)"
- "Medication, Order: Nifedipine Medications" using "Nifedipine Medications (2.16.840.1.113883.3.464.1003.1053)"
- "Medication, Order: Potentially Harmful Antidepressants for Older Adults" using "Potentially Harmful Antidepressants for Older Adults (2.16.840.1.113883.3.464.1003.1054)"
- "Medication, Order: Potentially Harmful Antihistamines for Older Adults" using "Potentially Harmful Antihistamines for Older Adults (2.16.840.1.113883.3.464.1003.1043)"
- "Medication, Order: Potentially Harmful Antiinfectives for Older Adults" using "Potentially Harmful Antiinfectives for Older Adults (2.16.840.1.113883.3.464.1003.196.12.1481)"
- "Medication, Order: Potentially Harmful Antiparkinsonian Agents for Older Adults" using "Potentially Harmful Antiparkinsonian Agents for Older Adults (2.16.840.1.113883.3.464.1003.1049)"
- "Medication, Order: Potentially Harmful Antipsychotics for Older Adults" using "Potentially Harmful Antipsychotics for Older Adults (2.16.840.1.113883.3.464.1003.196.12.1523)"
- "Medication, Order: Potentially Harmful Barbiturates for Older Adults" using "Potentially Harmful Barbiturates for Older Adults (2.16.840.1.113883.3.464.1003.1055)"
- "Medication, Order: Potentially Harmful Benzodiazepines for Older Adults" using "Potentially Harmful Benzodiazepines for Older Adults (2.16.840.1.113883.3.464.1003.196.12.1522)"
- "Medication, Order: Potentially Harmful Estrogens for Older Adults" using "Potentially Harmful Estrogens for Older Adults (2.16.840.1.113883.3.464.1003.1058)"
- "Medication, Order: Potentially Harmful Gastrointestinal Antispasmodics for Older Adults" using "Potentially Harmful Gastrointestinal Antispasmodics for Older Adults (2.16.840.1.113883.3.464.1003.1050)"
- "Medication, Order: Potentially Harmful Nonbenzodiazepine Hypnotics for Older Adults" using "Potentially Harmful Nonbenzodiazepine Hypnotics for Older Adults (2.16.840.1.113883.3.464.1003.196.12.1480)"
- "Medication, Order: Potentially Harmful Pain Medications for Older Adults" using "Potentially Harmful Pain Medications for Older Adults (2.16.840.1.113883.3.464.1003.1063)"
- "Medication, Order: Potentially Harmful Skeletal Muscle Relaxants for Older Adults" using "Potentially Harmful Skeletal Muscle Relaxants for Older Adults (2.16.840.1.113883.3.464.1003.1062)"
- "Medication, Order: Potentially Harmful Sulfonylureas for Older Adults" using "Potentially Harmful Sulfonylureas for Older Adults (2.16.840.1.113883.3.464.1003.1059)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer Type" using "Payer Type (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: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"

Supplemental Data Elements

▲ SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

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

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	Falls: Screening for Future Fall Risk		
CMS ID	139	eCQM Version Number	14.0.000
CBE Number	Not Applicable	GUID	bc5b4a57-b964-4399-9d40-667c896f31ea
Measurement Period	January 1, 2026 through December 31, 2026		
Measure Steward	National Committee for Quality Assurance		
Measure Developer	National Committee for Quality Assurance		
Measure Developer	American Medical Association (AMA)		
Endorsed By	None		
Description	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period This Physician Performance Measure (Measure) and related data specifications are owned by the National Committee for Quality Assurance (NCQA). NCQA is not responsible for any use of the Measure. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of the measure or specification. 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 may be used for internal, noncommercial purposes (e.g., use by healthcare providers in connection with their practices) without obtaining approval from NCQA. All other uses, including a commercial use (including but not limited to vendors using or embedding the measures and specifications into any product or service to calculate measure results for customers for any purpose), must be approved by NCQA and are subject to a license at the discretion of NCQA. The Physician Consortium for Performance Improvement's (PCPI) and American Medical Association's (AMA) significant past efforts and contributions to the development and updating of the measure are acknowledged. (C) 2012-2025 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) codes, descriptions and other data are copyright 2025. American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Some measure specifications contain coding from LOINC(R) (https://loinc.org). The LOINC table, LOINC codes, LOINC panels and form file, LOINC linguistic variants file, LOINC/RSNA Radiology Playbook, and LOINC/IEEE Medical Device Code Mapping Table are copyright 2004-2025 Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee, and are available at no cost under the license at https://loinc.org/kb/license/. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2024 International Health Terminology Standards Development Organisation. ICD-10 copyright 2025 World Health Organization. All Rights Reserved. Some measures use RxNorm, a standardized nomenclature and coding for clinical drugs and drug delivery devices, which is made publicly available courtesy of the U.S. National Library of Medicine (NLM), National Institutes of Health, Department of Health and Human Services. NLM is not responsible for the measures and does not endorse or recommend this or any other product. "HL7" is the registered trademark of Health Level Seven International.		
Copyright			
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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, & 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 four adults over 65 will fall each year (Centers for Disease Control and Prevention, 2023). 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 health 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 (AGS/BGS/AAOS), 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 Type: CITATION		
Reference	Reference Text: 'al-Aama, T. (2011). Falls in the elderly: spectrum and prevention. Can Fam Physician 57(7),771-6. Retrieved from https://pubmed.ncbi.nlm.nih.gov/21753098/ Reference Type: CITATION		
Reference	Reference Text: 'American Geriatrics Society and British Geriatrics Society. (2010). Prevention of Falls in Older Persons AGS BGS Clinical Practice Guideline 2010. Accessed December 8, 2023. Available at https://geriatricscareonline.org/toc/updated-american-geriatrics-societybritish-geriatrics-society-clinical-practice-guideline-for-prevention-of-falls-in-older-persons-and-recommendations/CL014/		

Reference	Reference Type: CITATION Reference Text: 'Centers for Disease Control and Prevention. (2023). "Facts about Falls" (May 12, 2023) https://www.cdc.gov/falls/facts.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., Carrollf, D.L., Hurley, A., et al. (2010). Fall Prevention in Acute Care Hospitals: A Randomized Trial. JAMA, 304(17), 1912-1918.'
Reference	Reference Type: CITATION Reference Text: 'Schneider, E.C., Shubert, T.E., & Harmon, K.J. (2010). Addressing the Escalating Public Health Issue of Falls Among Older Adults. NC Med J, 71(6), 547-52.'
Reference	Reference Text: 'Woolcott, J.C., Khan, K.M., Mitrovic, S., et al. (2011). The Cost of Fall Related Presentations to the ED: A Prospective, In-Person, Patient-Tracking Analysis of Health Resource Utilization. Osteoporos 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	None
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 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 day of "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 day of "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 day of "Measurement Period"
)
or exists ( ["Diagnosis": "Hospice Diagnosis"] HospiceCareDiagnosis
  where HospiceCareDiagnosis.prevalencePeriod overlaps day of "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": "Virtual Encounter"]
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 Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

["Patient Characteristic Sex": "Federal 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 "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- 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 Diagnosis" (2.16.840.1.113883.3.464.1003.1165)
- 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 "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Payer Type" (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)
- valueset "Virtual Encounter" (2.16.840.1.113883.3.464.1003.101.12.1089)

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)"
- "Diagnosis: Hospice Diagnosis" using "Hospice Diagnosis (2.16.840.1.113883.3.464.1003.1165)"
- "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: 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)"
- "Encounter, Performed: Virtual Encounter" using "Virtual Encounter (2.16.840.1.113883.3.464.1003.101.12.1089)"
- "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 Type" using "Payer Type (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: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"

Supplemental Data Elements

▲ SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

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

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	Closing the Referral Loop: Receipt of Specialist Report		
CMS ID	50	eCQM Version Number	14.0.000
CBE Number	Not Applicable	GUID	f58fc0d6-edf5-416a-8d29-79afbdf24dea
Measurement Period	January 1, 2026 through December 31, 2026		
Measure Steward	Centers for Medicare & Medicaid Services (CMS)		
Measure Developer	American Institutes for Research (AIR)		
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 This electronic clinical quality measure (Measure) and related data specifications are owned and stewarded by the Centers for Medicare & Medicaid Services (CMS). CMS contracted (Contract # 75FCMC18D0027/ Task Order #: 75FCMC24F0144) with the American Institutes for Research (AIR) to develop this electronic measure. AIR is not responsible for any use of the Measure. AIR makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and AIR has no liability to anyone who relies on such measures or specifications.		
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. AIR 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 2004-2024 American Medical Association. LOINC(R) is copyright 2004-2024 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2024 International Health Terminology Standards Development Organisation. 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.		
Disclaimer	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 inadequate care pathways between specialty and primary care. Studies suggest that both specialists and primary care providers (PCPs) are not satisfied with current processes (Institute for Healthcare Improvement / National Patient Safety Foundation, 2017; Greenwood-Lee et. al, 2018). Breakdowns in referral communication leads to worse health outcomes, increased cost, and appointment delays (Patel et. al, 2018; Odisho et. al, 2020). A 2018 analysis of primary care referrals to specialists found that of the 103,737 referral scheduling attempts analyzed, only 36,072 (34.8%) resulted in documented complete appointments, defined by the specialty clinician providing report to the PCP after the referral visit (Patel et. al, 2018). Technological and process-based updates can improve the referral loop process and increase rates of closing the referral loop. Ramelson et. al (2018) enhanced an EHR's Referral Manager module to meet the Controlled Risk Insurance Company's best practice steps and the requirements of both the CMS EHR Incentive Program and the National Committee for Quality Assurance Patient-Centered Medical Home program. Following the updates, 76.8% of referrals were completed and all defined referral process steps were easier to accomplish. Odisho et. al (2020) developed a referrals automation software to simplify the fax to referral process. Feedback from key stakeholder interviews noted that the software enhanced the referrals process by further streamlining and organizing the patient referral process. The Institute for Healthcare Improvement and the National Patient Safety Foundation (2017) reviewed the referrals process in the ambulatory care setting and found that organizational leaders, EHR vendors, regulatory agencies, clinicians, and patients all play a role in creating a referrals system that is effective, safe, convenient, and patient-centered.		
Clinical Recommendation Statement	None		
Improvement Notation	Higher score indicates better quality Reference Type: CITATION		
Reference	Reference Text: 'Greenwood-Lee, J., Jewett, L., Woodhouse, L., & Marshall, D. A. (2018). A categorisation of problems and solutions to improve patient referrals from primary to specialty care. BMC health services research, 18(1), 986. https://doi.org/10.1186/s12913-018-3745-y' Reference Type: CITATION		
Reference	Reference Text: 'Institute for Healthcare Improvement / National Patient Safety Foundation. (2017). Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era. https://www.ihl.org/resources/Pages/Publications/Closing-the-Loop-A-Guide-to-Safer-Ambulatory-Referrals.aspx' Reference Type: CITATION		
Reference	Reference Text: 'Odisho, A. Y., Lui, H., Yerramsetty, R., Bautista, F., Gleason, N., Martin, E., Young, J. J., Blum, M., & Neinstein, A. B. (2020). Design and development of referrals automation, a SMART on FHIR solution to improve patient access to specialty care. JAMIA open, 3(3), 405–412. https://doi.org/10.1093/jamiaopen/ooaa036' Reference Type: CITATION		
Reference	Reference Text: 'Patel, M. P., Schettini, P., O'Leary, C. P., Bosworth, H. B., Anderson, J. B., & Shah, K. P. (2018). Closing the Referral Loop: an Analysis of Primary Care Referrals to Specialists in a Large Health System. Journal of general internal medicine, 33(5), 715–721. https://doi.org/10.1007/s11606-018-4392-z' Reference Type: CITATION		
Reference	Reference Text: 'Ramelson, H., Nederlof, A., Karmiy, S., Neri, P., Kiernan, D., Krishnamurthy, R., Allen, A., & Bates, D. W. (2018). Closing the loop with an enhanced referral management system. Journal of the American Medical Informatics Association: JAMIA, 25(6), 715–721. https://doi.org/10.1093/jamia/ocy004' 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.		
Definition	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 measurement period is to be submitted by the deadline established by CMS. Therefore, eligible clinicians who refer patients towards the end of the measurement 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.
	A procedural report received from a specialist for an exam or procedure conducted (e.g., diabetic eye exam, colonoscopy, etc.) can satisfy the numerator requirement and successfully close the referral loop. A separate consultant note or consultant report is not required to close the referral loop in these circumstances.
	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 first clinician to whom the patient was referred
Numerator Exclusions	None
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

("Has Encounter during Measurement Period"
or "Has Intervention 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 day of Interval[start of "Measurement Period",
Date(year from start of "Measurement Period", 10, 31)]
return {
  identification: ReferralPerform.id,
  dateIntervention:
    end of Global."NormalizeInterval"(ReferralPerform.relevantDatetime, ReferralPerform.relevantPeriod)
}
)
union(["Intervention, Order": "Referral"] ReferralOrder
where ReferralOrder.authorDatetime during day of Interval[start of "Measurement Period", Date(year from start of "Measurement Period", 10, 31)]
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 day of "Measurement Period"
)
```

▲ Has Intervention during Measurement Period

```
exists ( ( ["Intervention, Performed": "Behavioral or Neuropsych Assessment"]
union ["Intervention, Performed": "Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)"]
union ["Intervention, Performed": "Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes"]
union ["Intervention, Performed": "Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes"]
union ["Intervention, Performed": "Psychotherapy for crisis; first 60 minutes"]
union ["Intervention, Performed": "Psych Visit Diagnostic Evaluation"]
union ["Intervention, Performed": "Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour"] ) Intervention
where Global."NormalizeInterval" ( Intervention.relevantDatetime, Intervention.relevantPeriod ) ends during day of "Measurement Period"
)
```

▲ Initial Population

```
( "Has Encounter during Measurement Period"
or "Has Intervention 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 day of "Measurement Period"
)
```

▲ SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

["Patient Characteristic Sex": "Federal 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 "Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour" ("CPT Code (96112)")
- code "Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)" ("CPT Code (96156)")
- code "Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes" ("CPT Code (96136)")

- code "Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes" ("CPT Code (96138)")
- code "Psychotherapy for crisis; first 60 minutes" ("CPT Code (90839)")
- valueset "Behavioral or Neuropsych Assessment" (2.16.840.1.113883.3.526.3.1023)
- 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 "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Payer Type" (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 "Preventive Care Services, Initial Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1022)
- valueset "Preventive Care, Established Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1024)
- valueset "Psych Visit Diagnostic Evaluation" (2.16.840.1.113883.3.526.3.1492)
- 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, 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 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, 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: Behavioral or Neuropsych Assessment" using "Behavioral or Neuropsych Assessment (2.16.840.1.113883.3.526.3.1023)"
- "Intervention, Performed: Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour" using "Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour (CPT Code 96112)"
- "Intervention, 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)"
- "Intervention, Performed: Psych Visit Diagnostic Evaluation" using "Psych Visit Diagnostic Evaluation (2.16.840.1.113883.3.526.3.1492)"
- "Intervention, Performed: Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes" using "Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes (CPT Code 96136)"
- "Intervention, Performed: Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes" using "Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes (CPT Code 96138)"
- "Intervention, Performed: Psychotherapy for crisis; first 60 minutes" using "Psychotherapy for crisis; first 60 minutes (CPT Code 90839)"
- "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 Type" using "Payer Type (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: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"

Supplemental Data Elements

▲ SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer Type"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

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

Risk Adjustment Variables

None

Measure Set	Not Applicable

eCQM Title	Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes		
CMS ID	1154	eCQM Version Number	1.0.000
CBE Number	Not Applicable	GUID	20a0b54a-4973-4d5c-9518-59139eb7d334
Measurement Period	January 1, 2026 through December 31, 2026		
Measure Steward	American Medical Association (AMA)		
Measure Developer	Health Services Advisory Group		
Measure Developer	American Medical Association (AMA)		
Endorsed By	None		
Description	Percentage of adult patients with risk factors for type 2 diabetes who are due for glycemic screening for whom the screening process was completed during the measurement period. Prediabetes Quality Measures (C) 2018-2025. American Medical Association. All rights reserved. CPT (R) 2025 American Medical Association ("AMA"). All rights reserved. You cannot, without express written permission from the AMA, copy, modify, distribute, display, or use CPT for any commercial purpose, including for productive use in a clinical setting. Any such use requires a separate license from the AMA. You agree that you shall not remove, obscure, or alter any proprietary rights notices (including copyright and trademark notices) which may be affixed to or contained within the measure.		
Copyright	Current Procedural Terminology (CPT [R] code(s) ("CPT Codes") information provided in the Measures is intended for reference and informational purposes only. Decisions regarding which CPT Code is appropriate must be made by physicians and/or their staff considering the clinical facts, circumstances, applicable coding and published AMA coding guideline and payer policies. The AMA does not dictate payer reimbursement policy and does not substitute for the professional judgment of the practitioner performing a procedure, who remains responsible for correct coding. The AMA is not engaged in the practice of medicine or dispensing medical services. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of the CPT code set, and the AMA is not recommending their use. Information contained in the measure includes information protected by intellectual property rights which are owned by the AMA. The Measures may also contain proprietary code sets not owned by the AMA. The AMA disclaims all liability for the use or accuracy of any such information. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. LOINC [R] copyright 2004-2025 Regenstrief Institute, Inc., SNOMED CLINICAL TERMS (SNOMED CT[R]) copyright 2004-2025, The International Health Information Standards Development Organisation (IHTSDO). ICD-10 is copyright 2024 World Health Organization. All Rights Reserved. The Prediabetes Quality Measure set descriptions and specifications (collectively, "Measures") are not clinical guidelines, do not establish a standard of medical care, and have not been tested for all potential applications. The Measures are not intended to diagnose or treat disease or other conditions. The Measures are not a medical device and have not been evaluated by the Food and Drug Administration. Information provided through the Measures is not intended to direct or substitute for the independent assessment or judgment of a qualified healthcare professional. The American Medical Association ("AMA") assumes no liability for use of the Measures, or data contained or not contained in the Measures. The AMA consents to the use, reproduction and distribution of the Measures for non-commercial purposes only (e.g., for use by health care providers in a professional setting). You cannot, without the express written consent of the AMA, use the Measures for any commercial purpose. Unauthorized commercial use of the Measures is expressly prohibited. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed, or distributed for commercial gain. These requirements apply to both you as an individual and to the corporate entity that you represent as an employee or agent, to the extent applicable.		
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Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment			
Rate Aggregation	None		
Rationale	This measure is critical to identifying patients with prediabetes who may benefit from interventions to prevent type 2 diabetes and identification of undiagnosed type 2 diabetes. The Centers for Disease Control and Prevention (CDC) estimates that approximately 97.6 million American adults have prediabetes (CDC, 2024). They note that more than 80% of adults with prediabetes are not aware that they have the condition. Regular screening for prediabetes is a critical first step to helping patients avoid the disability and costs associated with progression to type 2 diabetes. The measure gives credit for three types of tests that can be used to detect abnormal glucose metabolism: HbA1c, oral glucose tolerance, and fasting plasma glucose. When considering which plasma glucose screening codes to include in the measure, the measure development team carefully considered two potential unintended consequences related to the limited use of accompanying fasting status codes. If the measure specified plasma glucose screening too narrowly, it could incentivize over screening, which would impose added burden on clinicians and increased costs to some patients. Alternatively, if the measure specified plasma glucose screening too broadly, it could give credit for non-fasting plasma glucose tests that are not adequate for diagnostic purposes.		
Clinical Recommendation Statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions (B recommendation) (USPSTF, 2021). Evidence on the optimal screening interval for adults with an initial normal glucose test result is limited. Cohort and		

	modeling studies suggest that screening every 3 years may be a reasonable approach for adults with normal blood glucose levels (USPSTF, 2021). Prediabetes and type 2 diabetes can be detected by measuring fasting plasma glucose or HbA1c level, or with an oral glucose tolerance test. A fasting plasma glucose level of 126 mg/dL (6.99 mmol/L) or greater, an HbA1c level of 6.5% or greater, or a 2-hour post-load glucose level of 200 mg/dL (11.1 mmol/L) or greater are consistent with the diagnosis of type 2 diabetes. A fasting plasma glucose level of 100 to 125 mg/dL (5.55-6.94 mmol/L), an HbA1c level of 5.7% to 6.4%, or a 2-hour post-load glucose level of 140 to 199 mg/dL (7.77-11.04 mmol/L) are consistent with prediabetes (USPSTF, 2021).
Improvement Notation	Increased score indicates improvement - Higher score equals better quality Reference Type: CITATION
Reference	Reference Text: 'Centers for Disease Control and Prevention. (2024, July 23). National Diabetes Statistics Report. Retrieved November 15, 2024, from Diabetes website: https://www.cdc.gov/diabetes/php/data-research/' Reference Type: CITATION
Reference	Reference Text: 'U.S. Preventive Services Task Force. (2021). Screening for Prediabetes and Type 2 Diabetes: US Preventive Services Task Force Recommendation Statement. JAMA, 326(8), 736–743. https://doi.org/10.1001/jama.2021.12531'
Definition	None The measure is limited to patients aged 35 to 70 with overweight or obesity because it is recommended that all patients with those risk factors be screened for diabetes at least once every three years. However, this measure is not intended to discourage screening at younger ages, which the USPSTF recommends considering for adults with overweight or obesity and any of the following risk factors:
Guidance	- Race/ethnicity with disproportionately high incidence and prevalence of diabetes (American Indian/Alaska Native, Asian American, Black, Hispanic/Latino, or Native Hawaiian/Pacific Islander persons) - Family history of diabetes - History of gestational diabetes - History of polycystic ovarian syndrome It is recommended that every patient evaluated by this measure also identify payer, race, ethnicity, and sex. 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 with at least two outpatient clinical encounters or one preventive clinical encounter during the measurement period who have the following risk factors for type 2 diabetes: - Most recent BMI ≥ 25 kg/m² (BMI ≥ 23 kg/m² for Asian patients) during measurement period, AND - Age 35-70 at start of measurement period.
Denominator	All patients in the initial population.
Denominator Exclusions	- Patient's pregnancy overlaps measurement period. - Patient with diagnosis of advanced illness or limited life expectancy overlaps measurement period. - Patient with diagnosis of diabetes overlaps 2-year look-back period. - Patient with diagnosis of prediabetes overlaps 2-year look-back period. - Patient with glycemic screening performed during 2-year look-back period.
Numerator	Patients who had a glycemic screening test performed during the measurement period.
Numerator Exclusions	None
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

"Patients Aged 35 to 70 with an Office Visit During the Measurement Period"
and ("Most Recent BMI Equal to or Greater Than 25 and Is Not Asian"
or "Most Recent BMI Equal to or Greater Than 23 and Is Asian")

▲ Denominator

"Initial Population"

▲ Denominator Exclusions

exists "Has Pregnancy Diagnosis During Measurement Period"
or exists "Has Advanced Illness or Limited Life Expectancy"
or exists "Diabetes Diagnosis Overlaps 2 Year Look Back Period"
or exists "Prediabetes Diagnosis Overlaps 2 Year Look Back Period"
or "Has Glycemic Laboratory Test Performed During 2 Year Look Back Period"

▲ Numerator

exists "Glycemic Laboratory Test Performed During Measurement Period"

▲ Numerator Exclusions

None

⚡ Denominator Exceptions

None

⚡ Stratification

None

Definitions

⚡ Aged 35 to 70 at Start of Measurement Period

"AgeInYearsAt"(date from start of "Measurement Period") >= 35
and "AgeInYearsAt"(date from start of "Measurement Period") <= 70

⚡ Denominator

"Initial Population"

⚡ Denominator Exclusions

exists "Has Pregnancy Diagnosis During Measurement Period"
or exists "Has Advanced Illness or Limited Life Expectancy"
or exists "Diabetes Diagnosis Overlaps 2 Year Look Back Period"
or exists "Prediabetes Diagnosis Overlaps 2 Year Look Back Period"
or "Has Glycemic Laboratory Test Performed During 2 Year Look Back Period"

⚡ Diabetes Diagnosis Overlaps 2 Year Look Back Period

(["Diagnosis": "Diabetes"]) PriorDiabetes
where PriorDiabetes.prevalencePeriod overlaps "Look Back Period"

⚡ Glycemic Laboratory Test Performed During Measurement Period

(["Laboratory Test, Performed": "Glycemic Screening Tests"]) LabTestPerformed
where Global."NormalizeInterval" (LabTestPerformed.relevantDatetime, LabTestPerformed.relevantPeriod) during "Measurement Period"

⚡ Has Advanced Illness or Limited Life Expectancy

(["Diagnosis": "Advanced Illness"]
union ["Diagnosis": "Limited Life Expectancy"]) AdvancedIllness
where AdvancedIllness.prevalencePeriod overlaps "Measurement Period"

⚡ Has Glycemic Laboratory Test Performed During 2 Year Look Back Period

exists (["Laboratory Test, Performed": "Glycemic Screening Tests"]) TestingPerformed
where TestingPerformed.relevantPeriod during "Look Back Period"

⚡ Has Pregnancy Diagnosis During Measurement Period

["Diagnosis": "Pregnancy"] PregnancyDx
where PregnancyDx.prevalencePeriod overlaps "Measurement Period"

⚡ Initial Population

"Patients Aged 35 to 70 with an Office Visit During the Measurement Period"
and ("Most Recent BMI Equal to or Greater Than 25 and Is Not Asian"
or "Most Recent BMI Equal to or Greater Than 23 and Is Asian")

⚡ Look Back Period

Interval[start of "Measurement Period" - 2 years, start of "Measurement Period"]

⚡ Most Recent BMI Equal to or Greater Than 23 and Is Asian

exists from ["Physical Exam, Performed": "Body mass index (BMI) [Ratio]"] BMI
let RecentBMI: (Last(["Physical Exam, Performed": "Body mass index (BMI) [Ratio]"] MostRecentBMI
where Global."NormalizeInterval"(MostRecentBMI.relevantDatetime, MostRecentBMI.relevantPeriod) during "Measurement Period"
sort by start of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)))
where RecentBMI.result >= 23 'kg/m2'
and exists ["Patient Characteristic Race": "Asian"]

⚡ Most Recent BMI Equal to or Greater Than 25 and Is Not Asian

exists from ["Physical Exam, Performed": "Body mass index (BMI) [Ratio]"] BMI
let RecentBMI: (Last(["Physical Exam, Performed": "Body mass index (BMI) [Ratio]"] MostRecentBMI
where Global."NormalizeInterval"(MostRecentBMI.relevantDatetime, MostRecentBMI.relevantPeriod) during "Measurement Period"
sort by start of Global."NormalizeInterval"(relevantDatetime, relevantPeriod)))
where RecentBMI.result >= 25 'kg/m2'
and not exists ["Patient Characteristic Race": "Asian"]

⚡ Numerator

exists "Glycemic Laboratory Test Performed During Measurement Period"

⚡ Office Visit During the Measurement Period

["Encounter, Performed": "Outpatient Clinical Encounters"] OfficeVisit
where OfficeVisit.relevantPeriod during "Measurement Period"

⚡ Patients Aged 35 to 70 with an Office Visit During the Measurement Period

exists "Preventive Care Outpatient Visits During Measurement Period"
or Count("Office Visit During the Measurement Period") >= 2
and "Aged 35 to 70 at Start of Measurement Period" is true

⚡ Prediabetes Diagnosis Overlaps 2 Year Look Back Period

["Diagnosis": "Prediabetes (Borderline Diabetes)"]) PriorPrediabetes
where PriorPrediabetes.prevalencePeriod overlaps "Look Back Period"

▲ Preventive Care Outpatient Visits During Measurement Period

["Encounter, Performed": "Preventative Clinical Encounters"] PreventiveCare
where PreventiveCare.relevantPeriod ends 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": "Federal 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 "Asian" ("CDCREC Code (2028-9)")
- code "Body mass index (BMI) [Ratio]" ("LOINC Code (39156-5)")
- valueset "Advanced Illness" (2.16.840.1.113883.3.464.1003.110.12.1082)
- valueset "Diabetes" (2.16.840.1.113883.3.464.1003.103.12.1001)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Federal Administrative Sex" (2.16.840.1.113762.1.4.1021.121)
- valueset "Glycemic Screening Tests" (2.16.840.1.113762.1.4.1160.5)
- valueset "Limited Life Expectancy" (2.16.840.1.113883.3.526.3.1259)
- valueset "Outpatient Clinical Encounters" (2.16.840.1.113762.1.4.1160.24)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Prediabetes (Borderline Diabetes)" (2.16.840.1.113762.1.4.1222.419)
- valueset "Pregnancy" (2.16.840.1.113883.3.526.3.378)
- valueset "Preventative Clinical Encounters" (2.16.840.1.113762.1.4.1160.13)
- valueset "Race" (2.16.840.1.114222.4.11.836)

Data Criteria (QDM Data Elements)

- "Diagnosis: Advanced Illness" using "Advanced Illness (2.16.840.1.113883.3.464.1003.110.12.1082)"
- "Diagnosis: Diabetes" using "Diabetes (2.16.840.1.113883.3.464.1003.103.12.1001)"
- "Diagnosis: Limited Life Expectancy" using "Limited Life Expectancy (2.16.840.1.113883.3.526.3.1259)"
- "Diagnosis: Prediabetes (Borderline Diabetes)" using "Prediabetes (Borderline Diabetes) (2.16.840.1.113762.1.4.1222.419)"
- "Diagnosis: Pregnancy" using "Pregnancy (2.16.840.1.113883.3.526.3.378)"
- "Encounter, Performed: Outpatient Clinical Encounters" using "Outpatient Clinical Encounters (2.16.840.1.113762.1.4.1160.24)"
- "Encounter, Performed: Preventative Clinical Encounters" using "Preventative Clinical Encounters (2.16.840.1.113762.1.4.1160.13)"
- "Laboratory Test, Performed: Glycemic Screening Tests" using "Glycemic Screening Tests (2.16.840.1.113762.1.4.1160.5)"
- "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: Asian" using "Asian (CDCREC Code 2028-9)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: Federal Administrative Sex" using "Federal Administrative Sex (2.16.840.1.113762.1.4.1021.121)"
- "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": "Federal Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

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

Updated December 2025. *No changes for the 2026 Performance Year.*

- **Care Setting:** Ambulatory Care: Clinician Office/Clinic
- **MIPS Reporting Option:** Traditional MIPS
- **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:** Yes

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.

Numerator Exclusions: None

Note: Include only procedures performed through September 30 of the reporting period. This will allow the postoperative period to occur within the reporting year.

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
- Cataract, 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

Denominator Exceptions: None

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IRIS2: Glaucoma – Intraocular Pressure Reduction

Updated December 2025. *Changes for the 2026 Performance Year are noted below in red.*

- **Care Setting: Ambulatory Care:** Clinician Office/Clinic
- **MIPS Reporting Options:** Traditional MIPS, MVP
- **Reporting Options:**
 - IRIS Registry QCDR for EHR: groups and individuals
 - IRIS Registry QCDR manual data entry: groups and individuals
- **Measure Type:** Intermediate 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:** Yes

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 ≤ 22 mm HG
- Moderate Stage: IOP ≤ 18 mm HG
- Severe Stage: IOP ≤ 15 mm HG

Numerator Exclusions: None

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, 66984, 66982, 0191T, 03076T, 0449T, 0405T)
- Visual acuity findings: Count fingers (CF or FC), hand motion (HM), light perception (LP), no light perception (NLP)

Denominator Exceptions: None

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IRIS13: Diabetic Macular Edema: Loss of Visual Acuity

Updated December 2025. *Changes for the 2026 Performance Year are noted below in red.*

- **Care Setting:** Ambulatory Care: Clinician Office/Clinic
- **MIPS Reporting Options:** Traditional MIPS, MVP
- **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 of 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:** Yes

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)
- Aflibercept (EYLEA® HD) injections (CPT: 67028 and HCPCS: J3490, J3590 or C9399; J0177 as of 4/1/24)
- Brolucizumab (Beovu®) injections (CPT: 67028 and HCPCS: J0179)
- Farcimab (Vabysmo®) injections (CPT: 67028 and HCPCS: J2777)
- Ranibizumab-eqrn (Cimerli®) injections (CPT: 67028 and HCPCS: Q5128)

OR

- Fluocinolone acetonide (Iluvien®) injections (CPT: 67028 and HCPCS: J7313)
- Dexamethasone (Ozurdex®) injections (CPT: 67028 and HCPCS: J7312)
- Triamcinolone (Kenalog®) injections (CPT: 67028 and HCPCS: J3301)
- Triamcinolone acetonide (Triesence®) 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).

Numerator Exclusions: None

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 greater 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

Denominator Exceptions: None

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

Updated December 2025. *No changes for the 2026 Performance Year.*

- **Care Setting: Ambulatory Care:** Clinician Office/Clinic
- **MIPS Reporting Option:** Traditional MIPS
- **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:** Yes

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

Note: Include only procedures performed through October 31 of the reporting period. This will allow the posttreatment period to occur within the reporting year.

Numerator Exclusions: None

Denominator Exclusions: None

Denominator Exceptions: None

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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 2025. *No changes for the 2026 Performance Year.*

- **Care Setting:** Ambulatory Care: Clinician Office/Clinic
- **MIPS Reporting Option:** Traditional MIPS
- **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:** Yes

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).

Note: Include only procedures performed through November 30 of the reporting period. This will allow the postoperative period to occur within the reporting year.

Numerator Exclusions: None

Denominator Exclusions: None

Denominator Exceptions: None

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IRIS38: Endothelial Keratoplasty - Dislocation Requiring Surgical Intervention

Updated December 2025. *No changes for the 2026 Performance Year*

- **Care Setting: Ambulatory Care:** Clinician Office/Clinic
- **MIPS Reporting Option:** Traditional MIPS
- **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:** Yes

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.

Numerator Exclusions: None

Note: Include only procedures performed through September 30 of the reporting period. This will allow the postoperative period to occur within the reporting year.

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

Denominator Exceptions: None

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IRIS39: Glaucoma – Intraocular Pressure Reduction Following Trabeculectomy or an Aqueous Shunt Procedure

Updated December 2025. *No changes for the 2026 Performance Year.*

- **Care Setting: Ambulatory Care:** Clinician Office/Clinic
- **MIPS Report Options:** Traditional MIPS, MVP
- **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:** Yes

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 $\geq$ 20% from the pretreatment level or a reduction in the overall number of glaucoma medications. The procedure must be performed during the performance year.

Note: Include only procedures performed through August 31 of the reporting period. This will allow the posttreatment period to occur within the reporting 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

Numerator Exclusions: None

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)

Denominator Exceptions: None

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IRIS50: Amblyopia: Interocular visual acuity

Updated December 2025. *No changes for the 2026 Performance Year.*

- **Care Setting:** Ambulatory Care: Clinician Office/Clinic
- **MIPS Reporting Option:** Traditional MIPS
- **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:
 - A corrected interocular (or if not reported, the uncorrected) visual acuity difference < 0.23 logMAR 3-12 months after first diagnosis of amblyopia
 - 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
 - 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:** Yes

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 $< 0.23 \log\text{MAR}^*$ or an improvement of three or more Snellen lines ($\geq 0.30 \log\text{MAR}^{**}$) in the amblyopic eye or a final visual acuity in the amblyopic eye of 20/30 or better ($\leq 0.18 \log\text{MAR}^{***}$) 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

Numerator Exclusions: None

Denominator Exclusions: Patients with diagnosis of deprivation amblyopia (ICD 10: H53.01), cataract (ICD –10: H26.01-.06), aphakia (ICD-10: H27.00, H27.01, H27.02, H27.03), or pseudophakia (ICD-10: Z96.1)

Denominator Exceptions: None

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IRIS54: Complications After Cataract Surgery

Updated December 2025. *No changes for the 2026 Performance Year.*

- **Care Setting:** Ambulatory Care: Clinician Office/Clinic
- **MIPS Reporting Options:** Traditional MIPS, MVP
- **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 the operating room.
- **Risk Adjusted:** No
- **Performance Rate:** 1
- **High Priority Measure:** Yes
- **Inverse Measure:** Yes
- **Proportional Measure:** Yes

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

Numerator Exclusions: None

Denominator Exclusions: None

Denominator Exceptions: None

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

Updated December 2025. *No changes for the 2026 Performance Year.*

- **Care Setting:** Ambulatory Care: Clinician Office/Clinic
- **MIPS Reporting Options:** Traditional MIPS, MVP
- **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:** Yes

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 (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

Note: Include only procedures performed through August 31 of the reporting period. This will allow the postoperative period to occur within the reporting year.

Numerator Exclusions: None

Denominator Exclusions: None

Denominator Exceptions: None

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IRIS59: Regaining Vision After Cataract Surgery

Updated December 2025. *No Changes for the 2026 Performance Year.*

- **Care Setting:** Ambulatory Care: Clinician Office/Clinic
- **MIPS Reporting Option:** Traditional MIPS
- **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 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 Rates:** 3 and a weighted average
- **High Priority Measure:** Yes
- **Inverse Measure:** No
- **Proportional Measure:** Yes

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 for the three different performance rates.

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 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

Numerator Exclusions: None

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, 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,

Diabetic Retinopathy without 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, , E08.3531, 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

Denominator Exceptions: None

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IRIS61: Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery

Updated December 2025. *No changes for the 2026 Performance Year.*

- **Care Setting: Ambulatory Care:** Clinician Office/Clinic
- **MIPS Reporting Options:** Traditional MIPS, MVP
- **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 within 4 months following the cataract surgery.
- **Risk Adjusted:** No
- **Performance Rate:** 1
- **High Priority Measure:** Yes
- **Inverse Measure:** No
- **Proportional Measure:** Yes

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: 66987, 66988, 66989, 66991

WITHOUT

Modifier -55 (Postoperative management only) OR Modifier -56 (Preoperative management only)

How to Report the Measure

Numerator: 20/30 best-corrected distance visual acuity

Numerator Exclusions: None

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)

Denominator Exceptions: None

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.

Note: Include only procedures performed through Aug. 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

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IRIS63: Exudative Age-Related Macular Degeneration: Gain of Visual Acuity

Updated December 2025. *Changes for the 2026 Reporting Year are noted below in red.*

- **Care Setting:** Ambulatory Care: Clinician Office/Clinic
- **MIPS Reporting Option:** Traditional MIPS
- **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 exudative age-related macular degeneration, being treated with anti-VEGF agents, with a gain of 1 Snellen line or more (which is equivalent to 0.1 logMAR or more) of visual acuity within the past 12 months compared to pre-treatment. Weighted average of performance rates reported.
- **Risk Adjusted:** No
- **Performance Rate:** 2, and a weighted average
- **High Priority Measure:** Yes
- **Inverse Measure:** No
- **Proportional Measure:** Yes

To Which Patients Does the Measure Apply?

Denominator:

Rate 1: All patients aged 50 years of older with a diagnosis of exudative age-related macular degeneration ~~and documentation of laterality (OD, OS, OU)~~ with 5 or more treatments with Anti-VEGF Agents over the reporting year.

Rate 2: All patients aged 50 years of older with a diagnosis of exudative age-related macular degeneration ~~and documentation of laterality (OD, OS, OU)~~ with 1 to 4 treatments with Anti-VEGF Agents over the reporting year

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 and HCPCS):** Codes located in “CPT Codes”

Diagnosis Codes

- Exudative age-related macular degeneration (ICD-10: H35.3210, H35.3211, H35.3220, H35.3221, H35.3230, H35.3231)

CPT Codes

Treatment with Anti-VEGF agents

- 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)
- Ranibizumab (Lucentis®) injections (CPT: 67028 and HCPCS: J2778)
- Aflibercept (EYLEA®) injections (CPT: 67028 and HCPCS: J0178)

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; gain of 1 Snellen line or more (which is equivalent to 0.1 logMAR or more) of visual acuity. Visual acuity of the eye(s) being treated will be evaluated.

Notes: Include only procedures performed through November 15 of the reporting period. This will allow the post treatment period to occur within the reporting year.

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

Numerator Exclusions: None

Denominator Exclusions: None

Denominator Exceptions: None

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