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

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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

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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 Rivastigimine Galantamine
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,

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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)

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OR

Performance Not Met:	Most recent glycemic status assessment (HbA1c or GMI) level ≥ 8.0% and ≤ 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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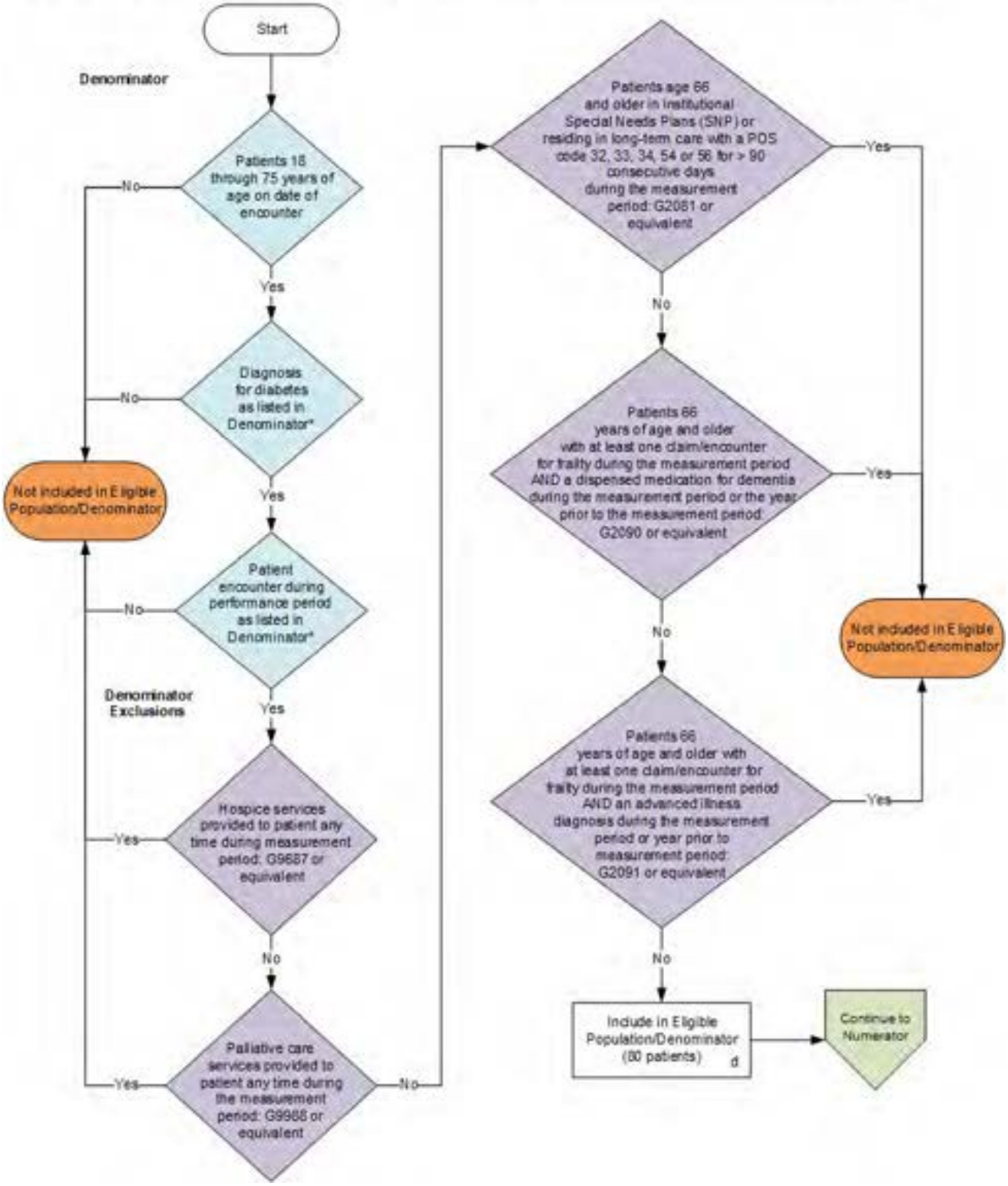
2026 Clinical Quality Measure Flow for Quality ID #001 (CBE 0059): Diabetes: Glycemic Status Assessment Greater Than 9%

INVERSE MEASURE: LOWER SCORE – BETTER

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



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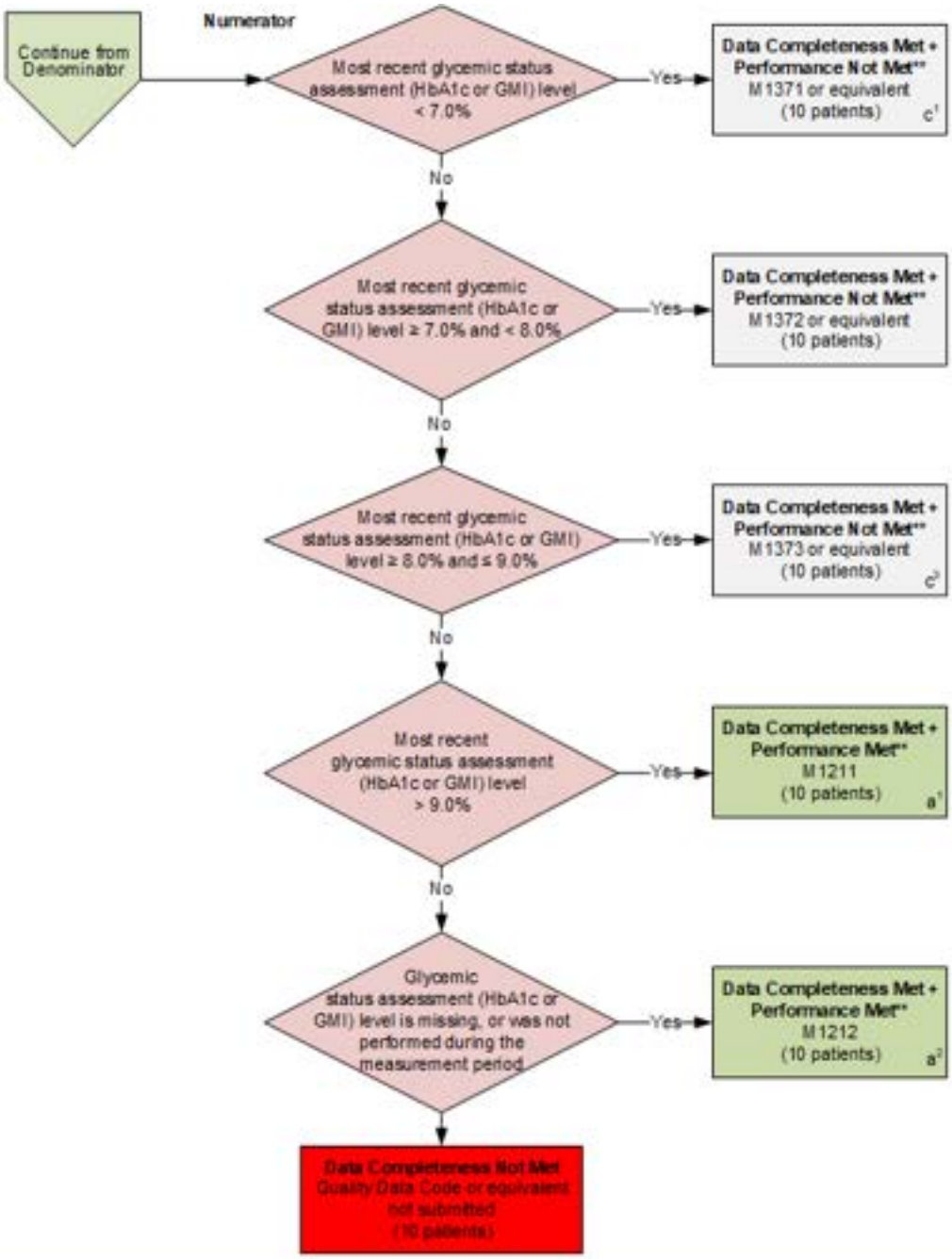

SAMPLE CALCULATIONS

Data Completeness=

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

Performance Rate=**

Performance Met (a^1+a^2=20 patients) / Data Completeness Numerator (50 patients) = 20 patients / 50 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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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

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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 c^1 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*.

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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*:

    a. 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 c^2 equals 10 patients in the Sample Calculation.

    b. 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.*

    a. 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 c^3 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.t* 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*:

    a. 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 a^1 equals 10 patients in the Sample Calculation.

    b. 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.*

    a. 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 a^2 equals 10 patients in the Sample Calculation.

    b. 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.*

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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.

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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:

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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

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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	Rivastigimine
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,

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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.

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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

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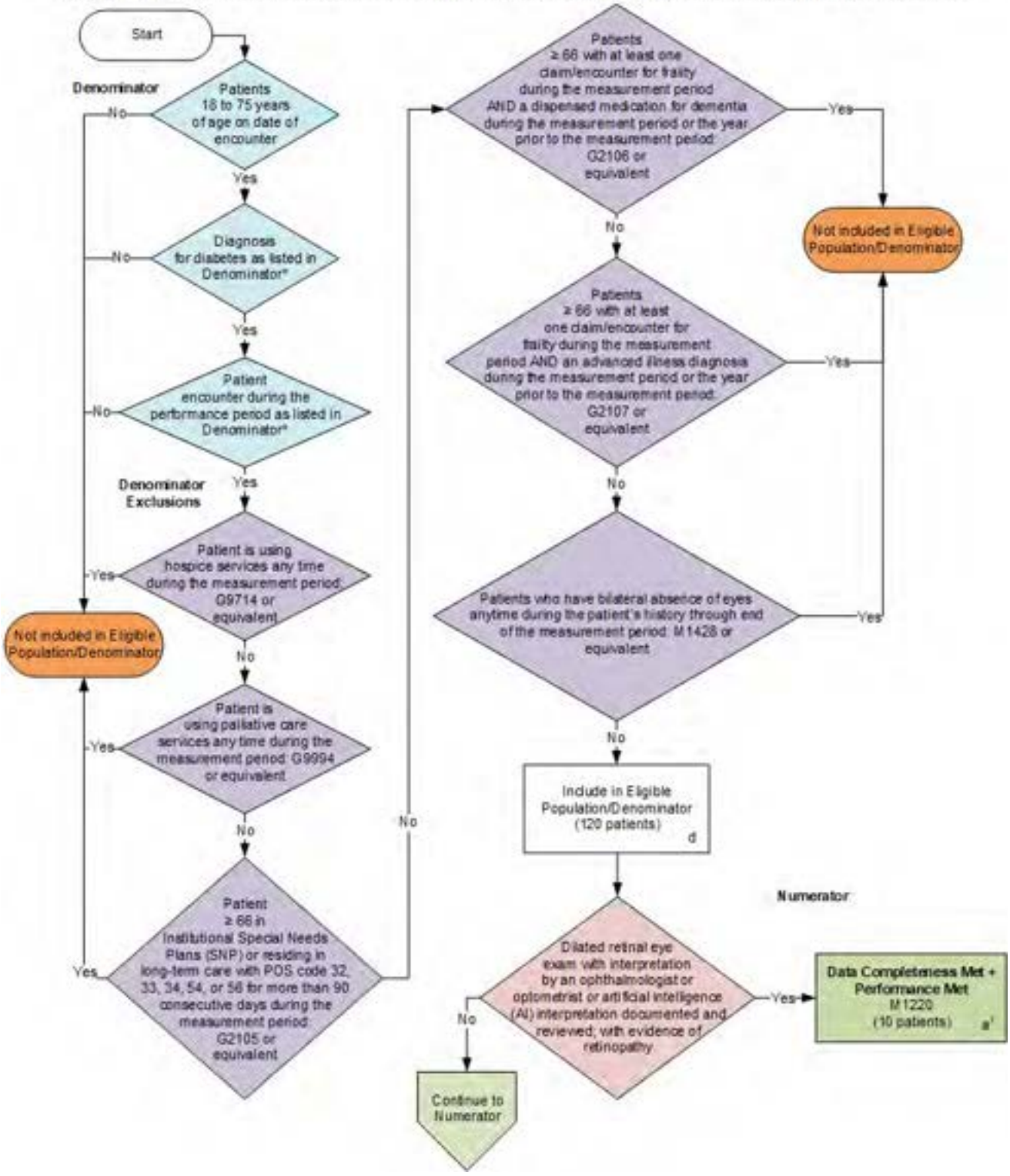
2026 Clinical Quality Measure Flow for Quality ID #117: Diabetes: Eye Exam

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



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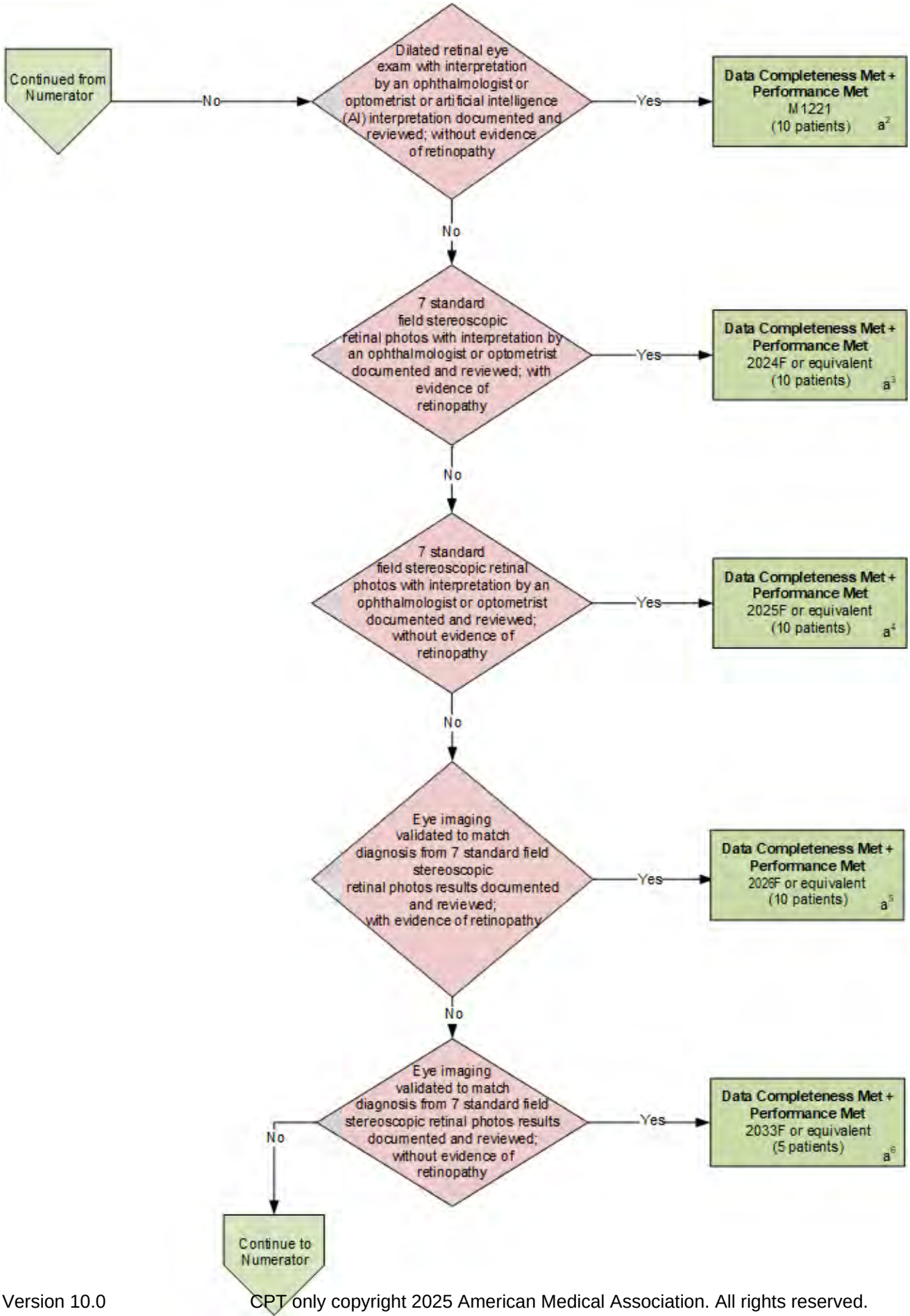

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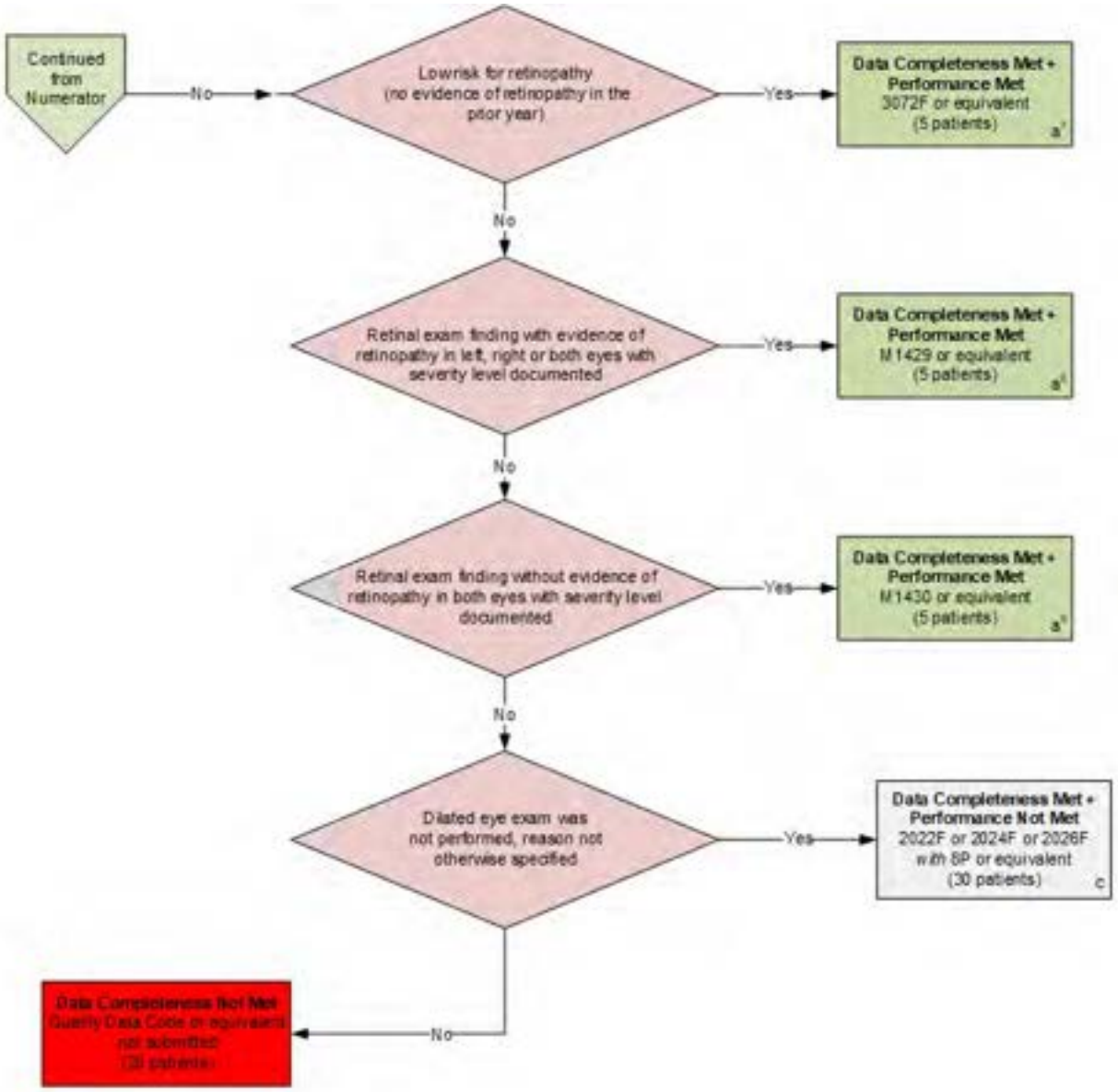

SAMPLE CALCULATIONS

Data Completeness=

Performance Met ($a^1+a^2+a^3+a^4+a^5+a^6+a^7+a^8+a^9$=70 patients) + Performance Not Met (c=30 patients) = 100 patients = **83.33%**

Eligible Population / Denominator (d=120 patients) = 120 patients

Performance Rate=

Performance Met ($a^1+a^2+a^3+a^4+a^5+a^6+a^7+a^8+a^9$=70 patients) = 70 patients = **70.00%**

Data Completeness Numerator (100 patients) = 100 patients

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

NOTE: Submission Frequency: Patient-Process

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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.

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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.

12. Start Numerator

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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 a^1 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 a^2 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 a^3 equals 10 patients in the Sample Calculation.

    b. If *7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy* equals No, proceed to check *7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy*.

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*.

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- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[4] equals 10 patients in the Sample Calculation.

b. If *7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy* equals No, proceed to check *Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy*.

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 a[5] equals 10 patients in the Sample Calculation.

    b. If *Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy* equals No, proceed to check *Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy*.

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 a[6] 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 a[7] 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*

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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 a^8 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 a^9 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 (a^1 plus a^2 plus a^3 plus a^4 plus a^5 plus a^6 plus a^7 plus a^8 plus a^9 equals 70 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population/Denominator (d equals 120 patients). All equals 100 patients divided by 120 patients. All equals 83.33 percent.

Performance Rate equals Performance Met (a^1 plus a^2 plus a^3 plus a^4 plus a^5 plus a^6 plus a^7 plus a^8 plus a^9 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

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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

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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- counters, 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

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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 =

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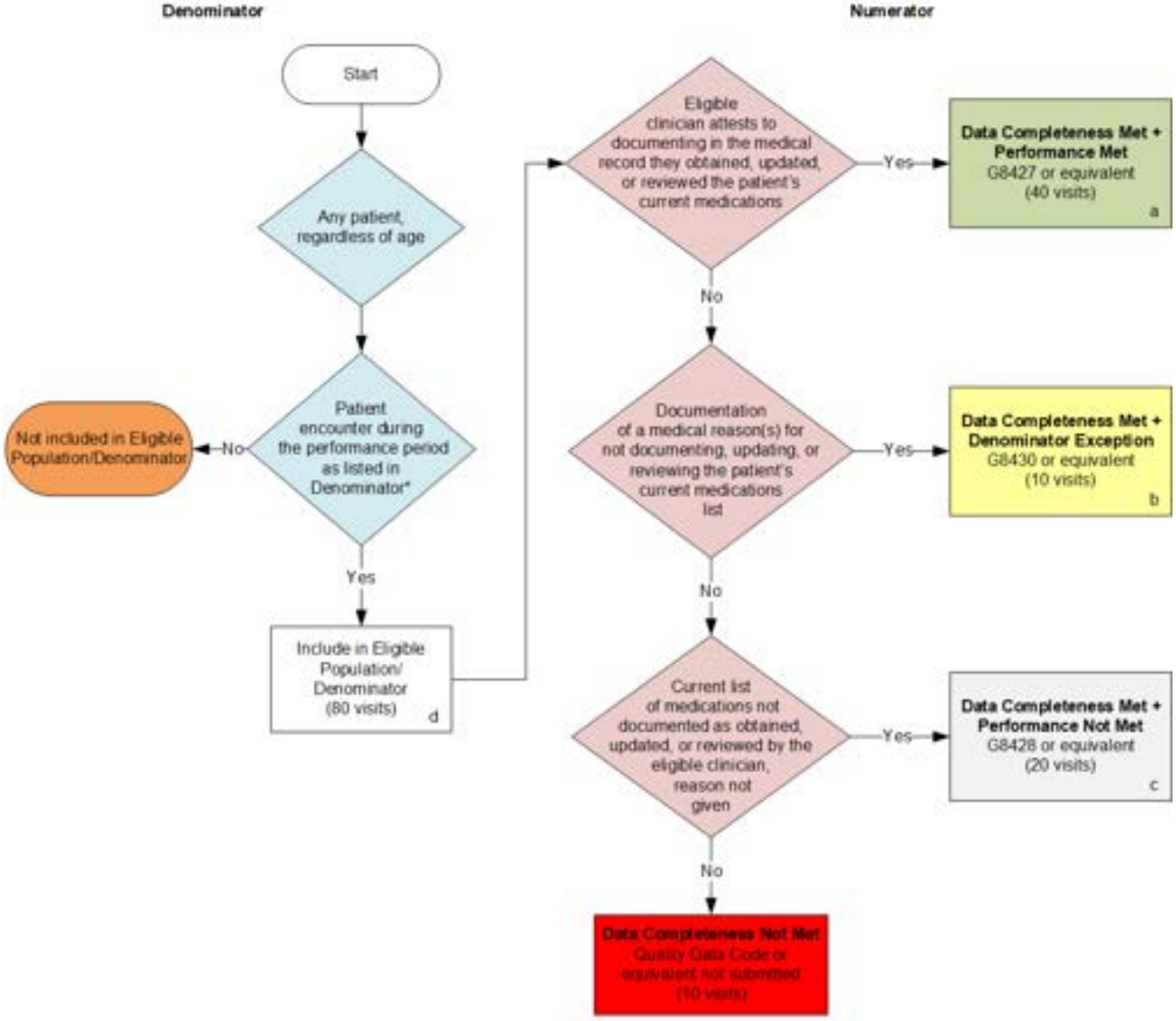
2026 Clinical Quality Measure Flow for Quality ID #130: Documentation of Current Medications in the Medical Record

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



SAMPLE CALCULATIONS

Data Completeness*

Performance Met (a=40 visits) + Denominator Exception (b=10 visits) + Performance Not Met (c=20 visits) = 70 visits = **87.50%**

Eligible Population / Denominator (d=80 visits) = 80 visits

Performance Rate*

Performance Met (a=40 visits) = 40 visits = **66.67%**

Data Completeness Numerator (70 visits) – Denominator Exception (b=10 visits) = 60 visits

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

NOTE: Submission Frequency: Visit

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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*:

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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

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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.

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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)

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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.

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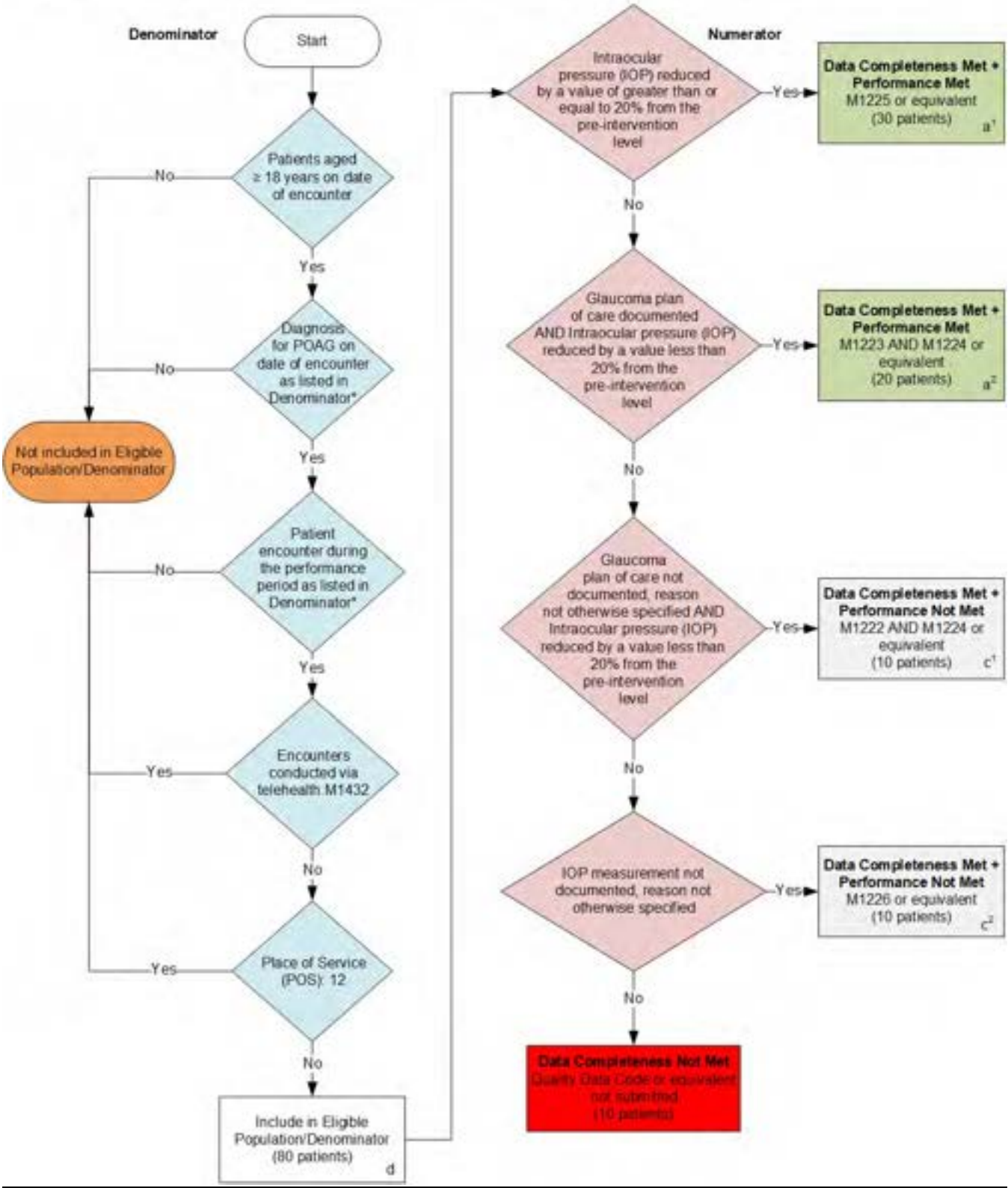
2026 Clinical Quality Measure Flow for Quality ID #141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care

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



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SAMPLE CALCULATIONS

Data Completeness*

Performance Met (a^1+a^2=50 patients) + Performance Not Met (c^1+c^2=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate*

Performance Met (a^1+a^2=50 patients) = 50 patients = **71.43%**

Data Completeness Numerator (70 patients) = 70 patients

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

NOTE: Submission Frequency: Patient-Process

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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*:

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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 a^1 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 a^2 equals 20 patients in the Sample Calculation.

    b. If *Glaucoma plan of care documented AND Intraocular pressure (IOP) reduced by a value less than 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 c^1 equals 10 patients in the Sample Calculation.

    b. If *Glaucoma plan of care not documented, reason not otherwise specified AND Intraocular pressure (IOP) reduced by a value less than 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 c^2 equals 10 patients in the Sample Calculation.

    b. If *IOP measurement not documented, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

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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

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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:

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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

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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

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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

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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

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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 Lenticonus	Q12.2, Q12.4, Q12.8
Prior Penetrating Keratoplasty	H18.601, H18.602, H18.603, H18.611, H18.612, H18.613, H18.621, H18.622, H18.623
Purulent Endophthalmitis	H44.001, H44.002, H44.003, H44.011, H44.012, H44.013, H44.021, H44.022, H44.023
Retinal Detachment with Retinal Defect	H33.001, H33.002, H33.003, H33.011, H33.012, H33.013, H33.021, H33.022, H33.023, H33.031, H33.032, H33.033, H33.041, H33.042, H33.043, H33.051, H33.052, H33.053, H33.41, H33.42, H33.43, H33.8
Retinal Vascular Occlusion	H34.11, H34.12, H34.13, H34.231, H34.232, H34.233, H34.8110, H34.8111, H34.8112, H34.8120, H34.8121, H34.8122, H34.8130, H34.8131, H34.8132, H34.8310, H34.8311, H34.8312, H34.8320, H34.8321, H34.8322, H34.8330, H34.8331, H34.8332
Retrolental Fibroplasias	H35.171, H35.172, H35.173
Scleritis	H15.021, H15.022, H15.023, H15.031, H15.032, H15.033, H15.041, H15.042, H15.043, H15.051, H15.052, H15.053, H15.091, H15.092, H15.093
Separation of Retinal Layers	H35.711, H35.712, H35.713, H35.721, H35.722, H35.723, H35.731, H35.732, H35.733
Traumatic Cataract	H26.101, H26.102, H26.103, H26.111, H26.112, H26.113, H26.121, H26.122, H26.123, H26.131, H26.132, H26.133
Uveitis	H44.111, H44.112, H44.113, H44.131, H44.132, H44.133
Vascular Disorders of Iris and Ciliary Body	H21.1X1, H21.1X2, H21.1X3
Visual Field Defects	H53.411, H53.412, H53.413, H53.421, H53.422, H53.423, H53.431, H53.432, H53.433, H53.451, H53.452, H53.453, H53.461, H53.462, H53.47, H53.481, H53.482, H53.483

NUMERATOR:

Cataract surgeries with best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following cataract surgery.

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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.

REFERENCES:

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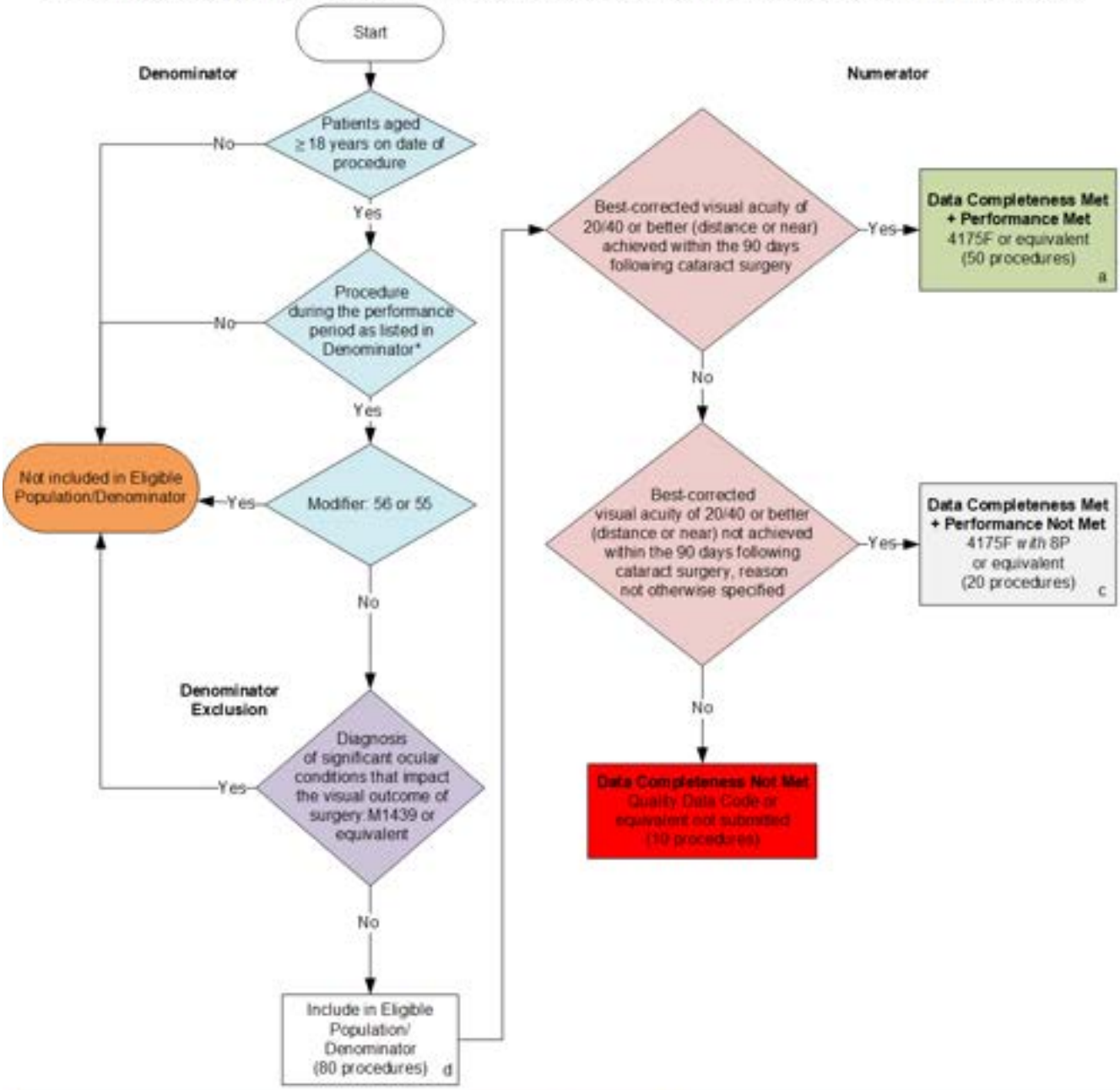
2026 Clinical Quality Measure Flow for Quality ID #191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

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



SAMPLE CALCULATIONS

Data Completeness=
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 #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

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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.

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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

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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,

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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)

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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

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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.

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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.

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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

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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.*

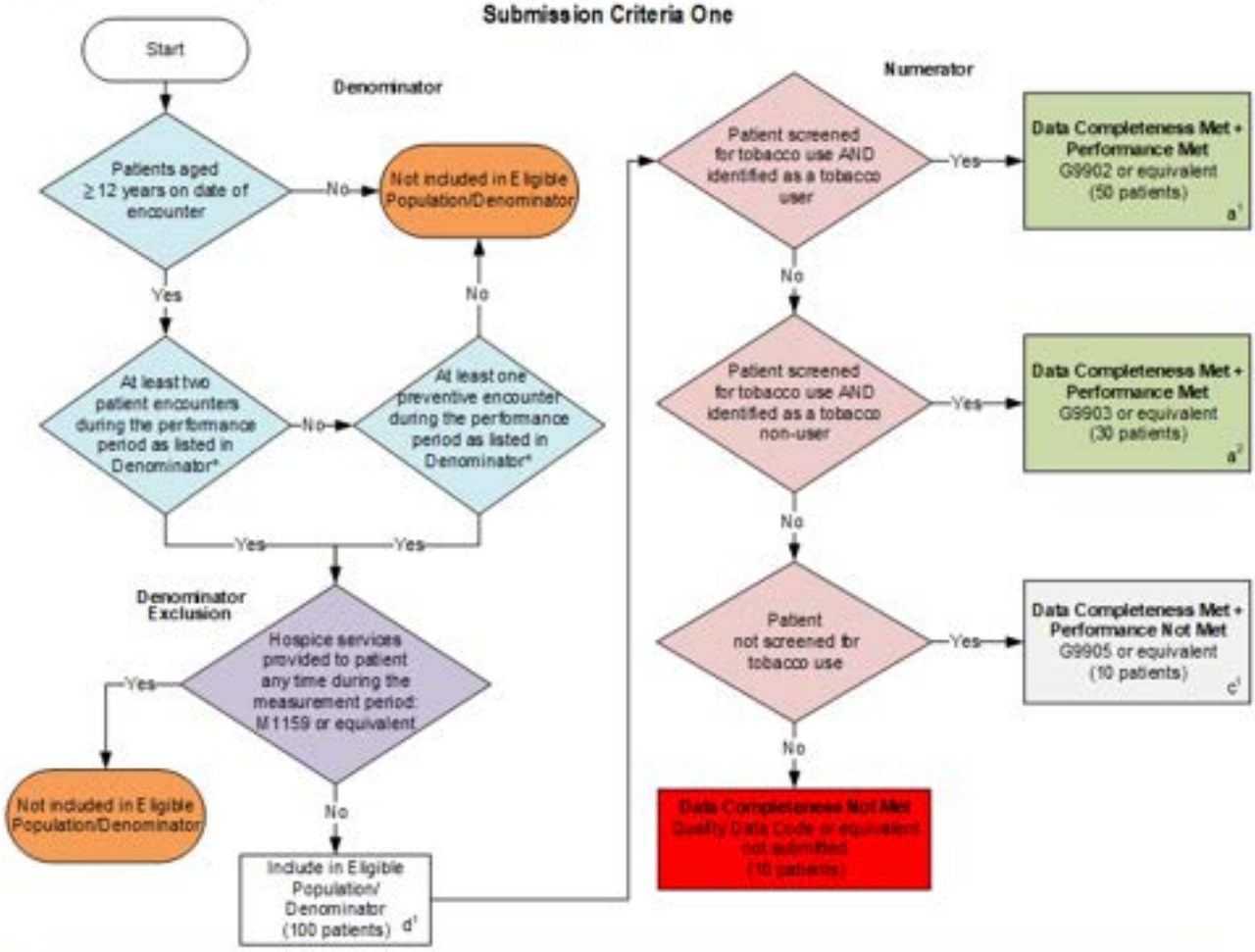
ACCOUNTABILITY REPORTING IN THE CMS MIPS PROGRAM: SAMPLE CALCULATIONS

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=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

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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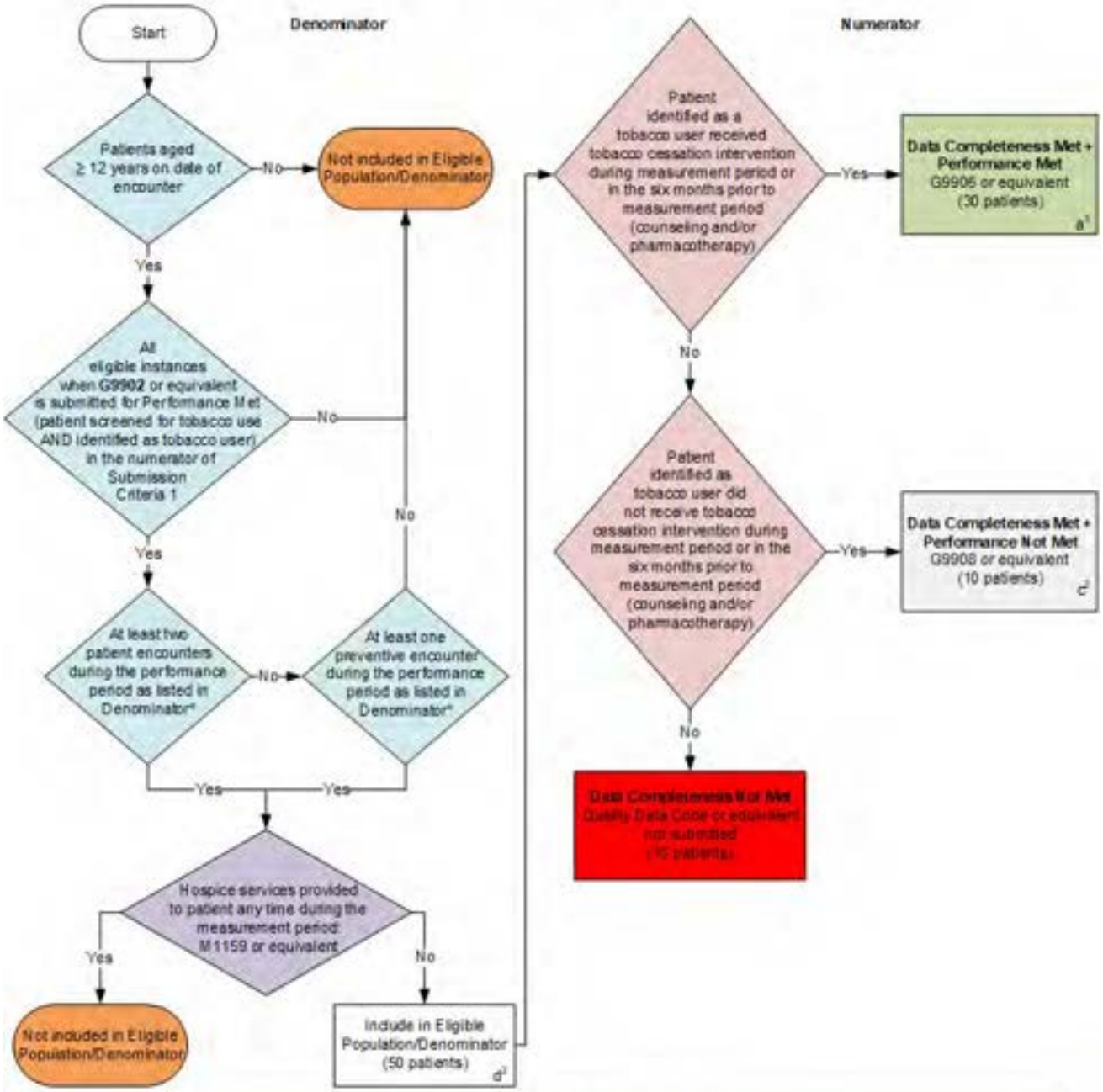
Submission Criteria Two



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

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

Performance Rate=
Performance Met (a^1=30 patients) / Data Completeness Numerator (40 patients) = 30 patients / 40 patients = **75.00%**

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

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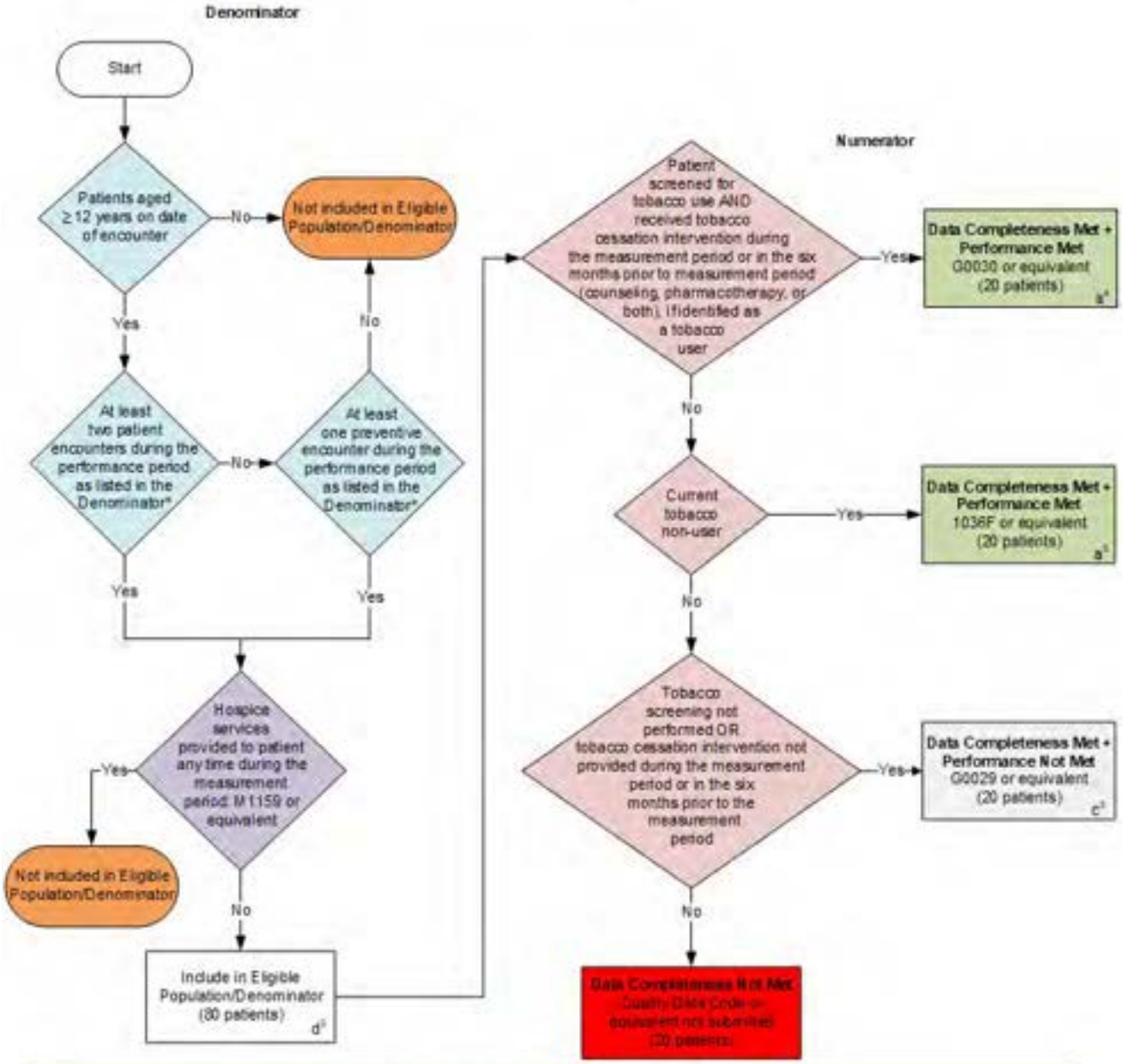
Submission Criteria Three



SAMPLE CALCULATIONS: SUBMISSION CRITERIA THREE

Data Completeness=
Performance Met (a^4+a^3=40 patients) + Performance Not Met (c^3=20 patients) = 60 patients = **75.00%**
Eligible Population / Denominator (d^3=80 patients) = 80 patients

Performance Rate=
Performance Met (a^4+a^3=40 patients) = 40 patients = **66.67%**
Data Completeness Numerator (60 patients) = 60 patients

*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*

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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 a^1 equals 50 patients in the Sample Calculation.

    b. If *Patient screened for tobacco use AND identified as a tobacco user* equals No, proceed to check *Patient screened for tobacco use AND identified as a tobacco non-user*.

9. Check *Patient screened for tobacco use AND identified as a tobacco non-user*:

    a. If *Patient screened for tobacco use AND identified as a tobacco non-user* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met letter* is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 30 patients in the Sample Calculation.

    b. If *Patient screened for tobacco use AND identified as a tobacco non-user* equals No, proceed to check *Patient not screened for tobacco use*.

10. Check *Patient not screened for tobacco use*:

    a. If *Patient not screened for tobacco use* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

    b. If *Patient not screened for tobacco use* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    - 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.

<u>Sample Calculations: Submission Criteria One</u>

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

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Performance Rate equals Performance Met (a^1 plus a^2 equals 80 patients) divided by Data Completeness Numerator (90 patients). All equals 80 patients divided by 90 patients. All equals 88.89 percent.

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

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Two:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 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*.

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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 a^3 equals 30 patients in the Sample Calculation.

    b. If *Patient identified as a tobacco user received tobacco cessation intervention during measurement period or in the six months prior to measurement period (counseling and/or pharmacotherapy)* equals No, proceed to check *Patient identified as tobacco user did not receive tobacco cessation intervention during measurement period or in the six months prior to measurement period (counseling and/or pharmacotherapy)*.

10. Check *Patient identified as tobacco user did not receive tobacco cessation intervention during measurement period or in the six months prior to measurement period (counseling and/or pharmacotherapy)*:

    a. If *Patient identified as tobacco user did not receive tobacco cessation intervention during measurement period or in the six months prior to measurement period (counseling and/or pharmacotherapy)* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    b. If *Patient identified as tobacco user did not receive tobacco cessation intervention during measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    - 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.

<u>Sample Calculations: Submission Criteria Two</u>

Data Completeness equals Performance Met (a^3 equals 30 patients) plus Performance Not Met (c^2 equals 10 patients) divided by Eligible Population/Denominator (d^2 equals 50 patients). All equals 40 patients divided by 50 patients. All equals 80.00 percent.

Performance Rate equals Performance Met (a^3 equals 30 patients) divided by Data Completeness Numerator (40

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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*:

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a. If *Patient screened for tobacco use AND received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling, pharmacotherapy, or both), if identified as a tobacco user* equals Yes, include in *Data Completeness Met and Performance Met*.

    - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^4 equals 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 a^5 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 c^3 equals 20 patients in the Sample Calculation.

    b. If *Tobacco screening not performed OR tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 20 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Three

Data Completeness equals Performance Met (a^4 plus a^5 equals 40 patients) plus Performance Not Met (c^3 equals 20 patients) divided by Eligible Population/Denominator (d^3 equals 80 patients). All equals 60 patients divided by 80 patients. All equals 75.00 percent.

Performance Rate equals Performance Met (a^4 plus a^5 equals 40 patients) divided by Data Completeness Numerator (60 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

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*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

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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

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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 Galantamine	Rivastigmine
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,

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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:

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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 ≥ 140 mmHg (G8753)
AND	
Performance Met:	Most recent diastolic blood pressure < 90 mmHg (G8754)
OR	
Performance Not Met:	Most recent diastolic blood pressure ≥ 90 mmHg (G8755)
OR	
Performance Not Met:	No documentation of blood pressure measurement, reason not given (G8756*)*

RATIONALE:

High blood pressure (HBP), also known as hypertension, is when the pressure in blood vessels is higher than normal (Centers for Disease Control and Prevention [CDC], 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 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 ≥ 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):

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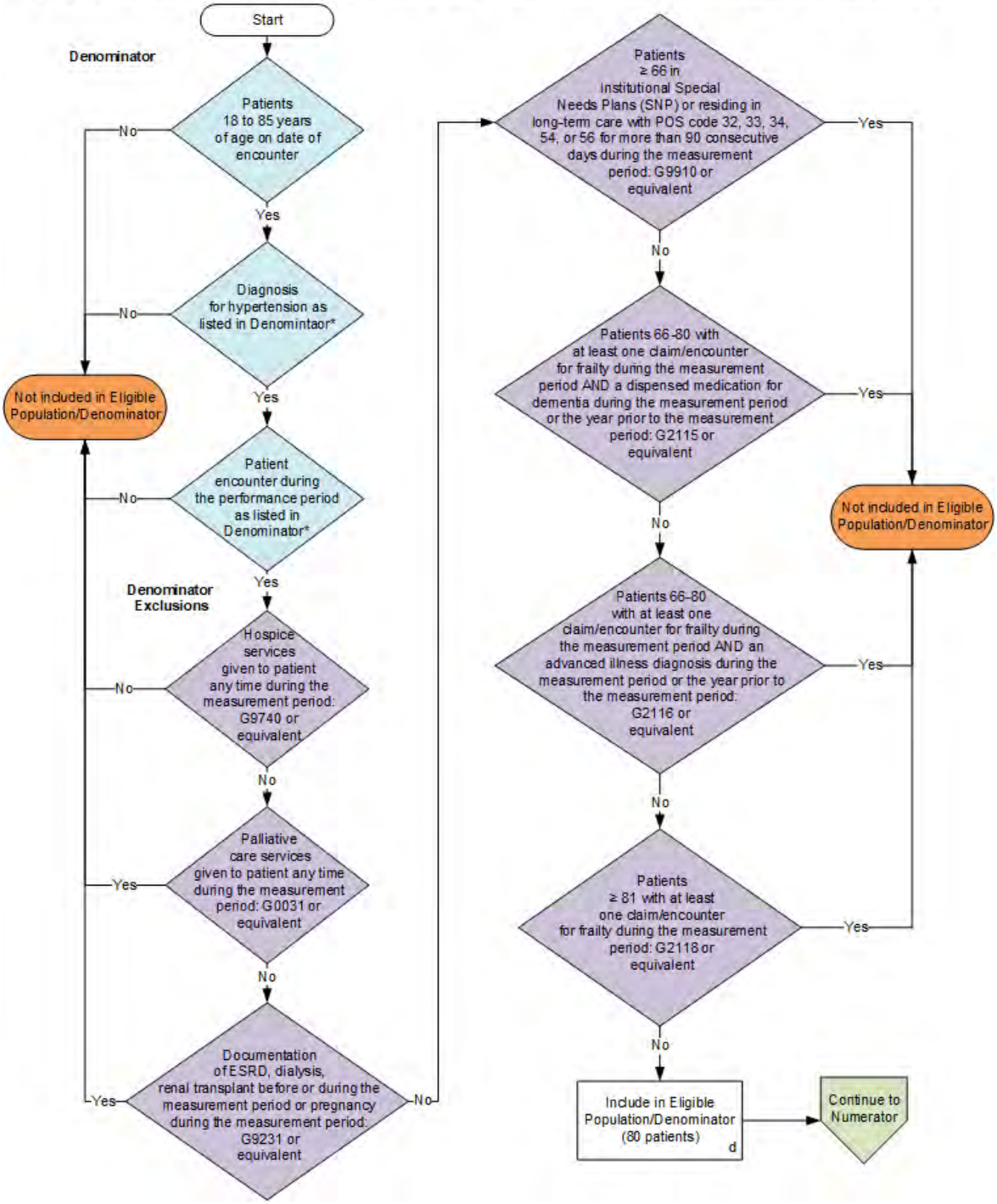
2026 Clinical Quality Measure Flow for Quality ID #236: Controlling High Blood Pressure

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



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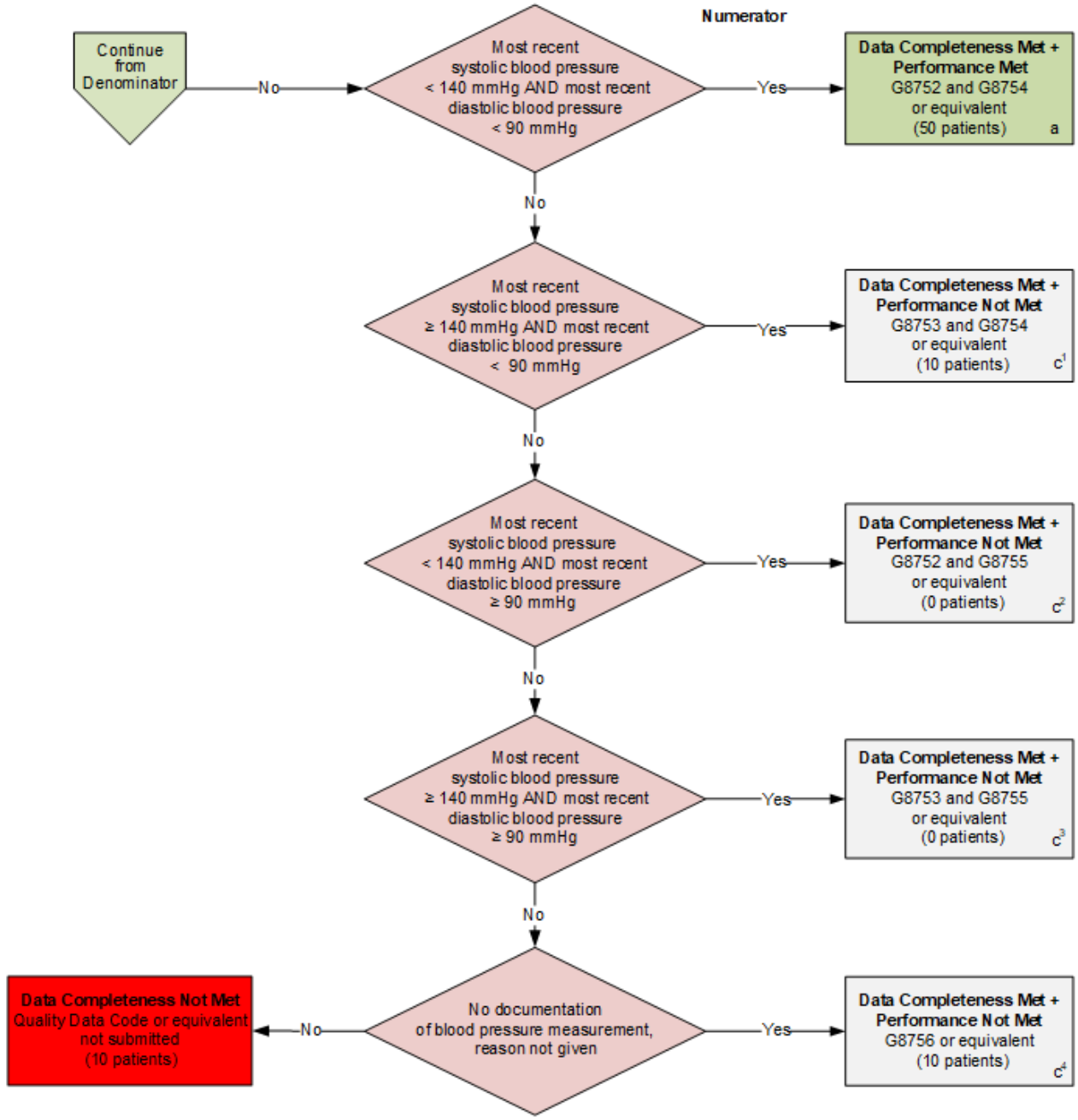

SAMPLE CALCULATIONS

Data Completeness=

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

Performance Rate=

Performance Met (a=50 patients) / Data Completeness Numerator (70 patients) = 50 patients / 70 patients = **71.43%**

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

NOTE : Submission Frequency: Patient-Intermediate

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v10

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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*

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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*

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mmHg:

a. If *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg* equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 50 patients in Sample Calculation.

b. If *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg* equals No, proceed to check *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg*.

15. Check to *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg*:

a. If to *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg* equals Yes, include in *Data Completeness Met and Performance Not Met*.

- *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

b. If to *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure less than 90 mmHg* equals No, proceed to check *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg*.

16. Check *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg*:

a. If *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg* equals Yes, include in *Data Completeness Met and Performance Not Met*.

- *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 0 patients in the Sample Calculation.

b. If *Most recent systolic blood pressure less than 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg* equals No, proceed to check *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg*.

17. Check *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg*:

a. If *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg* equals Yes, include in *Data Completeness Met and Performance Not Met*.

- *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^3 equals 0 patients in the Sample Calculation.

b. If *Most recent systolic blood pressure greater than or equal to 140 mmHg AND most recent diastolic blood pressure greater than or equal to 90 mmHg* equals No, proceed to check *No documentation of blood pressure measurement, reason not given*.

18. Check *No documentation of blood pressure measurement, reason not given*:

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a. If *No documentation of blood pressure measurement, reason not given* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

    - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^4 equals 10 patients in the Sample Calculation.

b. If *No documentation of blood pressure measurement, reason not given* equals No, proceed to *Data Completeness Not Met*.

19. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 50 patients) plus Performance Not Met (c^1 plus c^2 plus c^3 plus c^4 equals 20 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 50 patients) divided by Data Completeness Numerator (70 patients). All equals 50 patients divided by 70 patients. All equals 71.43 percent.

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

NOTE: Submission Frequency: Patient-Intermediate

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

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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.

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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.

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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 x 3) + (60 x 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 Chlorpheniramine Cyproheptadine Dimenhydrinate	Diphenhydramine (oral) Doxylamine Hydroxyzine Meclizine Promethazine Triprolidine

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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

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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,

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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 Brexpiprazole Cariprazine Chlorpromazine Clozapine Fluphenazine Haloperidol Iloperidone Loxapine Lurasidone	Molindone Olanzapine Paliperidone Perphenazine Pimavanserin Pimozide Quetiapine Risperidone Thioridazine Thiothixene Trifluoperazine Ziprasidone
Benzodiazepines, long, short and intermediate acting	Alprazolam Chlordiazepoxide Clobazam Clonazepam Clorazepate Diazepam Estazolam	Lorazepam Midazolam Oxazepam Temazepam Triazolam

*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

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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

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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.*

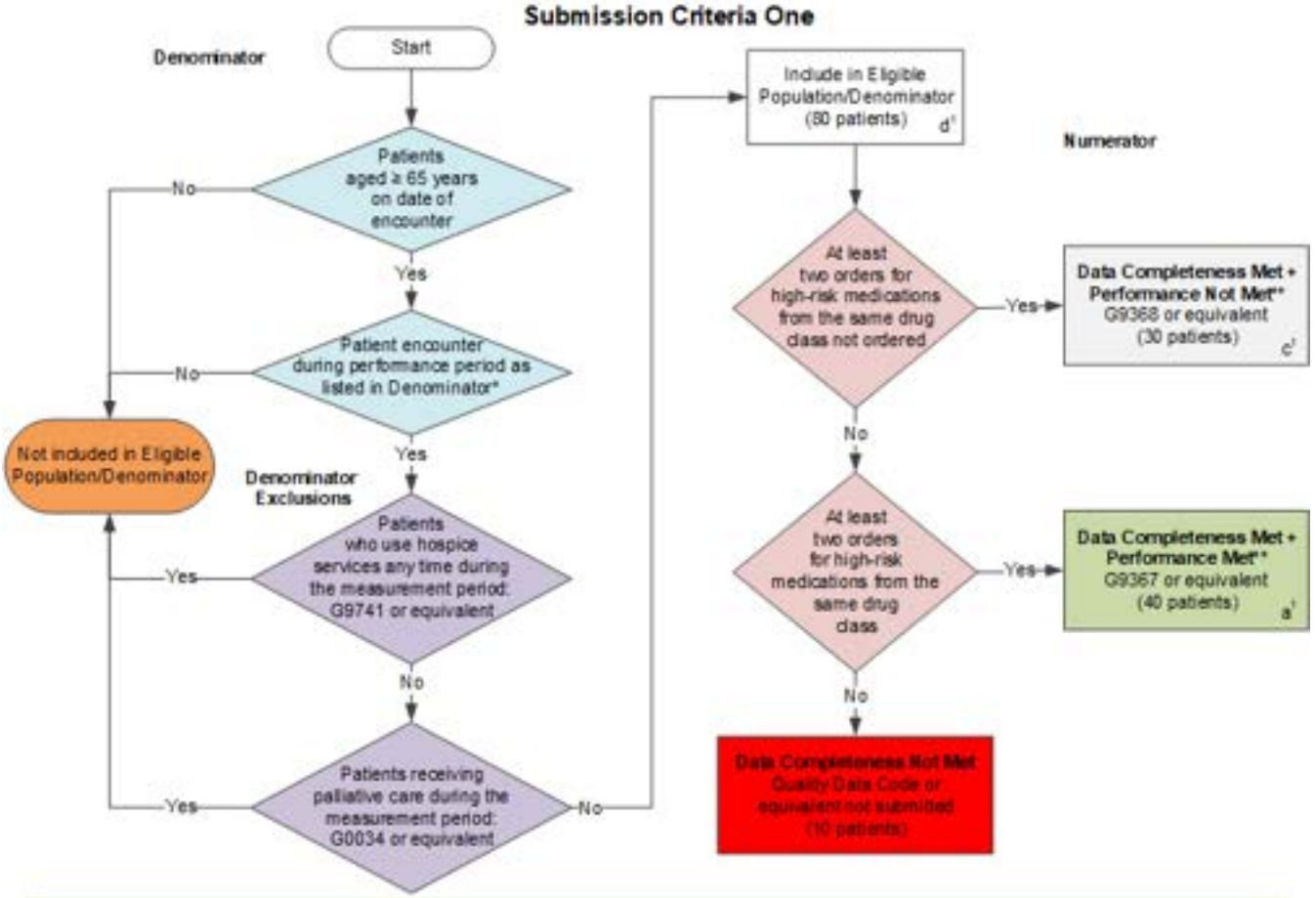
ACCOUNTABILITY REPORTING IN THE CMS MIPS PROGRAM: SAMPLE CALCULATIONS

Overall Data Completeness (Submission Criteria One)*=
Performance Met (a^1=40 patients) + Performance Not Met (c^1=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d^1=80 patients) = 80 patients

Overall Performance Rate (Submission Criteria One)*/=**
Performance Met (a^1=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

* See the posted measure specification for specific coding and instructions to submit this measure.
**A lower calculated performance rate for this measure indicates better clinical care or control.
NOTE: Submission Frequency: Patient-Process

Submission Criteria One



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=
Performance Met (a^1=40 patients) + Performance Not Met (c^1=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d^1=80 patients) = 80 patients

Performance Rate=
Performance Met (a^1=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

* See the posted measure specification for specific coding and instructions to submit this measure.
**A lower calculated performance rate for this measure indicates better clinical care or control.
NOTE: Submission Frequency: Patient-Process

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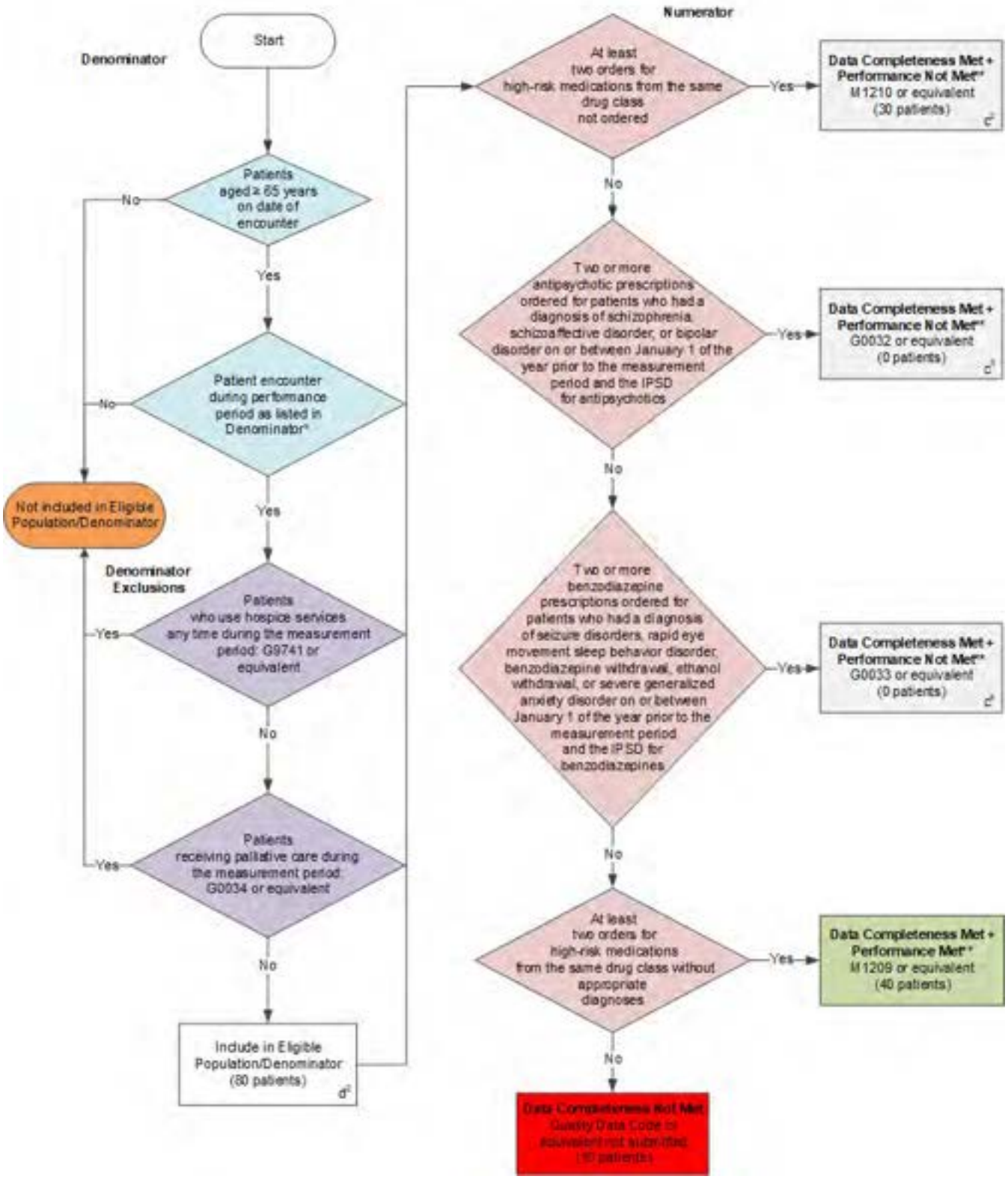
Submission Criteria Two



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SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness=

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

Performance Rate=

Performance Met (a^2=40 patients) / Data Completeness Numerator (70 patients) = 40 patients / 70 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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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 (a^1 equals 40 patients) plus Performance Not Met (c^1 equals 30 patients) divided by Eligible Population / Denominator (d^1 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Overall Performance Rate (Submission Criteria One)*/** equals Performance Met (a^1 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

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

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6. Denominator Population:

    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^1 equals 80 patients in the Sample Calculation.

7. Start Numerator

8. Check *At least two orders for high-risk medications from the same drug class not ordered*:

    a. If *At least two orders for high-risk medications from the same drug class not ordered* equals Yes, include in *Data Completeness Met and Performance Not Met***.

        - *Data Completeness Met and Performance Not Met*** letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 30 patients in the Sample Calculation.

    b. If *At least two orders for high-risk medications from the same drug class not ordered* equals No, proceed to check *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 a^1 equals 40 patients in Sample Calculation.

    b. If *At least two orders for high-risk medications from the same drug class* equals No, proceed to check *Data Completeness Not Met*.

10. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria One

Data Completeness equals Performance Met (a^1 equals 40 patients) plus Performance Not Met (c^1 equals 30 patients) divided by Eligible Population / Denominator (d^1 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

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

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

NOTE: Submission Frequency: Patient-Process

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Submission Criteria Two:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 65 years on date of encounter*:
    a. If *Patients aged greater than or equal to 65 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 65 years on date of encounter* equals Yes, proceed to check *Patient encounter during performance period as listed in Denominator**.
3. Check *Patient encounter during performance period as listed in Denominator**:
    a. If *Patient encounter during performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during performance period as listed in Denominator** equals Yes, proceed to check *Patients who use hospice services any time during the measurement period*.
4. Check *Patients who use hospice services any time during the measurement period*:
    a. If *Patients who use hospice services any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients who use hospice services any time during the measurement period* equals No, proceed to check *Patients receiving palliative care during the measurement period*.
5. Check *Patients receiving palliative care during the measurement period*:
    a. If *Patients receiving palliative care during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients receiving palliative care during the measurement period* equals No, include in *Eligible Population/Denominator*.
6. Denominator Population:
    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 80 patients in the Sample Calculation.
7. Start Numerator
8. Check *At least two orders for high-risk medications from the same drug class not ordered*:
    a. If *At least two orders for high-risk medications from the same drug class not ordered* equals Yes, include in *Data Completeness Met and Performance Not Met***.
        - *Data Completeness Met and Performance Not Met*** letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 30 patients in the Sample Calculation.
    b. If *At least two orders for high-risk medications from the same drug class not ordered* equals No, proceed to check *Two or more antipsychotic prescriptions ordered for patients who had a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder on or between January 1 of the year prior to the measurement period and the IPSD for antipsychotics*.

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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 c^3 equals 0 patients in the Sample Calculation.

    b. If *Two or more antipsychotic prescriptions ordered for patients who had a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder on or between January 1 of the year prior to the measurement period and the IPSD for antipsychotics* equals No, proceed to check *Two or more benzodiazepine prescriptions ordered for patients who had a diagnosis of seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, or severe generalized anxiety disorder on or between January 1 of the year prior to the measurement period and the IPSD for benzodiazepines*.

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 c^4 equals 0 patients in the Sample Calculation.

    b. If *Two or more benzodiazepine prescriptions ordered for patients who had a diagnosis of seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, or severe generalized anxiety disorder on or between January 1 of the year prior to the measurement period and the IPSD for benzodiazepines* equals No, proceed to check *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 a^2 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*:

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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

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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

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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

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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 AND recommended nonpharmacologic interventions OR Referral to Alternate/Primary Care Provider
First Hypertensive BP Reading	>=130	OR >= 80	Rescreen BP within 4 weeks AND recommended nonpharmacologic interventions OR Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	130-139 and NOT >=140	OR 80-89 and NOT >=90	Recommended nonpharmacologic intervention AND reassessment within 6 months AND an order for laboratory test or ECG for hypertension OR Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	>=140	OR >=90	Recommended nonpharmacologic intervention AND BP-lowering medication AND reassessment within 4 weeks AND an order for laboratory test or ECG for hypertension OR Referral to Alternate/Primary Care Provider

Patients with a Documented Reason for not Screening or no Follow-Up Plan for High Blood Pressure (Denominator Exceptions) –

- Documentation of medical reason(s) for not screening for high blood pressure (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status).
- Documentation of patient reason(s) for not screening for blood pressure measurements or for not ordering an appropriate follow-up intervention if patient BP is elevated or hypertensive (e.g., patient refuses).

NUMERATOR NOTE:
Although the recommended screening interval for a normal BP reading is every year, to meet the intent of this measure, BP screening and follow-up must be performed at every patient visit. For patients with Normal blood pressure, a follow-up plan is not required (G8783). Denominator Exception(s) are determined on the date of the denominator eligible encounter.

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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

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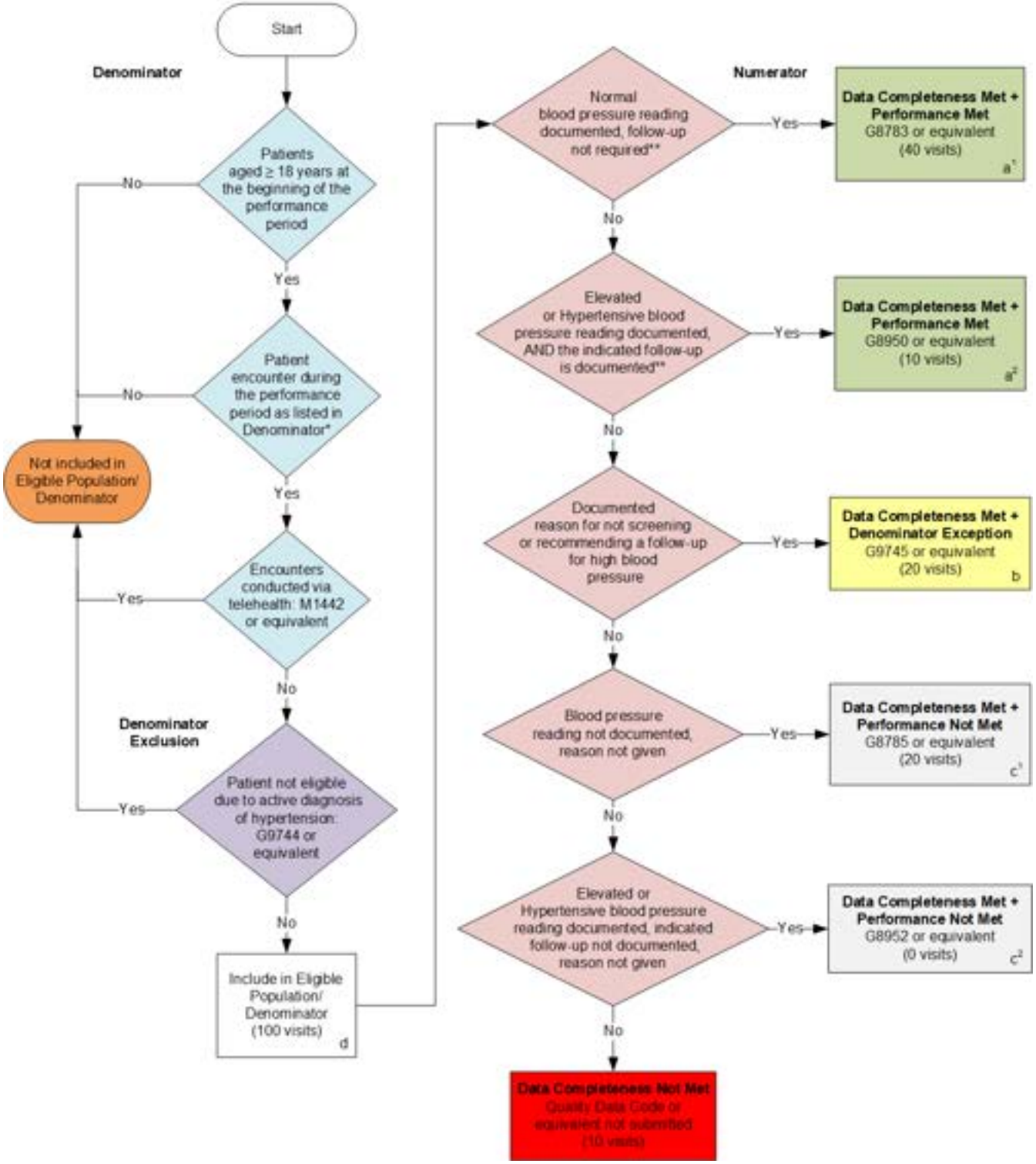
2026 Clinical Quality Measure Flow for Quality ID #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

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



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SAMPLE CALCULATIONS

Data Completeness*

Performance Met (a^1+a^2=50 visits) + Denominator Exception (b=20 visits) + Performance Not Met (c^1+c^2=20 visits) = 90 visits = **90.00%**

Eligible Population / Denominator (d=100 visits) = 100 visits

Performance Rate*

Performance Met (a^1+a^2=50 visits) = 50 visits = **71.43%**

Data Completeness Numerator (90 visits) – Denominator Exception (b=20 visits) = 70 visits

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

**See the posted measure specification for classifications of blood pressure values and corresponding follow-up plans.

NOTE: Submission Frequency: Visit

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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 a^1 equals 40 visits in the Sample Calculation.

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b. If *Normal blood pressure reading documented, follow-up not required*** equals No, proceed to check *Elevated or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented***.*

9. Check *Elevated or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented***:

   a. If *Elevated or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented*** equals Yes, include in *Data Completeness Met and Performance Met.*

      - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 10 visits in the Sample Calculation.

   b. If *Elevated or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented*** equals No, proceed to check *Documented reason for not screening or recommending a follow-up for high blood pressure.*

10. Check *Documented reason for not screening or recommending a follow-up for high blood pressure*:

    a. If *Documented reason for not screening or recommending a follow-up for high blood pressure* equals Yes, include in *Data Completeness Met and Denominator Exception.*

       - *Data Completeness Met and Denominator Exception* is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 20 visits in the Sample Calculation.

    b. If *Documented reason for not screening or recommending a follow-up for high blood pressure* equals No, proceed to check *Blood pressure reading not documented, reason not given*.

11. Check *Blood pressure reading not documented, reason not given*:

    a. If *Blood pressure reading not documented, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met.*

       - *Data Completeness Met and Performance Not Met* is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 20 visits in the Sample Calculation.

    b. If *Blood pressure reading not documented, reason not given* equals No, proceed to check *Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given.*

12. Check *Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given*:

    a. If *Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met.*

       - *Data Completeness Met and Performance Not Met* is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 0 visits in the Sample Calculation.

    b. If *Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given* equals No, proceed to check *Data Completeness Not Met.*

13. Check *Data Completeness Not Met:*

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- 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.

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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:

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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

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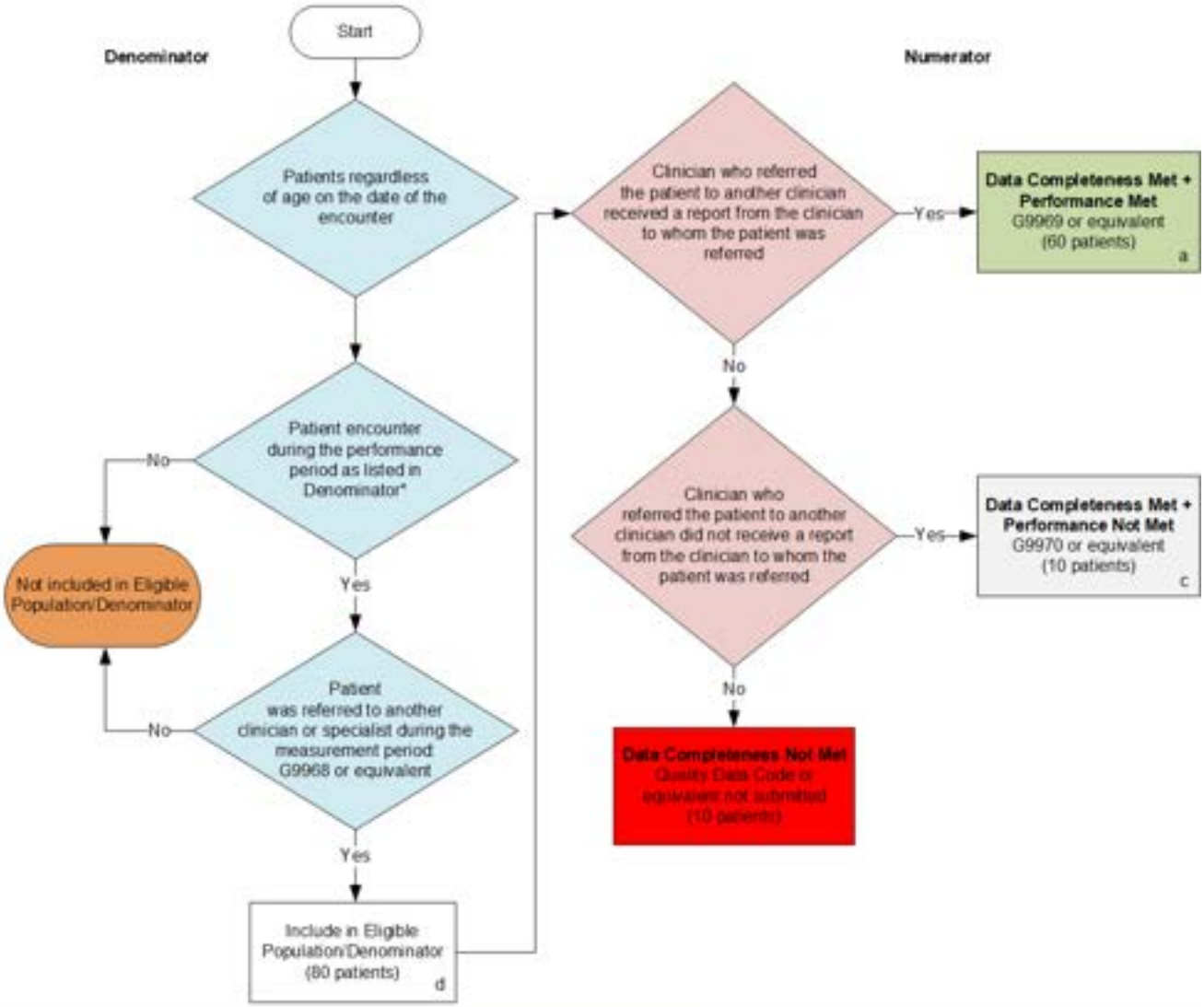
2026 Clinical Quality Measure Flow for Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report

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



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a=60 patients) + Performance Not Met (c=10 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=
Performance Met (a=60 patients) = 60 patients = **85.71%**
Data Completeness Numerator (70 patients) = 70 patients

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

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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.

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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

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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

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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:

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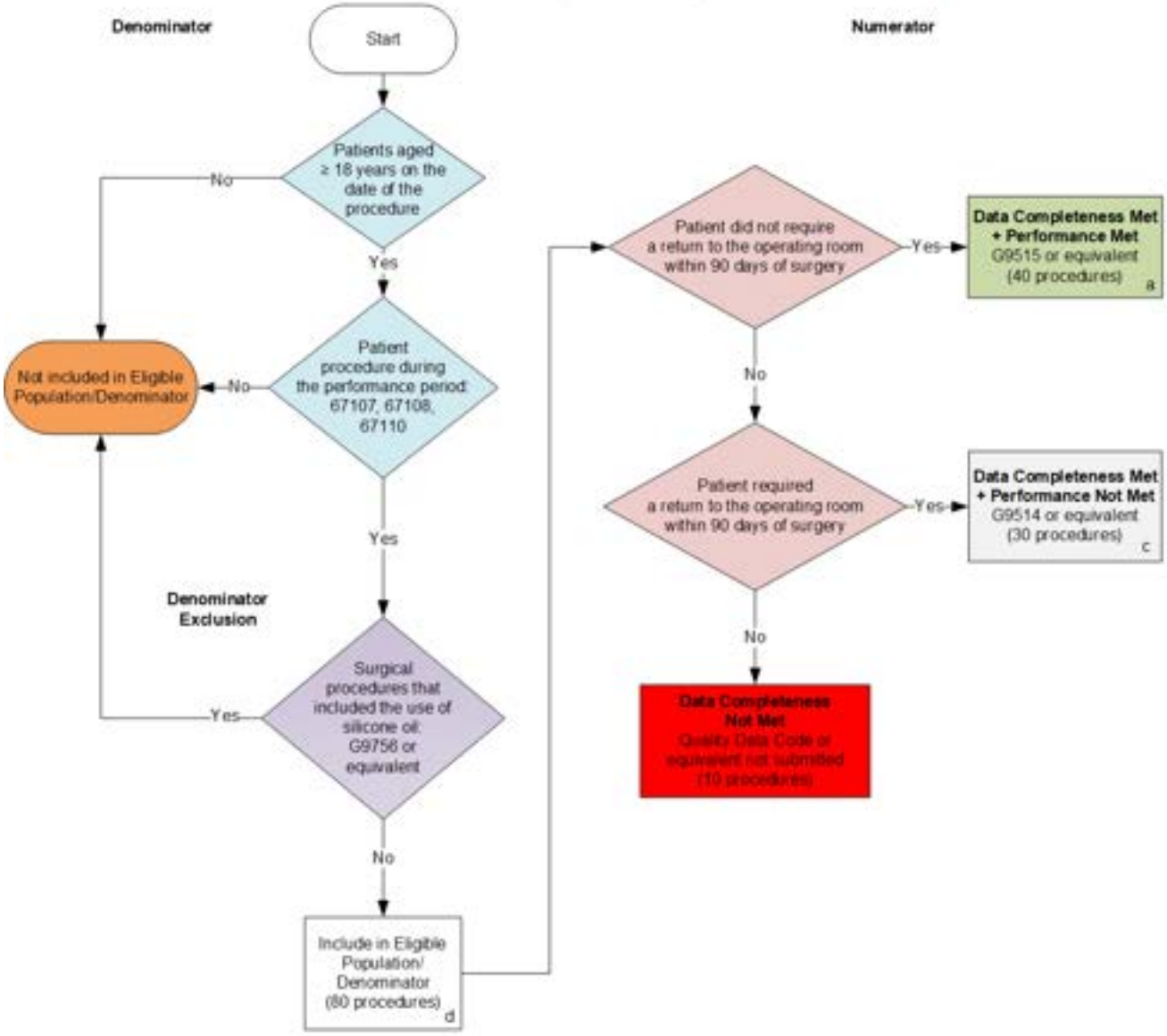
2026 Clinical Quality Measure Flow for Quality ID #384: Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery

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



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 procedures) + Performance Not Met (c=30 procedures) / Eligible Population / Denominator (d=80 procedures) = 70 procedures / 80 procedures = **87.50%**

Performance Rate=

Performance Met (a=40 procedures) / Data Completeness Numerator (70 procedures) = 40 procedures / 70 procedures = **57.14%**

See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Procedure

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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

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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)

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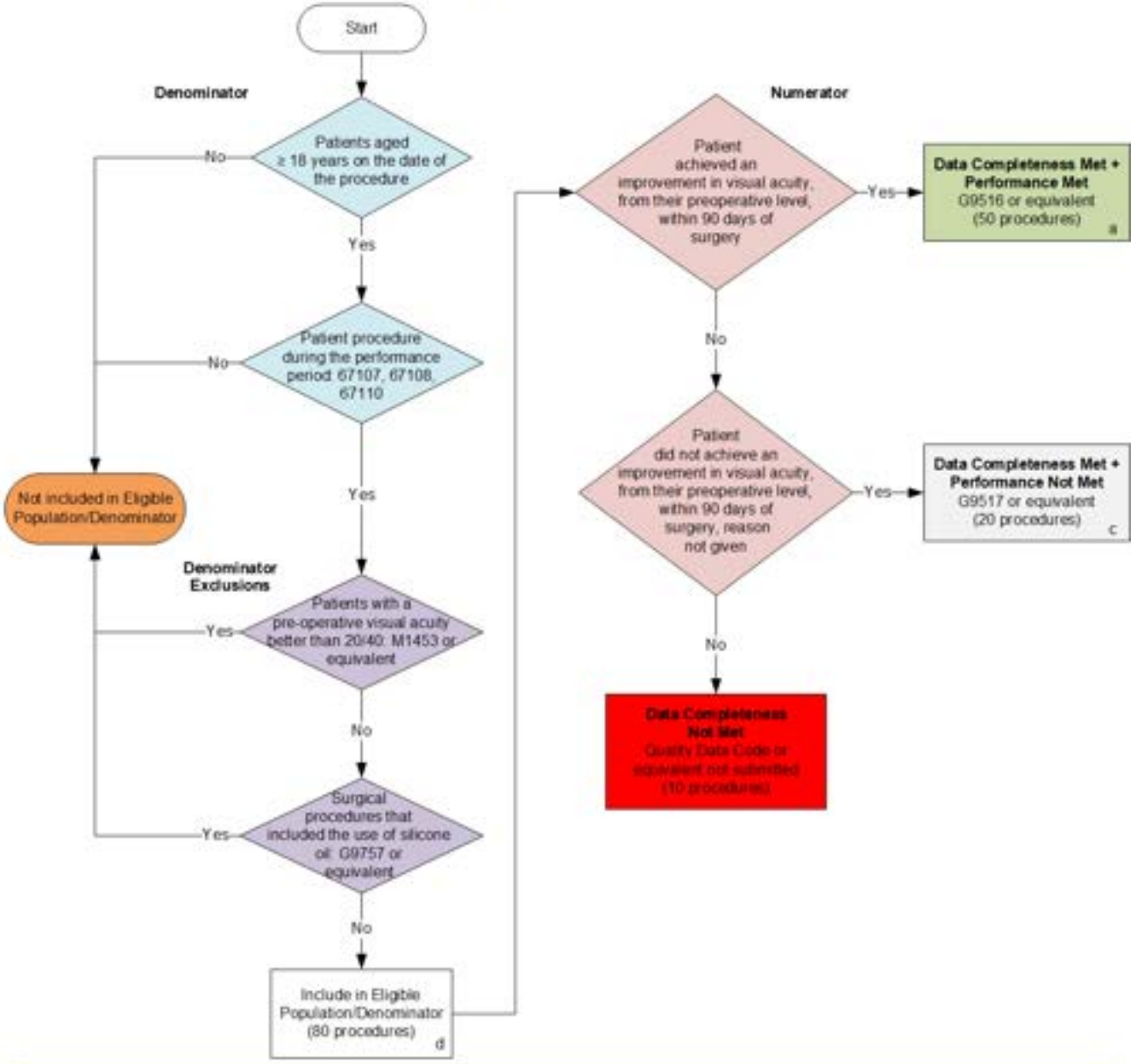
2026 Clinical Quality Measure Flow for Quality ID #385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery

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.

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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

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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.

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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:

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Page 2 of 6

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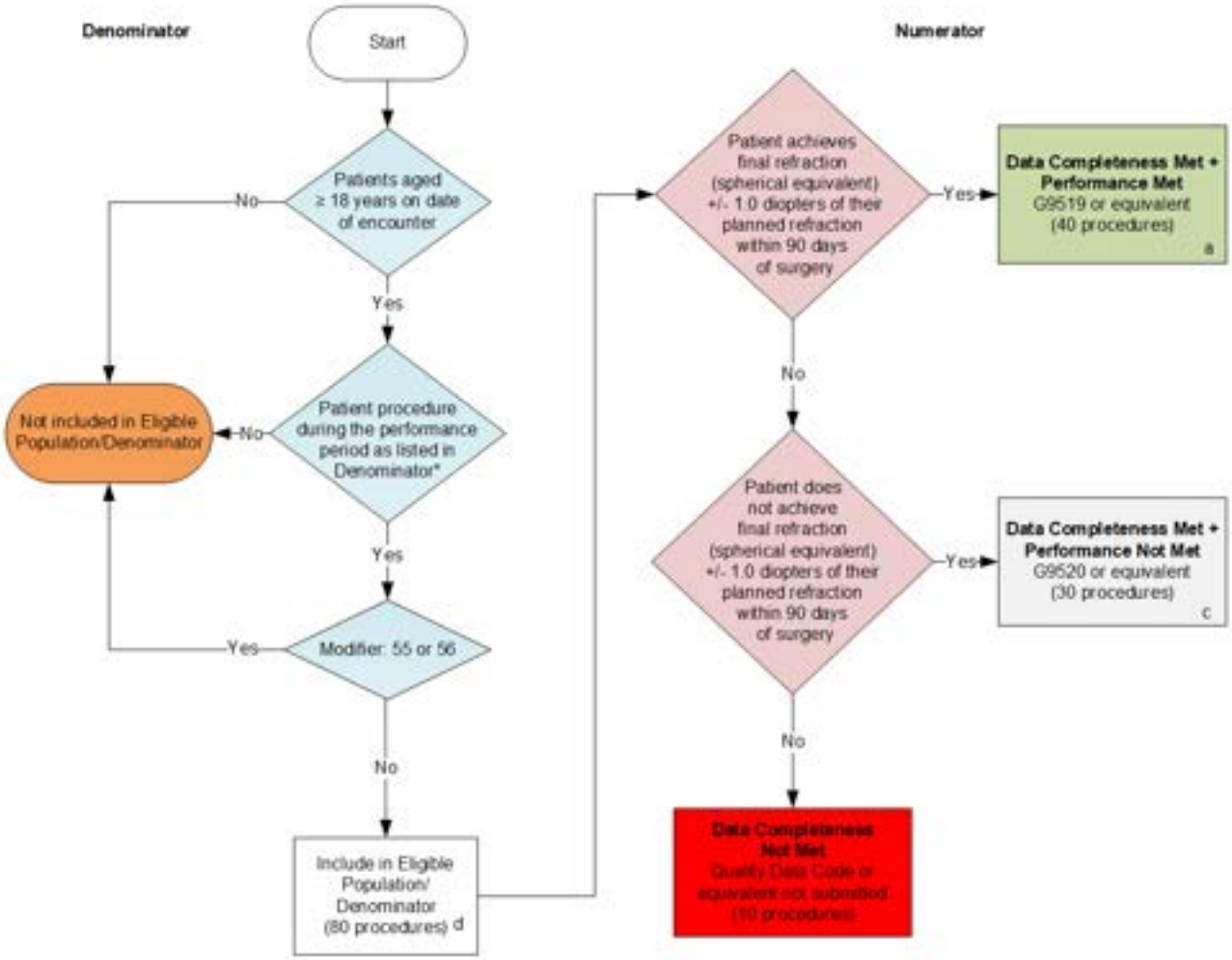
2026 Clinical Quality Measure Flow for Quality ID #389: Cataract Surgery: Difference Between Planned and Final Refraction

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.

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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

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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.

Denominator Instructions:

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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

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

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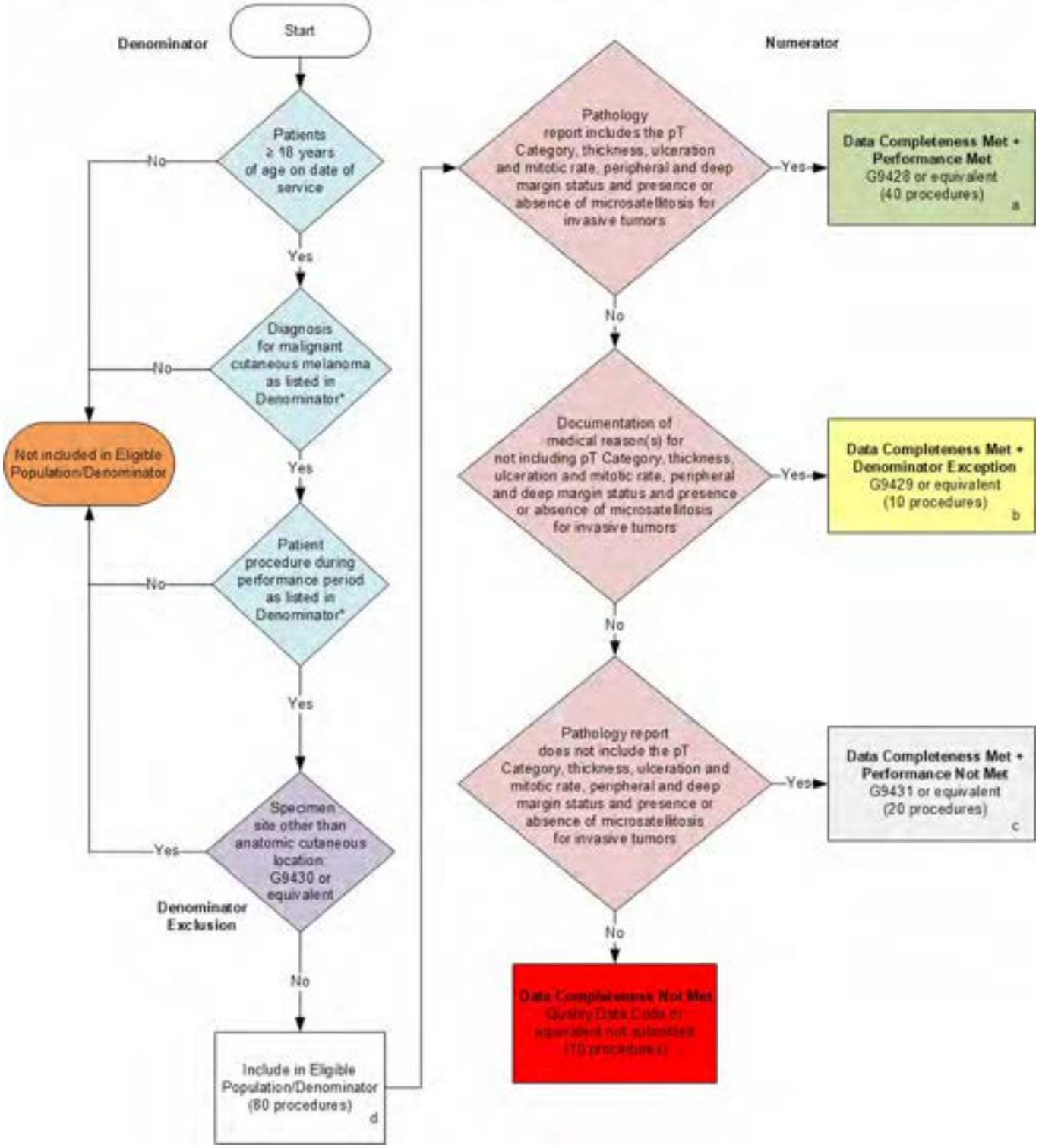

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SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 procedures) + Denominator Exception (b=10 procedures) + Performance Not Met (c=20 procedures) = 70 procedures = **87.50%**

Eligible Population / Denominator (d=80 procedures) = 80 procedures

Performance Rate=

Performance Met (a=40 procedures) = 40 procedures = **66.67%**

Data Completeness Numerator (70 procedures) – Denominator Exception (b=10 procedures) = 60 procedures

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

NOTE: Submission Frequency: Procedure

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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*

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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

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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.

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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/ Dermopathologist's tracking system:
- Date tissue specimen received
- Date pathology report was sent to the biopsying clinician

Numerator Options:

Performance Met:	Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, or melanoma (to include in situ disease) sent from the Pathologist/ Dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist (G9785)

OR

Denominator Exception:	Pathology report for tissue specimens produced from wide local excisions or re-excisions (M1166)

OR

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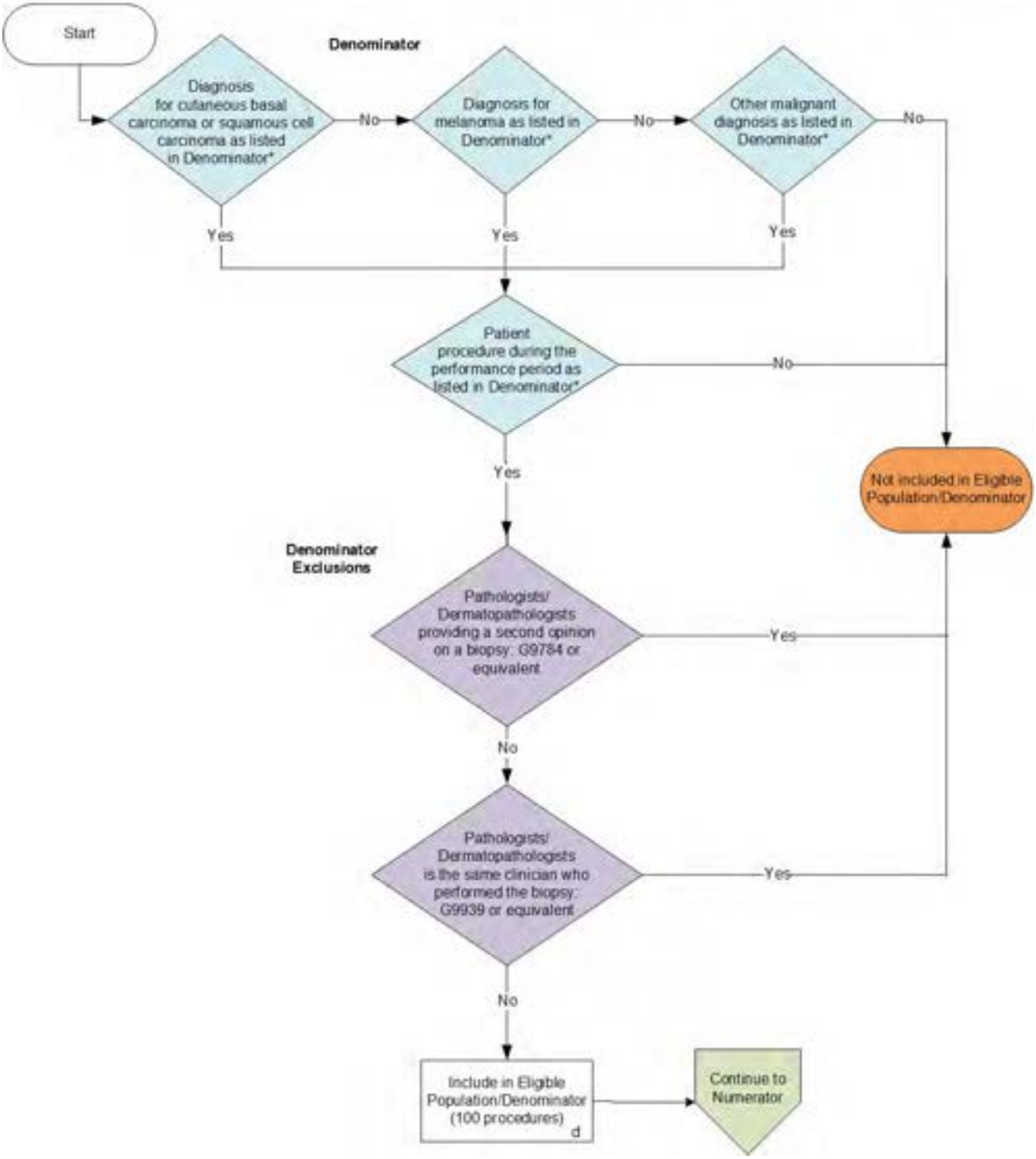
2026 Clinical Quality Measure Flow for Quality ID #440: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician

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



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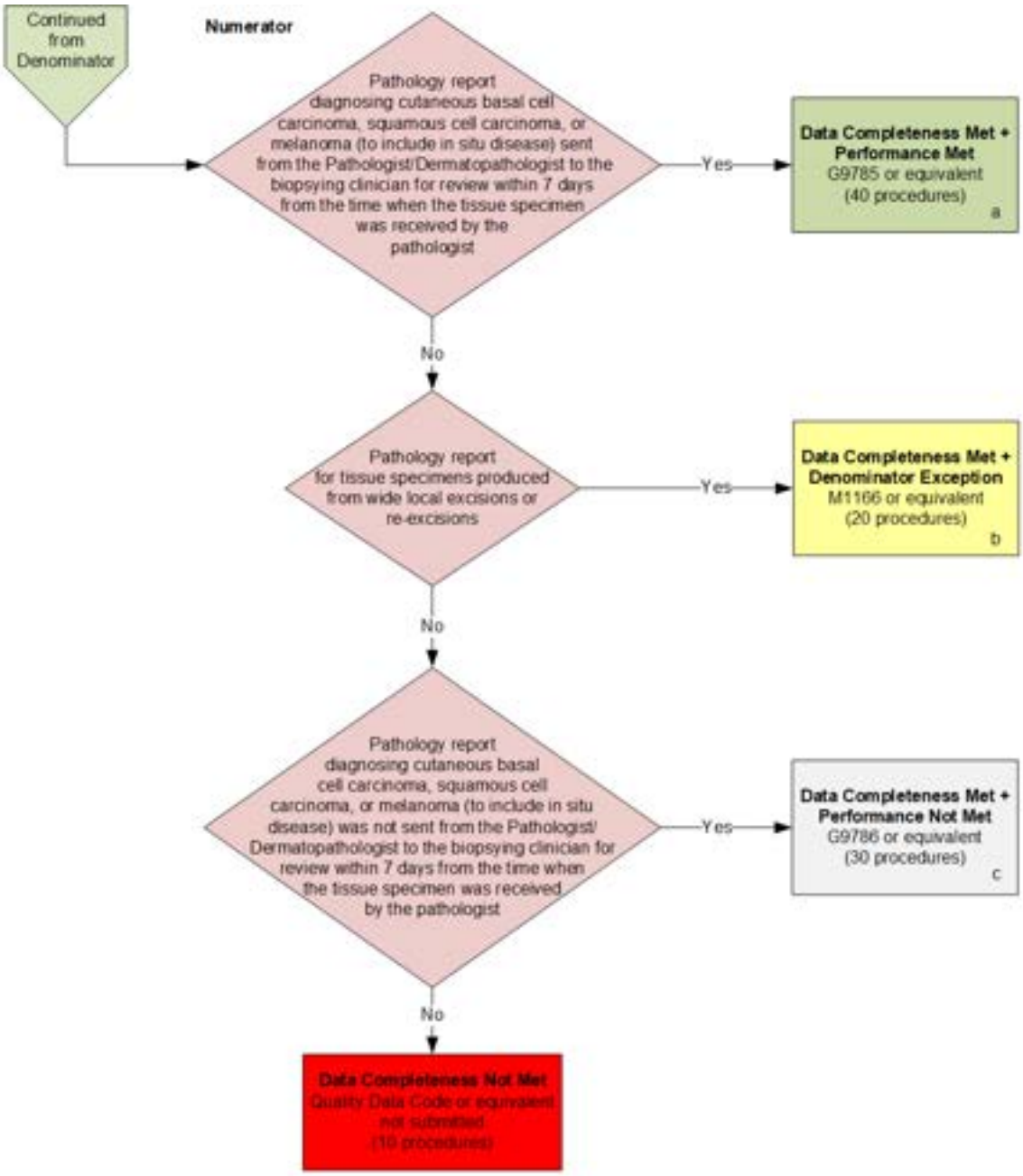

SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 procedures) + Denominator Exceptions (b=20 procedures) + Performance Not Met (c=30 procedures) / Eligible Population / Denominator (d=100 procedures) = 90 procedures / =100 procedures = **90.00%**

Performance Rate=

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

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

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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*.

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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*

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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

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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 ≤ 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

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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 ≤ 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.

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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 ≤ 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 acetonide 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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Aref AA, Scott IU, Oden NL, Ip MS, Blodi BA, VanVeldhuisen PC for the SCORE Study Investigator Group. Incidence, risk factors, and timing of elevated intraocular pressure after intravitreal triamcinolone acetonide injection for macular edema secondary to retinal vein occlusion. SCORE study report 15. JAMA Ophthalmol. 2015;133:1022-1029.

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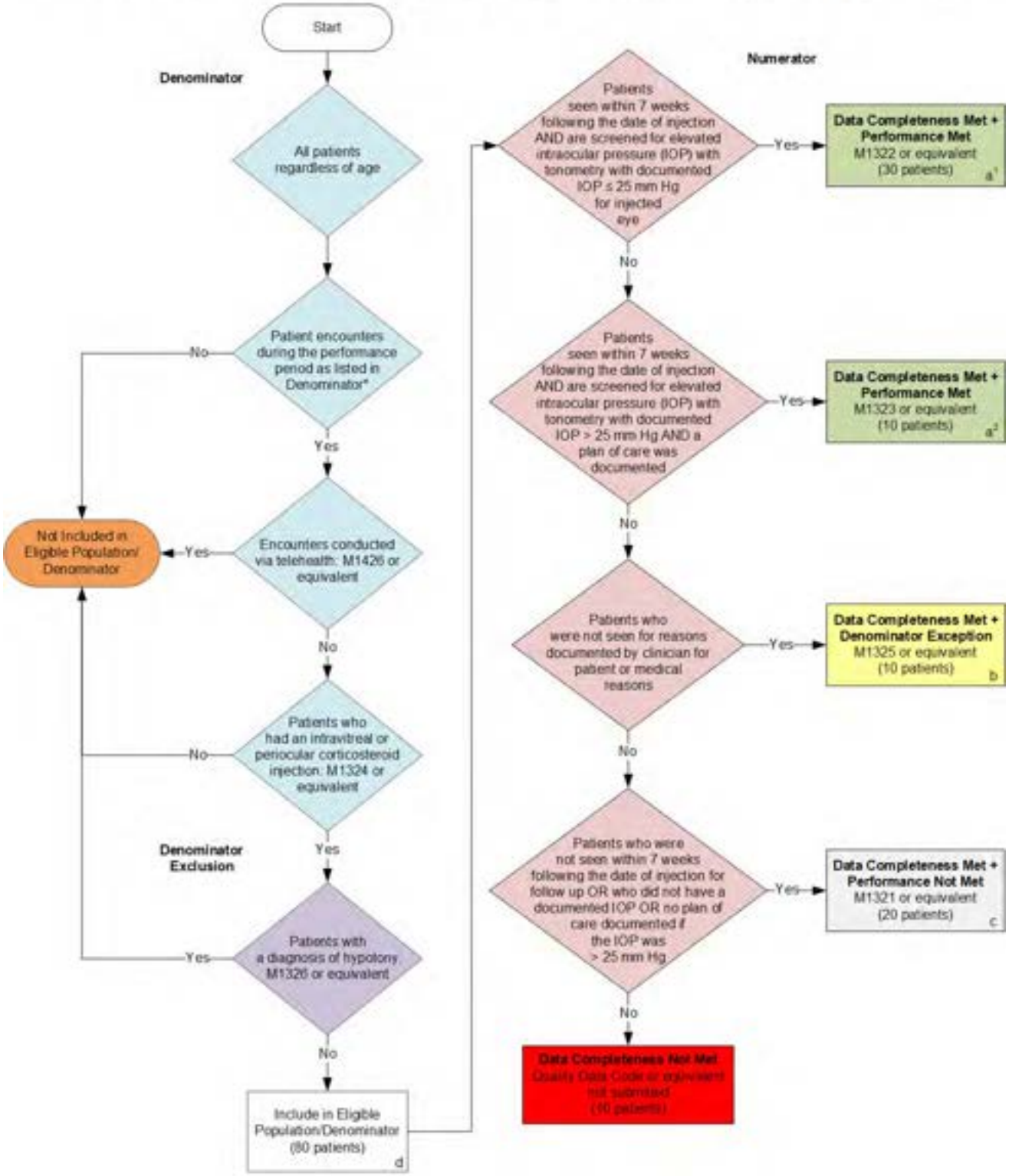
2026 Clinical Quality Measure Flow for Quality ID #499: Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy

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



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SAMPLE CALCULATIONS

Data Completeness =

Performance Met (a^1+a^2=40 patients) + Denominator Exception (b=10 patients) + Performance Not Met (c=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a^1+a^2=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (70 patients) – Denominator Exception (b=10 patients) = 60 patients

*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 #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*.

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- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 30 patients in the Sample Calculation.

b. If *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 a^2 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*.

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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

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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.

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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.

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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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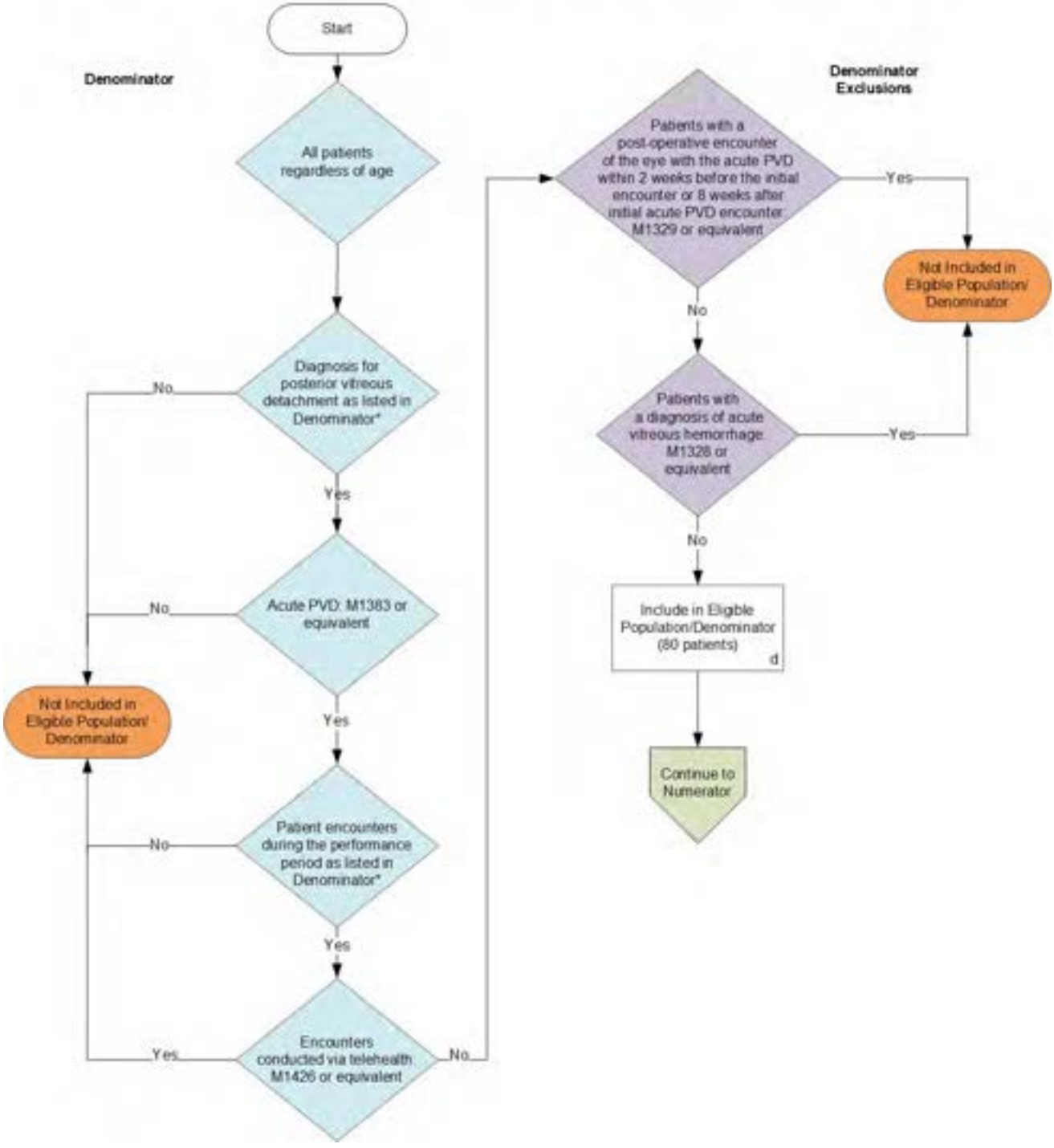
2026 Clinical Quality Measure Flow for Quality ID #500: Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up

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



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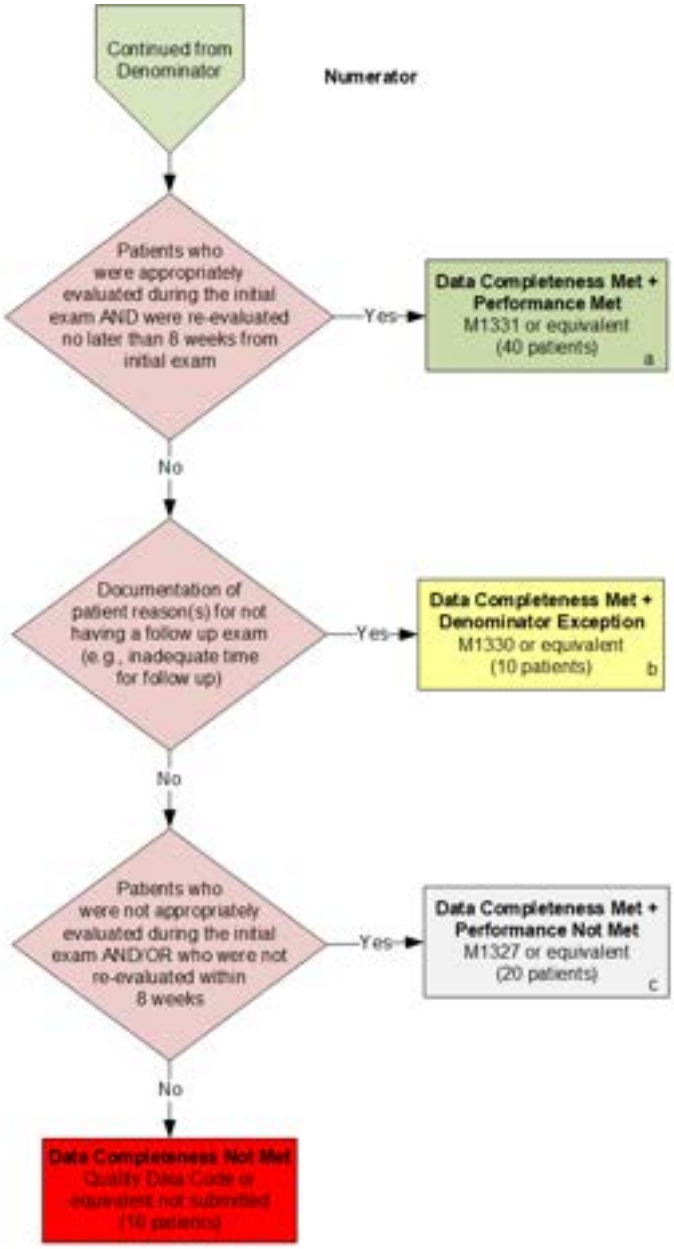

SAMPLE CALCULATIONS

Data Completeness =

Performance Met (a=40 patients) + Denominator Exception (b=10 patients) + Performance Not Met (c=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (70 patients) – Denominator Exception (b=10 patients) = 60 patients

*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 #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.

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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.

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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.

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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.

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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

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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.

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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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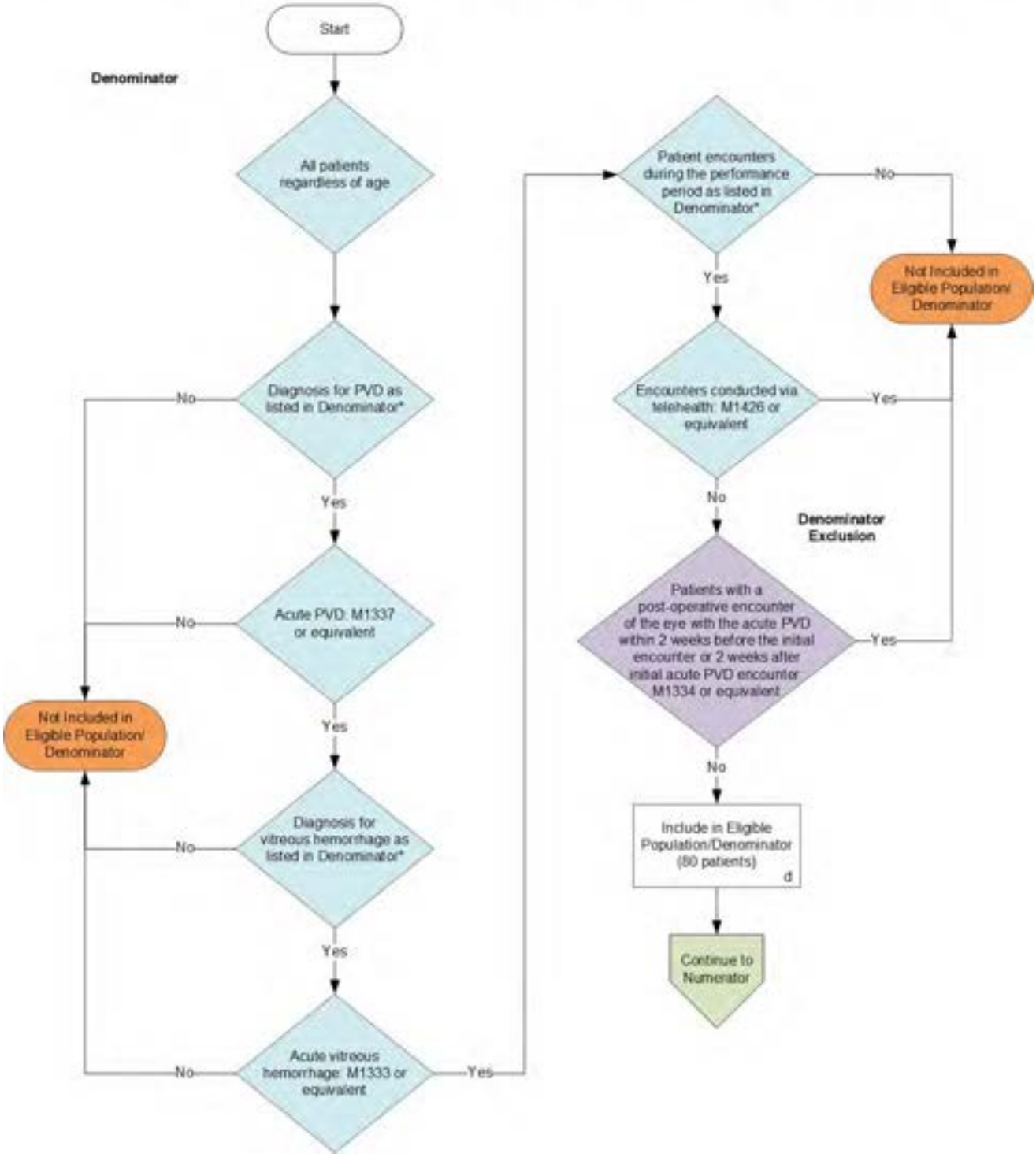
2026 Clinical Quality Measure Flow for Quality ID #501: Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up

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



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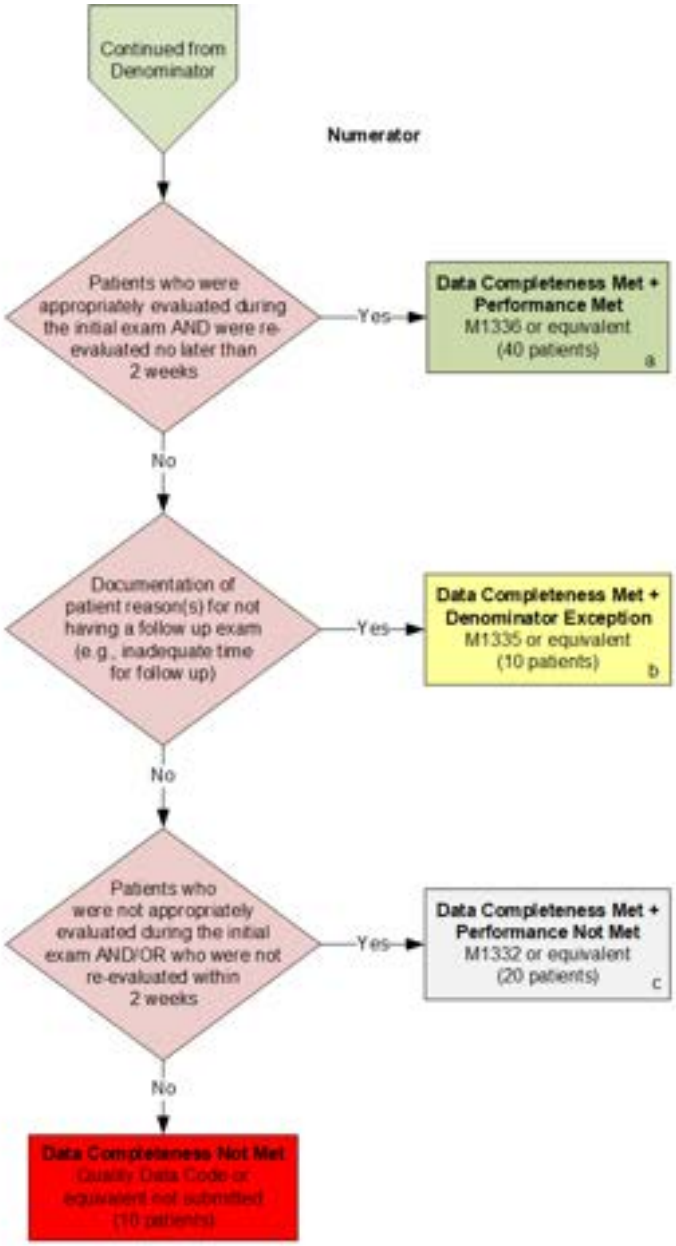

SAMPLE CALCULATIONS

Data Completeness =

Performance Met (a=40 patients) + Denominator Exception (b=10 patients) + Performance Not Met (c=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (70 patients) – Denominator Exception (b=10 patients) = 60 patients

*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

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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-

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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.

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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.

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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

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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

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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) =
Performance Met (a^1=40 patients) + Denominator Exception (b^1=10 patients) + Performance Not Met (c^1=20 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Overall Performance Rate (Submission Criteria 1)=
Performance Met (a^1=40 patients) = 40 patients = **66.67%**
Data Completeness Numerator (70 patients) – Denominator Exception (b^1=10 patients) = 60 patients

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

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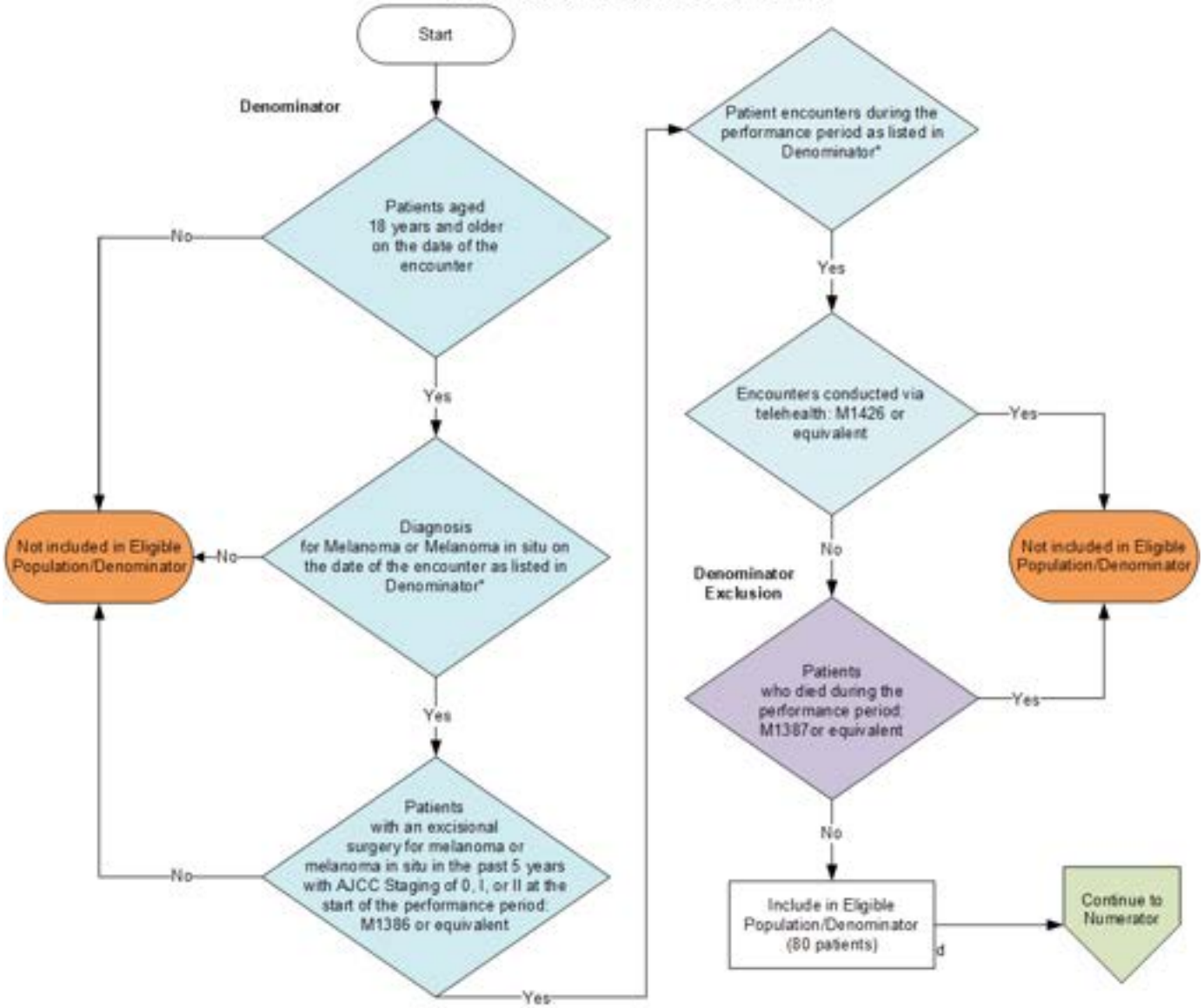
Submission Criteria One and Two



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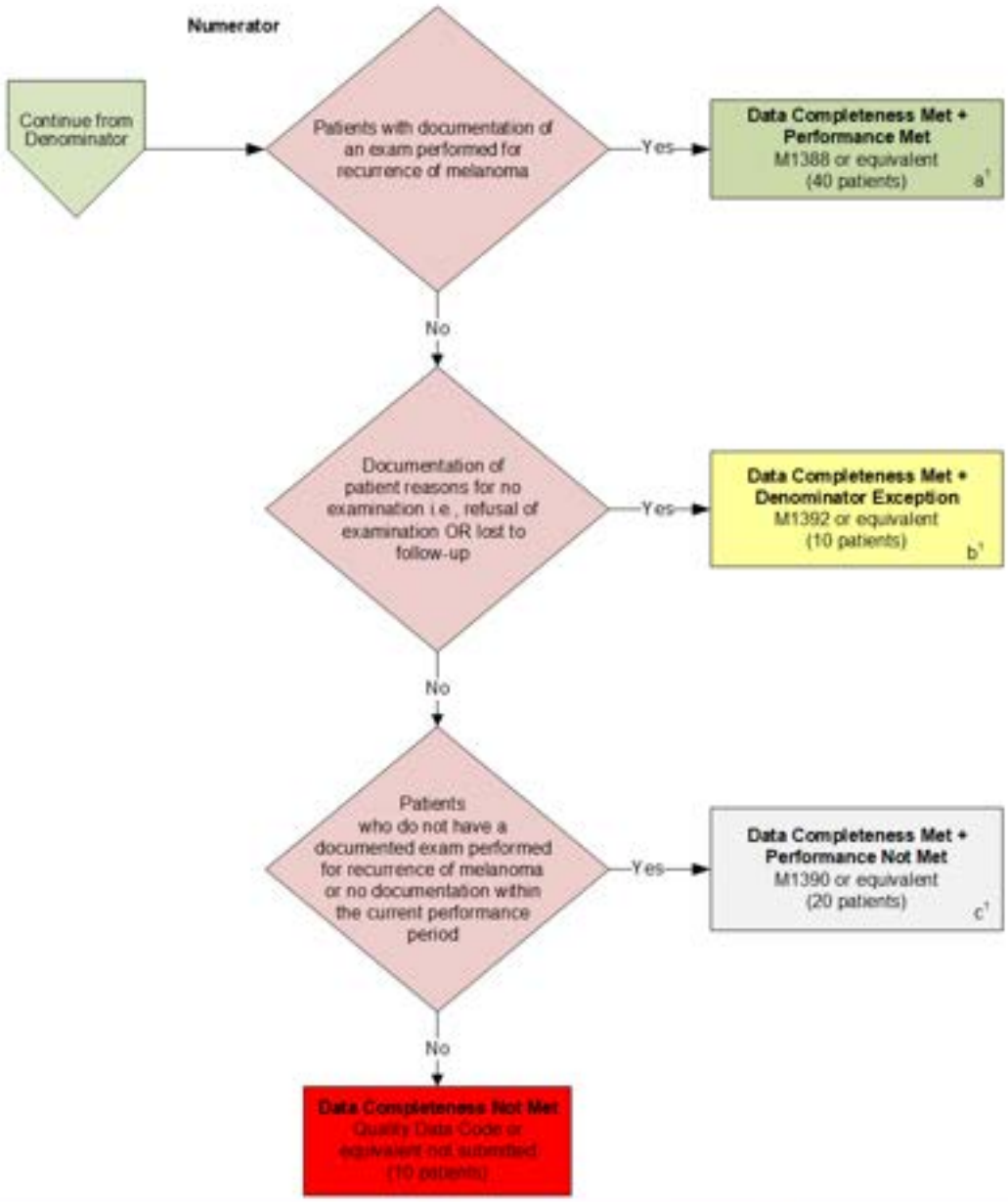
Submission Criteria One



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness*

Performance Met (a^1=40 patients) + Denominator Exception (b^1=10 patients) + Performance Not Met (c^1=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate*

Performance Met (a^1=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (70 patients) – Denominator Exception (b^1=10 patients) = 60 patients

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

NOTE: Submission Frequency: Patient-Process

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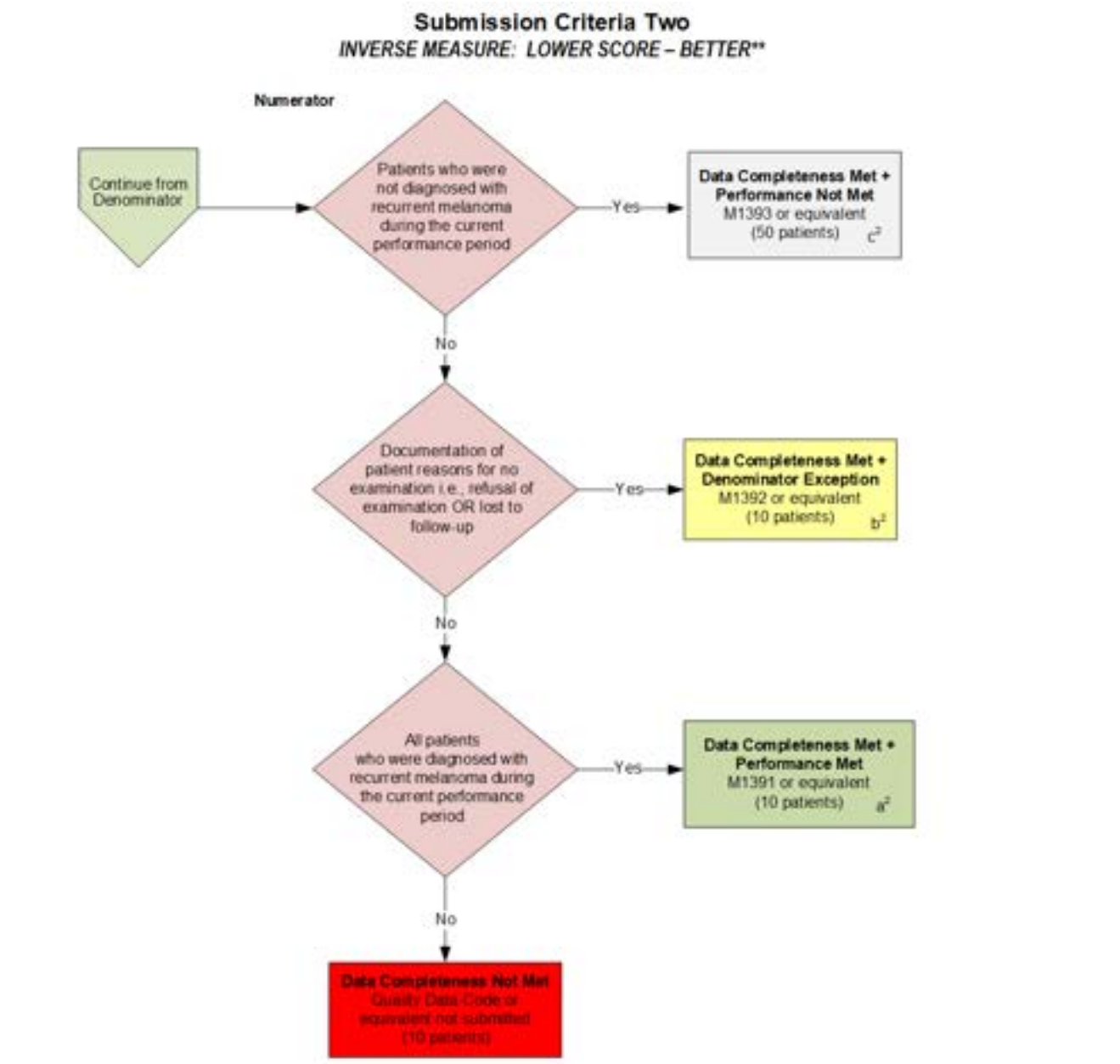

SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness*

Performance Met (a^2=10 patients) + Denominator Exception (b^2=10 patients) + Performance Not Met (c^2=50 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate*

Performance Met (a^2=10 patients) = 10 patients = **16.67%**

Data Completeness Numerator (70 patients) – Denominator Exception (b^2=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:

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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**

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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 a^1 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 b^1 equals 10 patients in the Sample Calculation.

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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 c^1 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 (a^1 equals 40 patients) plus Denominator Exception (b^1 equals 10 patients) plus Performance Met (c^1 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 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b^1 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure 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.

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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.

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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

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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.

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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

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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

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years or older (D recommendation)

REFERENCES:

Matsuda PN, Verrall AM, Finlayson ML, Molton IR, Jensen MP. Falls among adults aging with disability. Arch Phys Med Rehabil 2015; 96:464-71.

BG, Munneke M. Falls in patients with neuromuscular disorders. J Neurol Sci 2006; 251:87-90.

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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.

Carvalho GF, Almeida CS, Florencio LL, et al. Do patients with migraine experience an increased prevalence of falls and fear of falling? A cross-sectional study. Physiotherapy 2018; 104:424-429.

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)*=

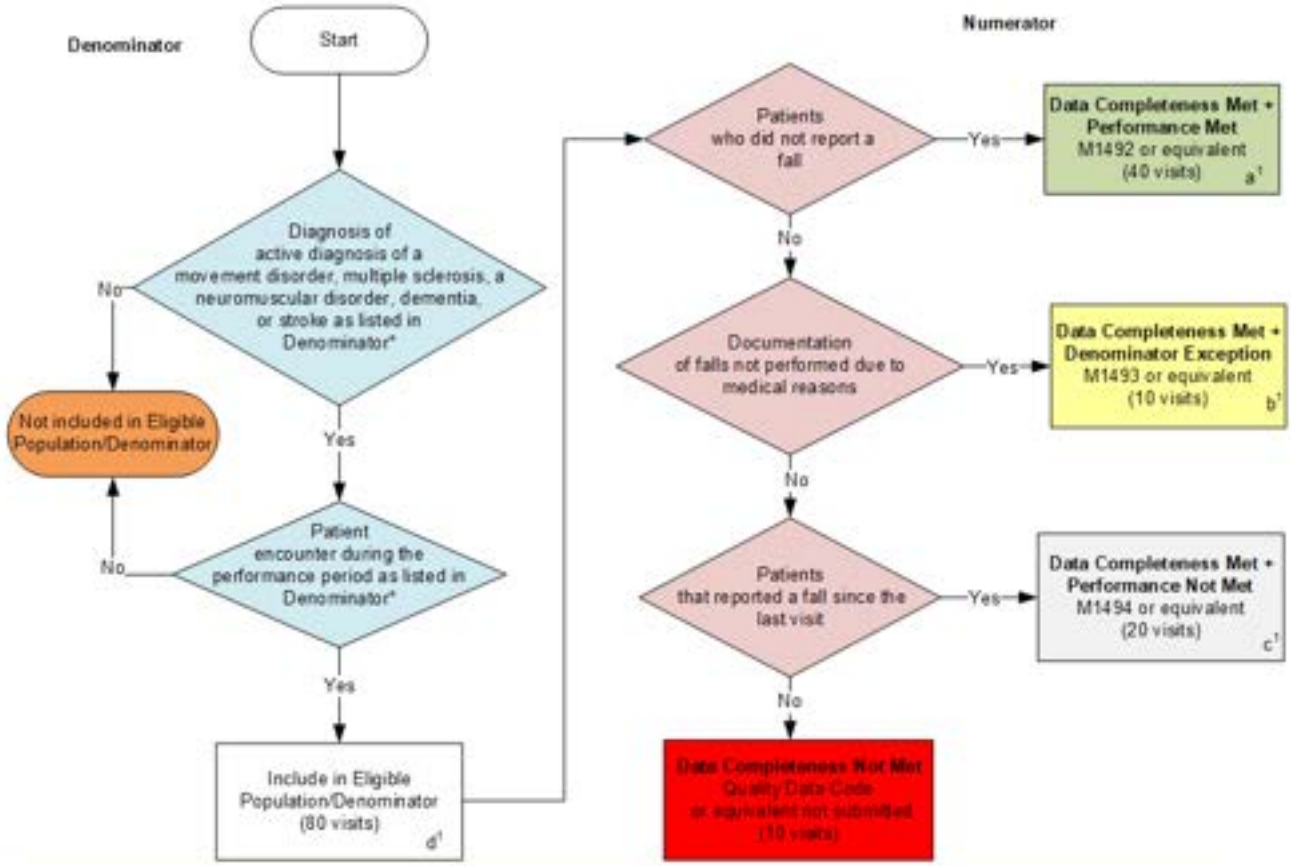
Performance Met (a^1=40 visits) + Denominator Exception (b^1 = 10 visits) +Performance Not Met (c^1=20 visits) / Eligible Population / Denominator (d^1=80 visits) = 70 visits / 80 visits = **87.50%**

Overall Performance Rate (Submission Criteria 2)*=

Performance Met (a^2=40 visits) / Data Completeness Numerator (70 visits) – Denominator Exception (b^2 = 10) = 40 visits / 60 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=

Performance Met (a^1=40 visits) + Denominator Exception (b^1 = 10 visits) +Performance Not Met (c^1=20 visits) / Eligible Population / Denominator (d^1=80 visits) = 70 visits / 80 visits = **87.50%**

Performance Rate=

Performance Met (a^1=40 visits) / Data Completeness Numerator (70 visits) – Denominator Exception (b^1 = 10 visits) = 40 visits / 60 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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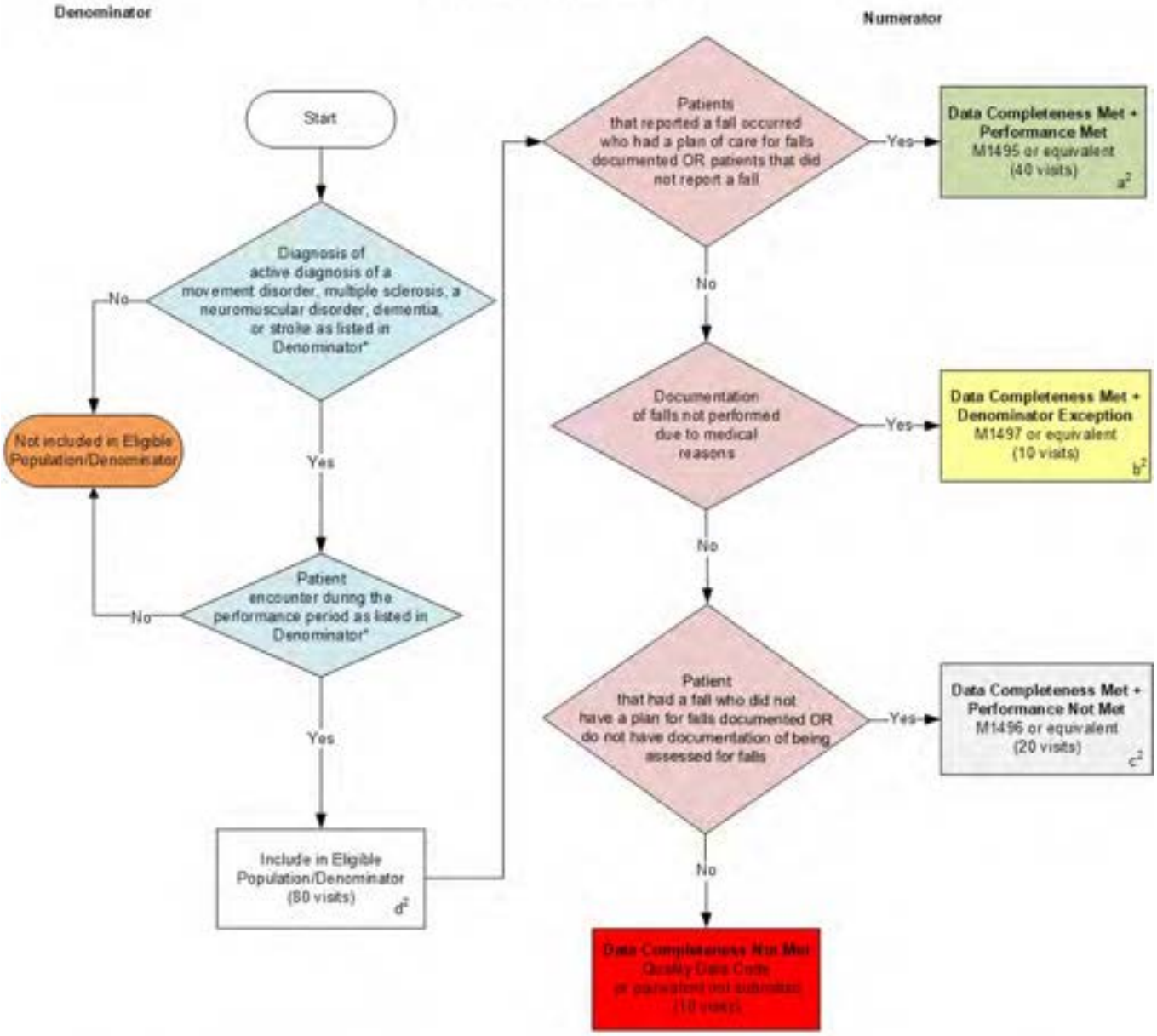
Submission Criteria Two



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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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 (a^1 equals 40 patients) plus Denominator Exceptions (b^1 equals 10 patients) plus Performance Not Met (c^1 equals 20 patients) divided by Eligible Population/Denominator (d^1 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Overall Performance Rate (Submission Criteria 2) Performance Met (a^2 equals 40 patients) divided by Data Completeness Numerator (b^2 equals 10 patients) minus Denominator Exceptions (b^2 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

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

NOTE: Submission Frequency: 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 d^1 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.*

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- *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 40 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 b^1 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 c^1 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 (a^1 equals 40 patients) plus Denominator Exceptions (b^1 equals 10 patients) plus Performance Not Met (c^1 equals 20 patients) divided by Eligible Population/Denominator (d^1 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 equals 40 patients) divided by Data Completeness Numerator (equals 70 patients) minus Denominator Exceptions (b^1 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

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

NOTE: Submission Frequency: 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:

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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 d^2 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 a^2 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 b^2 equals 10 patients in the Sample Calculation.

    b. If *Documentation of falls not performed due to medical reasons* equals No, proceed to

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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 c^2 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 (a^2 equals 40 patients) plus Denominator Exceptions (b^2 equals 10 patients) plus Performance Not Met (c^2 equals 20 patients) divided by Eligible Population/Denominator (d^2 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^2 equals 40 patients) divided by Data Completeness Numerator (b^2 equals 10 patients) minus Denominator Exceptions (b^2 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

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

NOTE: Submission Frequency: 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.

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