Quality ID #497: Preventive Care and Wellness (Composite)

2024 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients who received age- and sex-appropriate preventive screenings and wellness services. This measure is a composite of seven component measures that are based on recommendations for preventive care by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), American Association of Clinical Endocrinology (AACE), and American College of Endocrinology (ACE).

INSTRUCTIONS:
This composite measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. However, the individual performance rates have different submission frequencies. This composite measure is intended to reflect the quality of services provided for preventative care and wellness. This composite 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. For accountability reporting in the CMS MIPS program, all seven performance rates must be submitted, and a weighted average will be used for performance.

This measure will be calculated with 7 performance rates:

1) Percentage of patients who received an influenza immunization or who reported previous receipt of an influenza immunization
2) Percentage of patients who received a pneumococcal vaccination on or after their 60th birthday
3) Percentage of patients with a mammogram during the 27 months prior to the end of the measurement period
4) Percentage of patients with one or more appropriate colorectal cancer screenings
5) Percentage of patients with a documented BMI, with follow-up plan if applicable, during the encounter or during the previous 12 months
6) Percentage of patients screened for tobacco use and, if identified as a tobacco user, received cessation intervention during the encounter or within the previous six months
7) Percentage of visits where patients were screened for high blood pressure with a documented follow-up plan, as indicated

NOTE: *Patient encounters for this measure conducted via telehealth (including but not limited to encounters coded with GQ, GT, 95, POS 02, POS 10) are allowable except for Submission Criteria 5 and Submission Criteria 7.*

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third-party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third-party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third-party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

SUBMISSION CRITERIA 1: ALL PATIENTS WHO WERE SCREENED FOR INFLUENZA VACCINATION

DENOMINATOR (SUBMISSION CRITERIA 1):
All patients aged 6 months and older seen for a visit during the measurement period

DENOMINATOR NOTE: *For the purposes of the program, in order to submit on the flu season 2023-2024, the patient must have a qualifying encounter between January 1 and March 31, 2024. In order to submit on the flu season 2024-2025, the patient must have a qualifying encounter between October 1 and December 31, 2024. A qualifying encounter needs to occur within the flu season that is being submitted; any additional encounter(s) may occur at any time within the measurement 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 1):
Patients aged ≥ 6 months
AND
Patient encounter during January thru March and/or October thru December (CPT or HCPCS): 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 98980, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381*, 99382*, 99383*, 99384*, 99385*, 99386*, 99387*, 99391*, 99392*, 99393*, 99394*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99421, 99422, 99423, 99429*, 99457, 99512*, G0438, G0439, G2250, G2251, G2252
AND NOT
DENOMINATOR EXCLUSIONS:
Hospice services provided to patient any time during the measurement period: M1303
OR
Anaphylaxis due to the vaccine on or before the date of the encounter: M1311

NUMERATOR (SUBMISSION CRITERIA 1):
Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

Definition:
Previous Receipt – Receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

Numerator Instructions:
The numerator for this measure can be met by submitting either administration of an influenza vaccination or that the patient reported previous receipt of the current season's influenza immunization. If the performance of the numerator is not met, a MIPS eligible clinician can submit a valid denominator exception for having not administered an influenza vaccination. For MIPS eligible clinicians submitting a denominator exception for this measure, there should be a clear rationale and documented reason for not administering an influenza immunization if the patient did not indicate previous receipt, which could include a medical reason (e.g., patient allergy), patient reason (e.g., patient declined), or system reason (e.g., vaccination not available). The system reason should be indicated only for cases of disruption or shortage of influenza vaccination supply.

NUMERATOR NOTE: *Denominator Exception(s) are determined at the time of the denominator eligible encounter during the current flu season.*

Numerator Options:

Performance Met: Influenza immunization administered or previously received **(M1299)**

OR

Denominator Exception: Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons) **(M1300)**

OR

Performance Not Met: Influenza immunization was not administered, reason not given **(M1308)**

AND

SUBMISSION CRITERIA 2: ALL PATIENTS WHO WERE SCREENED FOR PNEUMOCOCCAL VACCINATION STATUS FOR OLDER ADULTS

DENOMINATOR (SUBMISSION CRITERIA 2):
Patients 65 years of age and older with a visit during the measurement period

DENOMINATOR NOTE: **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 90945, 90947, 90960, 90961, 90962, 90966, 90970, 98980, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99387*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99421, 99422, 99423, 99429*, 99457, 99512*, G0438, G0439, G2250, G2251, G2252
AND NOT
DENOMINATOR EXCLUSIONS:
Patient had anaphylaxis due to the pneumococcal vaccine any time during or before the measurement period: M1306
OR
Hospice services provided to patient any time during the measurement period: M1303

NUMERATOR (SUBMISSION CRITERIA 2):
Patients who were administered any pneumococcal conjugate vaccine or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period

NUMERATOR NOTE: *The measure provides credit for adults 65 years of age and older who have received any pneumococcal vaccine on or after the patient's 19th birthday.*
Patient reported vaccine receipt, when recorded in the medical record, is acceptable for meeting the numerator.

Numerator Options:

Performance Met: Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period **(M1305)**

OR

Performance Not Met: Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period **(M1304)**

AND

SUBMISSION CRITERIA 3: ALL PATIENTS WHO WERE SCREENED FOR BREAST CANCER

DENOMINATOR (SUBMISSION CRITERIA 3):
Women 41-74 years of age with a visit during the measurement period

***DENOMINATOR NOTE*:** *The intent of this measure component is that starting at age 40 women should have one or more mammograms every 24 months with a 3-month grace period. The intent of the exclusion for individuals age 66 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 exclusion allows clinicians to engage in shared decision making with patients about the benefits and risks of screening when an individual has limited life expectancy.*

*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 41 to 74 years of age at the beginning of the measurement period
AND
Patient encounter during the performance period (CPT or HCPCS): 98980, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99386*, 99387*, 99396*, 99397*, 99421, 99422, 99423, 99457, G0438, G0439, G2250, G2251, G2252
AND NOT
DENOMINATOR EXCLUSIONS:
Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy: M1280
OR
Hospice services provided to patient any time during the measurement period: M1303
OR
Palliative care services provided to patient any time during the measurement period: M1309
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: M1284
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: M1291
OR
Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period: M1292

Table: Dementia Exclusion Medications

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

Codes to identify Frailty (CPT, HCPCS or ICD-10-CM): 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, 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

Codes to identify Advanced Illness (ICD-10-CM): 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, G20.A1, G20.A2, G20.B1, G20.B2, G20.C, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.170, J84.178, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6

NUMERATOR (SUBMISSION CRITERIA 3):
Women with one or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period

Definition:
Mammography screening is defined by a bilateral screening (both breasts) of breast tissue. If only one breast is present, unilateral screening (one side) must be performed on the remaining breast.

Numerator Instructions:
This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening.

Please note the measure may include screenings performed outside the age range of patients referenced in the initial population. Screenings that occur prior to the measurement period are valid to meet measure criteria.

NUMERATOR NOTE: *Patient reported mammograms, when recorded in the medical record, are acceptable for meeting the numerator.*

Numerator Options:

Performance Met:	Screening, diagnostic, film digital or digital breast Tomosynthesis (3D) mammography results documented and reviewed **(M1302)**
OR	
Performance Not Met:	Screening, diagnostic, film, digital or digital breast Tomosynthesis (3D) mammography results were not documented and reviewed, reason not otherwise specified **(M1285)**

AND

SUBMISSION CRITERIA 4: ALL PATIENTS WHO WERE SCREENED FOR COLORECTAL CANCER SCREENING

DENOMINATOR (SUBMISSION CRITERIA 4):
Patients 45-75 years of age 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 45 to 75 years of age on date of encounter

AND

Patient encounter during the performance period (CPT or HCPCS): 98980, 99202, 99203, 99204, 99205,99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99386*, 99387*, 99396*, 99397*, 99421, 99422, 99423, 99457, G0438, G0439, G2250, G2251, G2252

AND NOT

DENOMINATOR EXCLUSIONS:

Patients with a diagnosis or past history of total colectomy or colorectal cancer: M1295

OR

Hospice services provided to patient any time during the measurement period: M1303

OR

Palliative care services provided to patient any time during the measurement period: M1309

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: M1284

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: M1291

OR

Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period: M1292

Table: Dementia Exclusion Medications

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

Codes to identify Frailty (CPT, HCPCS or ICD-10-CM): 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, 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

Codes to identify Advanced Illness (ICD-10-CM): 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, G20.A1, G20.A2, G20.B1, G20.B2, G20.C, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, I09.81, I11.0, I12.0, I13.0, I13.11, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, J43.0, J43.1, J43.2, J43.8, J43.9, J68.4, J84.10, J84.112, J84.170, J84.178, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92, J98.2, J98.3, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9, K74.00, K74.01, K74.02, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69, N18.5, N18.6

NUMERATOR (SUBMISSION CRITERIA 4):

Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period
- Computed tomography (CT) colonography during the measurement period or the four years prior to the measurement period
- Stool DNA (sDNA) with FIT test during the measurement period or the two years prior to the measurement period

NUMERATOR GUIDANCE

Do not count digital rectal exam (DRE)-acquired fecal occult blood tests (FOBTs) performed in an office setting or performed on a sample collected via DRE.

Please note the measure may include screenings performed outside the age range of patients referenced in the initial population. Screenings that occur prior to the measurement period are valid to meet measure criteria.

NUMERATOR NOTE: *Patient reported procedures and diagnostic studies, when recorded in the medical record, are acceptable for meeting the numerator.*

Numerator Options:

Performance Met:	Colorectal cancer screening results documented and reviewed **(M1277)**
OR	
Performance Not Met:	Colorectal cancer screening results were not documented and reviewed; reason not otherwise specified **(M1315)**

AND

SUBMISSION CRITERIA 5: ALL PATIENTS WHO WERE SCREENED FOR BODY MASS INDEX (BMI): SCREENING AND FOLLOW-UP PLAN

DENOMINATOR (SUBMISSION CRITERIA 5):
All patients aged 18 and older on the date of the encounter with at least one qualifying encounter during the measurement period

Definition:
Not Eligible for BMI Screening or Follow-Up Plan (Denominator Exclusions) – A patient is not eligible if one or more of the following reasons are documented:

- Patients receiving palliative or hospice care on the date of the current encounter or any time prior to the current encounter
- Patients who are pregnant on the date of the current encounter or any time during the measurement period prior to the current encounter

DENOMINATOR NOTE**:** **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):
Patients aged ≥18 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97802, 97803, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99236, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99424, 99491, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447, G0473
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02, POS 10, FQ, 93
WITHOUT
Place of Service (POS): 12
AND NOT
DENOMINATOR EXCLUSIONS:
Documentation stating the patient has received or is currently receiving palliative or hospice care: M1307
OR
Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter: M1298

NUMERATOR (SUBMISSION CRITERIA 5):
Patients with a documented BMI during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the encounter

Definitions:
Normal BMI Parameters – Age 18 years and older BMI ≥ 18.5 and < 25 kg/m2
BMI – Body mass index (BMI) is a number calculated using the Quetelet index: weight divided by height squared (W/H2) and is commonly used to classify weight categories. "BMI" can be calculated using:

Metric Units: BMI = Weight (kg) / (Height (m) x Height (m))
OR
English Units: BMI = Weight (lbs) / (Height (in) x Height (in)) x 703

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI outside of normal parameters. A "follow-up plan" may include, but is not limited to:

- Documentation of education
- Referral (for example a Registered Dietitian Nutritionist (RDN), occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), for lifestyle/behavioral therapy
- Pharmacological interventions
- Dietary supplements
- Exercise counseling
- Nutrition counseling

Patients with a Documented Reason for Not Screening BMI (Denominator Exception) –
Patient Reason:

- Patients who refuse measurement of height and/or weight on the date of the current encounter or any time during the measurement period prior to the current encounter.

OR

Medical Reason:

- Patients with a documented medical reason for not documenting BMI such as patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Patients with a Documented Reason for Not Documenting a Follow-up Plan for BMI Outside Normal Parameters (Denominator Exception) –
Medical Reason(s):

- Patients (e.g., elderly patients 65 years of age or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as illness or physical disability, mental illness, dementia, confusion, or nutritional deficiency such as vitamin/mineral deficiency; patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Numerator Instructions:

- **Height and Weight** – An eligible clinician or their staff is required to measure both height and weight. Both height and weight must be measured within twelve months of the current encounter. Self-reported values cannot be used.
  - The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider.
  - If more than one BMI is reported during the measurement period, the most recent BMI will be used to determine if the performance has been met.
- **Follow-Up Plan** – If the most recent documented BMI is outside of normal parameters, then a follow- up plan is documented during the encounter or during the previous twelve months of the current encounter. The documented follow-up plan must be based on the most recent documented

BMI, outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above or below normal parameters". (See Definitions for examples of follow-up plan treatments).

- **Performance Met for M1293 & M1287**
  - If the provider documents a BMI and a follow-up plan for a BMI outside normal parameters at the current encounter **OR**
  - If the patient has a documented BMI within the previous twelve months of the current encounter, the provider documents a follow-up plan for a BMI outside normal parameters at the current encounter **OR**
  - If the patient has a documented BMI within the previous twelve months of the current encounter **AND** the patient has a documented follow-up plan for a BMI outside normal parameters within the previous twelve months of the current encounter

Numerator Options:

Performance Met:	BMI is documented within normal parameters and no follow-up plan is required **(M1296)**
OR	
Performance Met:	BMI is documented above normal parameters and a follow-up plan is documented **(M1293)**
OR	
Performance Met:	BMI is documented below normal parameters and a follow-up plan is documented **(M1287)**
OR	
Denominator Exception:	BMI not documented due to medical reason OR patient refusal of height or weight measurement **(M1297)**
OR	
Denominator Exception:	BMI is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason **(M1286)**
OR	
Performance Not Met:	BMI not documented and no reason is given **(M1314)**
OR	
Performance Not Met:	BMI documented outside normal parameters, no follow-up plan documented, no reason given **(M1276)**

AND

SUBMISSION CRITERIA 6: ALL PATIENTS WHO WERE SCREENED FOR TOBACCO USE: SCREENING AND CESSATION INTERVENTION

Submission Criteria 6 will be calculated with 3 performance rates:

A. Percentage of patients aged 12 years and older who were screened for tobacco use one or more times within the measurement period
B. Percentage of patients aged 12 years and older who were identified as a tobacco user during the measurement period who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period
C. 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 denominator of Submission Criteria 6b is a subset of the resulting numerator for Submission Criteria 6a, as Submission Criteria 6b is limited to assessing if patients identified as tobacco users received an appropriate tobacco cessation intervention. For all patients, Submission Criteria 6a and 6c are applicable, but Submission Criteria 6b will only be applicable for those patients who are identified as tobacco users. Therefore, data for every patient that meets the age and encounter requirements will only be submitted for Submission Criteria 6a and 6c, whereas data submitted

for Submission Criteria 6b will be for a subset of patients who meet the age and encounter requirements, as the denominator has been further limited to those who were identified as tobacco users.

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. For accountability reporting in the CMS MIPS program, the rate for Submission Criteria 6b is used for the composite performance rate. For the purposes of submitting Submission Criteria 6, use the data completeness determined in Submission Criteria 6a.

DENOMINATOR (SUBMISSION CRITERIA 6 – PERFORMANCE RATE A):
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, 98980, 99024, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99421, 99422, 99423, 99457, 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*, G0438, G0439
AND NOT
DENOMINATOR EXCLUSION:
Hospice services provided to patient any time during the measurement period: M1303

NUMERATOR (SUBMISSION CRITERIA 6 – PERFORMANCE RATE A):
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 M1312.

Numerator Options:

Performance Met:	Patient screened for tobacco use AND identified as a tobacco user **(M1283)**
OR	
Performance Met:	Patient screened for tobacco use AND identified as a tobacco non-user **(M1282)**
OR	
Performance Not Met:	Patient not screened for tobacco use **(M1312)**

DENOMINATOR (SUBMISSION CRITERIA 6 – PERFORMANCE RATE B):
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 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
All eligible instances when **M1283** is submitted for Performance Met (patient screened for tobacco use and identified as a tobacco user) in the numerator of Submission Criteria 6 – Performance Rate A
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, 98980, 99024, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99421, 99422, 99423, 99457, 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*, G0438, G0439
AND NOT
DENOMINATOR EXCLUSION:
Hospice services provided to patient any time during the measurement period: M1303

NUMERATOR (SUBMISSION CRITERIA 6 – PERFORMANCE RATE B):
Patients who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period

Definition:
Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy. Note: Concepts aligned with brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) are included in the numerator. Other concepts such as written

self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Counseling also may be of longer duration or be performed more frequently, as evidence shows that higher-intensity interventions are associated with higher tobacco cessation rates (U.S. Preventive Services Task Force, 2021).

NUMERATOR NOTE: *If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.*

This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code M1301.

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) **(M1301)**
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) **(M1289)**

DENOMINATOR (SUBMISSION CRITERIA 6 – PERFORMANCE RATE C):
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, 98980, 99024, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99421, 99422, 99423, 99457, 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*, G0438, G0439
AND NOT
DENOMINATOR EXCLUSION:
Hospice services provided to patient any time during the measurement period: M1303

NUMERATOR (SUBMISSION CRITERIA 6 – PERFORMANCE RATE C):
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 – Includes any type of tobacco.

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 M1313.

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 M1310.

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 **(M1310)**
OR	
Performance Met:	Current tobacco non-user **(M1316)**

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 **(M1313)**

AND

SUBMISSION CRITERIA 7: ALL PATIENTS WHO WERE SCREENED FOR HIGH BLOOD PRESSURE AND FOLLOW-UP DOCUMENTED

DENOMINATOR (SUBMISSION CRITERIA 7):
All patient visits for patients aged 18 years and older at the beginning of the measurement period

Definition:
Not Eligible for High Blood Pressure Screening (Denominator Exclusion) – Patient has an active diagnosis of hypertension prior to the current encounter

***DENOMINATOR NOTE*:** **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years at the beginning of the measurement period
AND
Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92546, 92622, 92625, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99236, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99424, 99491, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, G0101, G0402, G0438, G0439
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02, POS 10, FQ, 93
AND NOT
DENOMINATOR EXCLUSION:
Patient not eligible due to active diagnosis of hypertension: M1290

NUMERATOR (SUBMISSION CRITERIA 7):
Patient visits where patients were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is elevated or hypertensive

Definitions:
Blood Pressure (BP) Classification – BP is defined by four (4) BP reading classifications: Normal, Elevated, First Hypertensive, and Second Hypertensive Readings

- Normal BP: Systolic BP (SBP) < 120 mmHg AND Diastolic BP (DBP) < 80 mmHg
- Elevated BP: SBP of 120-129 mmHg AND DBP < 80 mmHg
- First Hypertensive Reading: SBP of ≥130 mmHg OR DBP of ≥ 80 mmHg without a previous SBP of ≥ 130 mmHg OR DBP of ≥ 80 mmHg during the 12 months prior to the encounter
- Second Hypertensive Reading: Requires a SBP ≥ 130 mmHg OR DBP ≥ 80 mmHg during the current encounter AND a most recent BP reading within the last 12 months SBP ≥ 130 mmHg OR DBP ≥ 80 mmHg

Recommended BP Follow-Up – The 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults from the American College of Cardiology and American Heart Association (2017 Guideline) recommends BP screening and thresholds as defined under Blood Pressure

Classifications and recommends interventions based on the current BP reading as listed in the "Recommended Blood Pressure Follow- Up" Table below.

Recommended Nonpharmacologic Interventions (Lifestyle Modifications) – The 2017 Guideline outlines nonpharmacologic interventions which must include one or more of the following as indicated:

- Weight Reduction
- 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 in 2 to 6 months **AND** recommended nonpharmacologic interventions **OR** Referral to Alternate/Primary Care Provider
First Hypertensive BP Reading	≥ 130	OR ≥ 80	Rescreen BP > 1 day and < 4 weeks **AND** recommended nonpharmacologic interventions **OR** Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	130-139 and NOT ≥ 140	OR 80-89 and NOT ≥ 90	Recommended nonpharmacologic intervention **AND** reassessment in 2 to 6 months **AND** an order for laboratory test or ECG for hypertension **OR** Referral to Alternate/Primary Care Provider
Second Hypertensive BP Reading	≥ 140	OR ≥ 90	Recommended nonpharmacologic intervention **AND** BP-lowering medication **AND** reassessment within 4 weeks **AND** an order for laboratory test or ECG for hypertension **OR** Referral to Alternate/Primary Care Provider

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

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

NUMERATOR NOTE: *Although the recommended screening interval for a normal BP reading is every year, to meet the intent of this measure, BP screening and follow-up must be performed at every patient visit. For patients with Normal blood pressure, a follow-up plan is not required (M1294). Denominator Exception(s) are determined on the date of the denominator eligible encounter.*

Numerator Options:

Performance Met:	Normal blood pressure reading documented, follow-up not required **(M1294)**
OR	
Performance Met:	Elevated or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented **(M1278)**
OR	
Denominator Exception:	Documented reason for not screening or recommending a follow-up for high blood pressure **(M1288)**
OR	
Performance Not Met:	Blood pressure reading not documented, reason not given **(M1281)**
OR	
Performance Not Met:	Elevated or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given **(M1279)**

RATIONALE:

With rising rates of certain chronic conditions in the general population, wellness and preventive care have become increasingly important to improve outcomes and reduce costs. Research shows that performing the preventive services identified in the measure leads to identification of disease earlier in the care process (screenings) or prevention of disease (immunizations), which enables treatment to begin earlier, potentially improving patient outcomes. The composite measure can provide an opportunity for providers and patients to identify and manage a patient's health risks for many preventable conditions. This measure assigns a single performance score reflecting overall eligible clinician delivery of age- and sex-appropriate preventive screenings and wellness services to their patients. The seven services in this measure are (1) influenza vaccination, (2) pneumococcal vaccination, (3) breast cancer screening, (4) colorectal-cancer screening, (5) body mass index screening and follow-up, (6) tobacco use screening and intervention, and (7) screening for high blood pressure and follow-up. The services contained in the measure are recommended by USPSTF, ACIP, and AACE/ACE and apply to the general population (rather than a specific age group with specific risks, for example, older adults with cardiovascular risk). Although increased use of preventive care services may cause a short-term increase in health care costs, it may result in better quality of life and care. A study of preventive services covered under the Affordable Care Act examined the extent to which lives could be saved if adults over 18 received them, including some addressed by this measure. The article states that preventive services ameliorate 9 of the 10 leading causes of death in America and could save at least 100,000 lives (Fox and Shaw 2015). Among the services referenced are screening for breast cancer, colon cancer, blood pressure, diabetes, and tobacco cessation, as well as influenza and pneumococcal vaccination. Higher rates of patient compliance with the appropriate and recommended preventive services could save additional lives and ensure better health outcomes.

Composites can overcome statistical challenges such as small sample sizes while reducing data burden for interpretability (Peterson et al., 2010; Samuel, 2014; van Doorn-Klomberg et al., 2012). Due to the condensed nature of the composite's information, it is more feasible to track a broader, more comprehensive range of metrics than otherwise possible, making composites well suited for pay-for-performance incentives or consumer decisions about clinicians (Peterson et al., 2010). Composite measures are an important strategy to maintain data fidelity as they are more likely to be stable over time, making incentives less sensitive to individual measure performance (Martsolf, 2012; Prentice et al., 2016). Potential implementation of this composite measure not only provides a more

comprehensive assessment of a clinician's performance of preventive care than any single measure, but also provides CMS an opportunity to replace the individual measures in the program with a more robust measure, which aligns with the meaningful measure framework's goal to include fewer, more robust measures in the program overall.

CLINICAL RECOMMENDATION STATEMENTS:

Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications. For each recipient, a licensed and age-appropriate vaccine should be used. Advisory Committee on Immunization Practices (ACIP) makes no preferential recommendation for a specific vaccine when more than one licensed, recommended, and age-appropriate vaccine is available. During the 2022–23 influenza season, the following types of vaccines are expected to be available quadrivalent, containing hemagglutinin (HA) derived from one influenza A(H1N1)pdm09 virus, one influenza A(H3N2) virus, one influenza B/Victoria lineage virus, and one influenza B/Yamagata lineage virus. Inactivated influenza vaccines (IIV4s), recombinant influenza vaccine (RIV4), and live attenuated influenza vaccine (LAIV4) are expected to be available. (CDC/Advisory Committee on Immunization Practices [ACIP], 2022).

Adults aged ≥ 65 years who have not previously received pneumococcal conjugate vaccine (PCV) or whose previous vaccination history is unknown should receive 1 dose of PCV (either PCV20 or PCV15). Adults aged 19–64 years with certain underlying medical conditions or other risk factors who have not previously received PCV or whose previous vaccination history is unknown should receive 1 dose of PCV (either PCV20 or PCV15).

Dosing schedule for PCV15: When PCV15 is used, it should be followed by a dose of PPSV23. The recommended interval between administration of PCV15 and PPSV23 is ≥1 year. A minimum interval of 8 weeks can be considered for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak to minimize the risk for IPD caused by serotypes unique to PPSV23 in these vulnerable groups.

Adults with previous PPSV23 only: Adults who have only received PPSV23 may receive a PCV (either PCV20 or PCV15) ≥1 year after their last PPSV23 dose. When PCV15 is used in those with history of PPSV23 receipt, it need not be followed by another dose of PPSV23.

Adults with previous PCV13: The incremental public health benefits of providing PCV15 or PCV20 to adults who have received PCV13 only or both PCV13 and PPSV23 have not been evaluated. These adults should complete the previously recommended PPSV23 series (Kobayashi et al., 2022).
The CDC further clarifies that the previous pneumococcal recommendations remain in effect pending further evaluation and recommends using the following information for guidance on the number of and interval between any remaining recommended doses of PPSV23 following previous receipt of PCV13 (CDC, 2022).

- For adults 65 years or older without an immunocompromising condition, cerebrospinal fluid leak, or cochlear implant, CDC recommends 1 dose of PPSV23 at age 65 years or older. Administer a single dose of PPSV23 at least 1 year after PCV13 was received. Their pneumococcal vaccinations are complete.

- For adults 19 years or older with a cerebrospinal fluid leak or cochlear implant, CDC recommends 1 dose of PPSV23 before age 65 years and 1 dose of PPSV23 at age 65 years or older. Administer a single dose of PPSV23 at least 8 weeks after PCV13 was received. If the adult is 65 years or older, their pneumococcal vaccinations are complete. If the adult was younger than 65 years old when the first dose of PPSV23 was given, then administer a final dose of PPSV23 once they turn 65 years old and at least 5 years have passed since PPSV23 was first given. Their pneumococcal vaccinations are complete.

- Adults 19 years or older with an immunocompromising condition, CDC recommends 2 doses of PPSV23 before age 65 years and 1 dose of PPSV23 at age 65 years or older. Administer a single dose of PPSV23 at least 8 weeks after PCV13 was received. If the patient was younger than 65 years old when the first dose of PPSV23 was given and has not turned 65 years old yet, administer a second dose of PPSV23 at least 5 years after the first dose of PPSV23. This is the last dose of PPSV23 that should be given prior to 65 years of age. Once the patient turns 65 years old and at least 5 years have passed since PPSV23 was last given, administer a final dose of PPSV23 to complete their pneumococcal vaccinations.

For adults who have received PCV13 but have not completed their recommended pneumococcal vaccine series with PPSV23, one dose of PCV20 may be used if PPSV23 is not available. If PCV20 is used, their pneumococcal vaccinations are complete.

The U.S. Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 40-74 years (B recommendation) (USPSTF, 2023).

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women aged 75 years or older (I statement) (USPSTF, 2023).

The USPSTF concludes that the current evidence is insufficient to assess the benefits and harms of digital breast tomosynthesis (DBT) as a primary screening method for breast cancer (I Statement) (USPSTF, 2016).

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of adjunctive screening for breast cancer using breast ultrasonography, magnetic resonance imaging, in women identified to have dense breasts on an otherwise negative screening mammogram (I statement) (USPSTF, 2023).

The National Comprehensive Cancer Network (NCCN) and the American College of Radiology (ACR) recommend using conventional mammography or DBT for screening women at low, intermediate or high risk for breast cancer (NCCN, 2021) (ACR, 2017).

The U.S. Preventive Services Task Force (2021) recommends screening for colorectal cancer in adults aged 45 to 49 years. This is a Grade B recommendation (U.S. Preventive Services Task Force 2021).

The U.S. Preventive Services Task Force (2021) recommends screening for colorectal cancer in adults aged 50 to 75 years. This is a Grade A recommendation (U.S. Preventive Services Task Force, 2021).

Appropriate screenings are defined by any one of the following:
-Colonoscopy (every 10 years)
-Flexible sigmoidoscopy (every 5 years)
-Fecal occult blood test (annually)
-Stool DNA (sDNA) with FIT test (every 3 years)
-Computed tomographic colonography (every 5 years)

All adults should be screened annually using a BMI measurement. BMI measurements >25kg/m2 should be used to initiate further evaluation of overweight or obesity after taking into account age, gender, ethnicity, fluid status, and muscularity; therefore, clinical evaluation and judgment must be used when BMI is employed as the anthropometric indicator of excess adiposity, particularly in athletes and those with sarcopenia (Garvey, et al., 2016 AACE/ACE Guidelines, 2016. pp. 12-13) (Grade A).

Overweight and Underweight Categories:
Underweight <18.5; Normal weight 18.5-24.9; Overweight 25-29.9; Obese class I 30-34.9; Obese class II 35-39.9; Obese class III >40 (Garvey, et al., 2016 AACE/ACE Guidelines, 2016. p. 15).

BMI cutoff point value of ≥23 kg/m2 should be used in the screening and confirmation of excess adiposity in Asian adults (Garvey, et al., 2016 AACE/ACE Guidelines, 2016,. p. 13) (Grade B).

Lifestyle/Behavioral Therapy for Overweight and Obesity should include behavioral interventions that enhance adherence to prescriptions for a reduced-calorie meal plan and increased physical activity (behavioral interventions can include: self-monitoring of weight, food intake, and physical activity; clear and reasonable goal-setting; education pertaining to obesity, nutrition, and physical activity; face-to-face and group meetings; stimulus control; systematic approaches for problem solving; stress reduction; cognitive restructuring [i.e., cognitive behavioral therapy], motivational interviewing; behavioral contracting; psychological counseling; and mobilization of social support structures) (Garvey, et al., 2016 AACE/ACE Guidelines, 2016. p. 22) (Grade A).

Behavioral lifestyle intervention should be tailored to a patient's ethnic, cultural, socioeconomic, and educational background (Garvey, et al., 2016 AACE/ACE Guidelines, 2016. p. 22) (Grade B).

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians offer or refer adults with a BMI of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.

Interventions:

- Effective intensive behavioral interventions were designed to help participants achieve or maintain a weight loss of at least five percent through a combination of dietary changes and increased physical activity
- Most interventions lasted for one to two years, and the majority had at least 12 sessions in the first year
- Most behavioral interventions focused on problem solving to identify barriers, self-monitoring of weight, peer support, and relapse prevention
- Interventions also provided tools to support weight loss or weight loss maintenance (e.g., pedometers, food scales, or exercise videos) (Grade B) (USPSTF, 2018).

Nutritional safety for the elderly should be considered when recommending weight reduction. "A clinical decision to forego obesity treatment in older adults should be guided by an evaluation of the potential benefits of weight reduction for day-to-day functioning and reduction of the risk of future cardiovascular events, as well as the patient's motivation for weight reduction. Care must be taken to ensure that any weight reduction program minimizes the likelihood of adverse effects on bone health or other aspects of nutritional status" (NHLBI Obesity Education Initiative, 1998, p. 91) (Evidence Category D). In addition, weight reduction prescriptions in older persons should be accompanied by proper nutritional counseling and regular body weight monitoring (NHLBI Obesity Education Initiative, 1998, p. 91).

The possibility that a standard approach to weight loss will work differently in diverse patient populations must be considered when setting expectations about treatment outcomes (NHLBI Obesity Education Initiative, 1998, p. 97) (Evidence Category B).

The US Preventive Services Task Force (USPSTF) recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2021).

The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2021)

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women (Grade I Statement) (U.S. Preventive Services Task Force, 2021).

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of electronic cigarettes (e-cigarettes) for tobacco cessation in adults, including pregnant persons. The USPSTF recommends that clinicians direct patients who use tobacco to other tobacco cessation interventions with proven effectiveness and established safety (Grade I Statement) (U.S. Preventive Services Task Force, 2021).

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

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

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008).

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008).

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008).

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008).

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 (2021).

COPYRIGHT:

SUBMISSION CRITERIA 1 COPYRIGHT:

The performance Measure is not a clinical guideline and does not establish a standard of medical care, and has not been tested for all potential applications.

THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Due to technical limitations, registered trademarks are indicated by (R) or [R] and unregistered trademarks are indicated by (TM) or [TM].

SUBMISSION CRITERIA 2 COPYRIGHT:

Physician Performance Measure (Measures) and related data specifications were developed by the National Committee for Quality Assurance (NCQA). NCQA is not responsible for any use of the Measure. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in the Measure.

The Measure can be reproduced and distributed, without modification, for noncommercial purposes (e.g., use by healthcare providers in connection with their practices) without obtaining approval from NCQA. Commercial use is defined as the sale, licensing, or distribution of the Measure for commercial gain, or incorporation of the Measure into a product or service that is sold, licensed or distributed for commercial gain. All commercial uses or requests for modification must be approved by NCQA and are subject to a license at the discretion of NCQA. (C) 2012-2023 National Committee for Quality Assurance. All Rights Reserved.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. NCQA disclaims all liability for use or accuracy of any CPT or other codes contained in the specifications.

CPT® codes, descriptions and other data are copyright 2004-2023 American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

LOINC® copyright 2004-2023 Regenstrief Institute, Inc.

This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2023 International Health Terminology Standards Development Organisation. ICD-10 copyright 2023 World Health Organization. All Rights Reserved.

SUBMISSION CRITERIA 3 COPYRIGHT:

This Physician Performance Measure (Measure) and related data specifications are owned and were developed by the National Committee for Quality Assurance (NCQA). NCQA is not responsible for any use of the Measure. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in the Measure.

The Measure can be reproduced and distributed, without modification, for noncommercial purposes (e.g., use by healthcare providers in connection with their practices) without obtaining approval from NCQA. Commercial use is defined as the sale, licensing, or distribution of the Measure for commercial gain, or incorporation of the Measure into a product or service that is sold, licensed or distributed for commercial gain. All commercial uses or requests for modification must be approved by NCQA and are subject to a license at the discretion of NCQA. (C) 2012-2023 National Committee for Quality Assurance. All Rights Reserved.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. NCQA disclaims all liability for use or accuracy of any CPT or other codes contained in the specifications.

CPT® codes, descriptions and other data are copyright 2004-2023 American Medical Association. CPT is a trademark of the American Medical Association. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use

LOINC® copyright 2004-2023 Regenstrief Institute, Inc.

This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2023 International Health Terminology Standards Development Organisation.

ICD-10 is copyright 2023 World Health Organization. All Rights Reserved.

SUBMISSION CRITERIA 4 COPYRIGHT:

This Physician Performance Measure (Measure) and related data specifications are owned and were developed by the National Committee for Quality Assurance (NCQA). NCQA is not responsible for any use of the Measure. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in the Measure.

The Measure can be reproduced and distributed, without modification, for noncommercial purposes (e.g., use by healthcare providers in connection with their practices) without obtaining approval from NCQA. Commercial use is defined as the sale, licensing, or distribution of the Measure for commercial gain, or incorporation of the Measure into a product or service that is sold, licensed or distributed for commercial gain. All commercial uses or requests for modification must be approved by NCQA and are subject to a license at the discretion of NCQA. (C) 2012-2023 National Committee for Quality Assurance. All Rights Reserved.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. NCQA disclaims all liability for use or accuracy of any CPT or other codes contained in the specifications.

CPT® codes, descriptions and other data are copyright 2004-2023 American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

LOINC® copyright 2004-2023 Regenstrief Institute, Inc.

This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2023 International Health Terminology Standards Development Organisation.

ICD-10 is copyright 2023 World Health Organization. All Rights Reserved.

SUBMISSION CRITERIA 5 COPYRIGHT:

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

THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.

CPT® contained in the Measure specifications is copyright 2004-2023 American Medical Association. LOINC® is copyright 2004-2023 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms® (SNOMED CT®)

SUBMISSION CRITERIA 6 COPYRIGHT:

This Physician Performance Measure (Measure) and related data specifications are owned and copyrighted by the National Committee for Quality Assurance (NCQA). NCQA is not responsible for any use of the Measure. The Measure is not a clinical guideline and does not establish a standard of medical care and has not been tested for all potential applications.

THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in the Measure.

The Measure can be reproduced and distributed, without modification, for noncommercial purposes (e.g., use by healthcare providers in connection with their practices) without obtaining approval from NCQA. Commercial use is defined as the sale, licensing, or distribution of the Measure for commercial gain, or incorporation of the Measure into a product or service that is sold, licensed or distributed for commercial gain. All commercial uses or requests for modification must be approved by NCQA and are subject to a license at the discretion of NCQA.
(C) 2012-2023 National Committee for Quality Assurance. All Rights Reserved.

Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. NCQA disclaims all liability for use or accuracy of any third party codes contained in the specifications.

CPT® codes, descriptions and other data are copyright 2004-2023 American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

LOINC® copyright 2004-2023 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2023 International Health Terminology Standards Development Organisation.

ICD-10 copyright 2023 World Health Organization. All Rights Reserved.

SUBMISSION CRITERIA 7 COPYRIGHT:

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

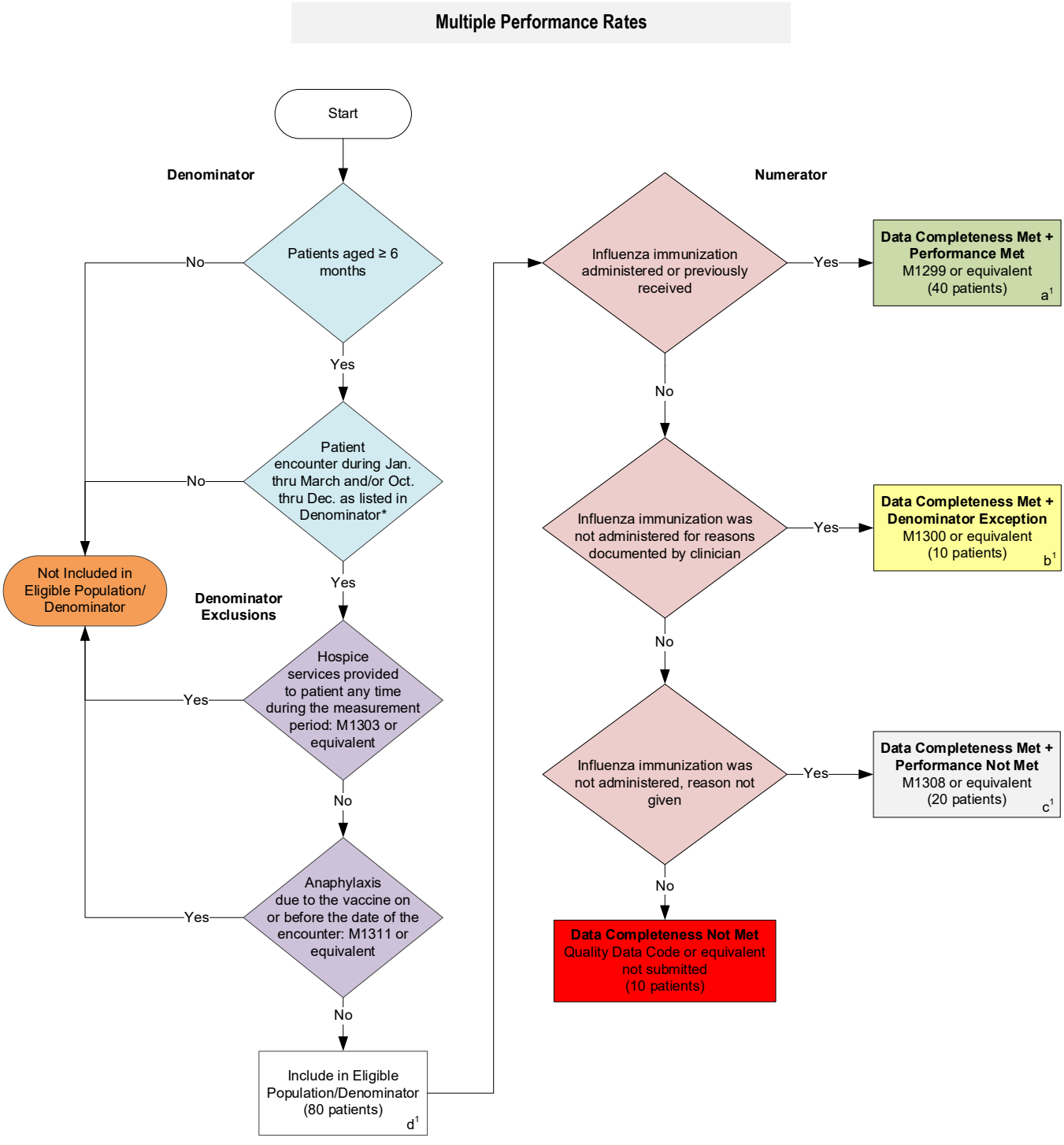
THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.

CPT® contained in the Measure specifications is copyright 2004-2023 American Medical Association. LOINC® is copyright 2004-2023 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2023 International Health Terminology Standards Development Organisation. ICD-10 is copyright 2023 World Health Organization. All Rights Reserved.

2024 Clinical Quality Measure Flow for Quality ID #497:
Preventive Care and Wellness (Composite)
Submission Criteria One: All Patients Who Were Screened for Influenza Vaccination

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



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness =

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

Eligible Population / Denominator (d^1=80 patients) = 80 patients

Performance Rate=

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

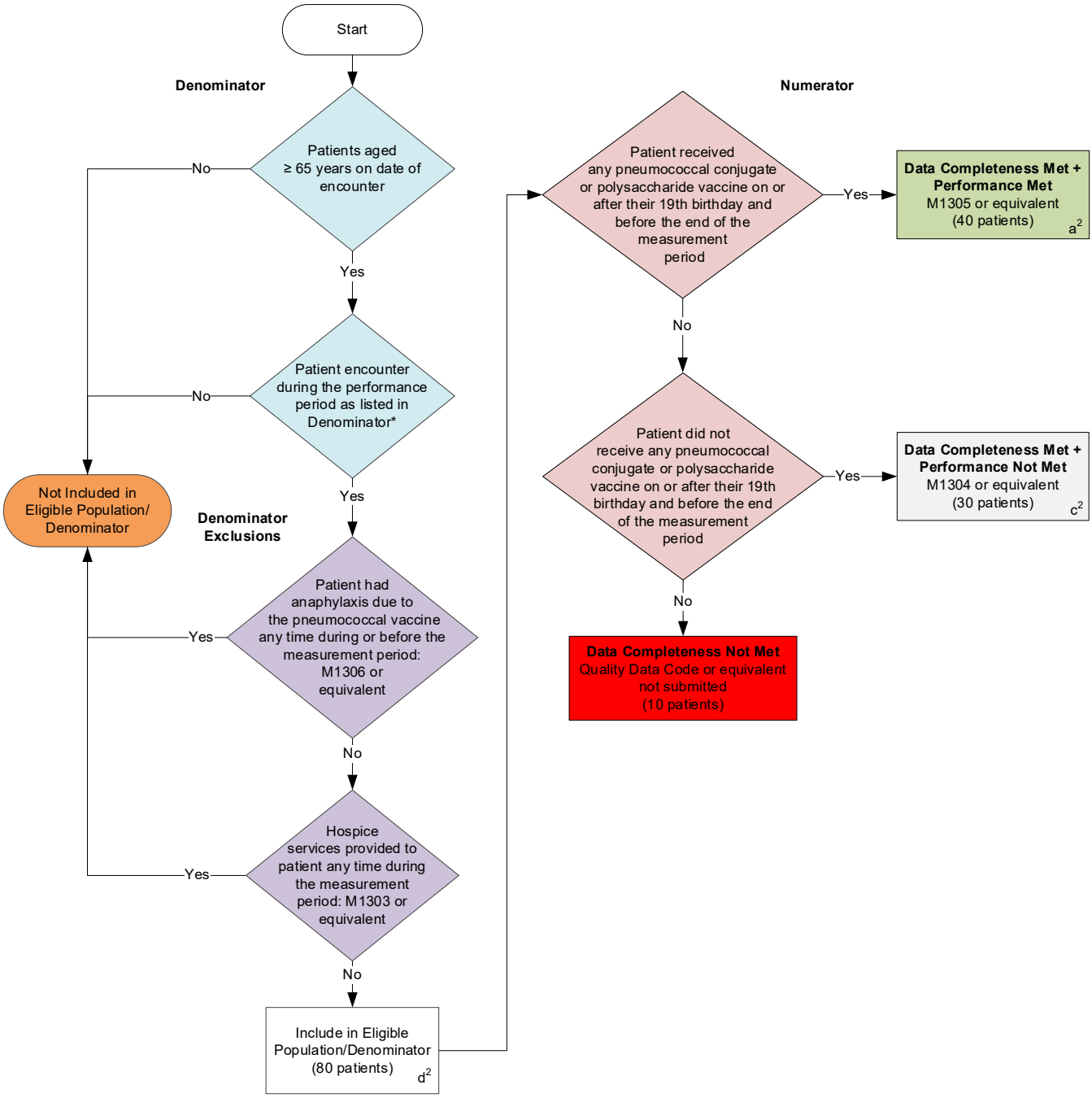
Data Completeness Numerator (70 patients) – Denominator Exception (b^1=10 patients) = 60 patients

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

NOTE: Submission Frequency: Patient-Periodic

v8

Submission Criteria Two: All Patients Who Were Screened for Pneumococcal Vaccination Status for Older Adults



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

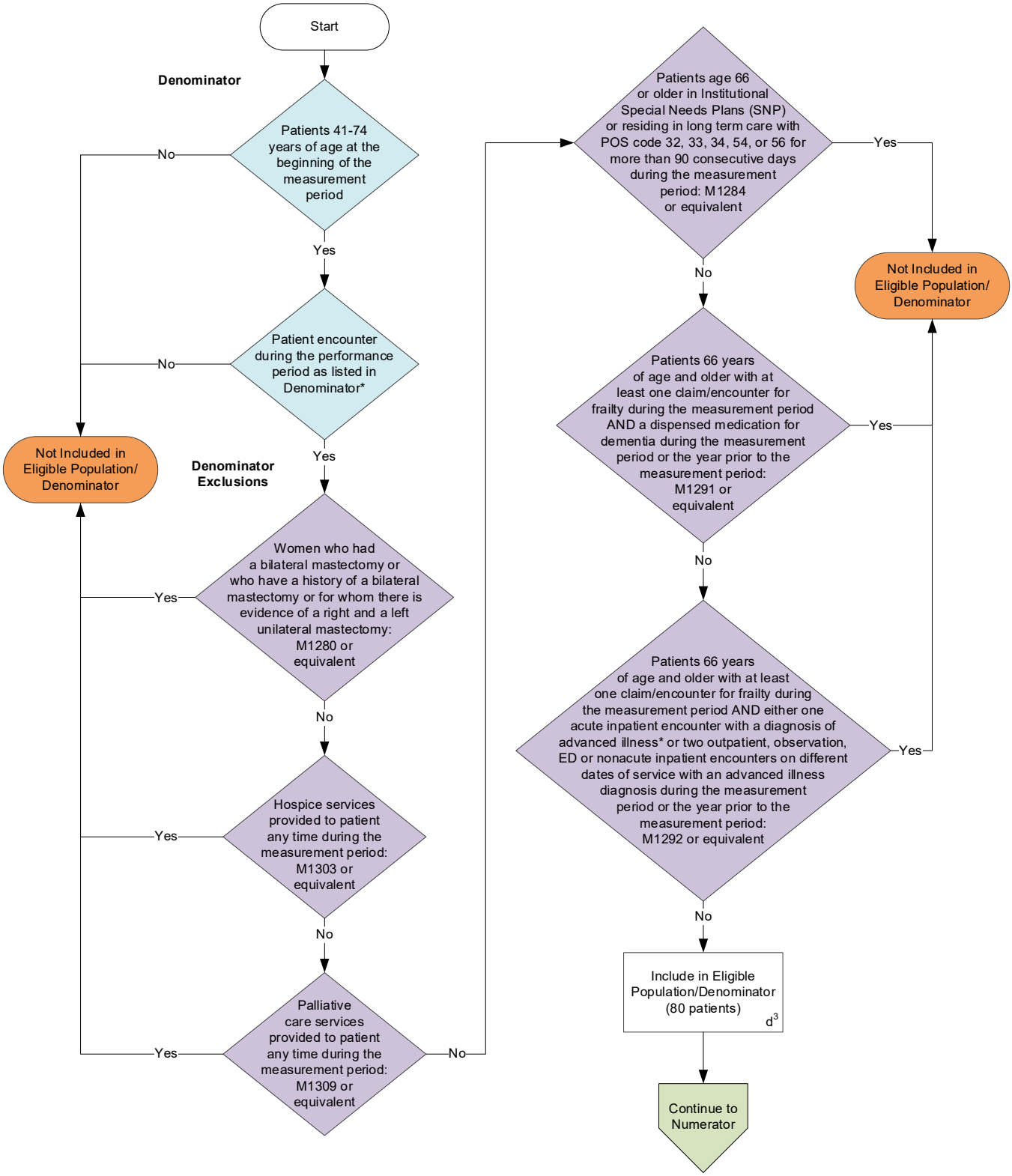
Data Completeness =
Performance Met (a^2=40 patients) + Performance Not Met (c^2=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d^2=80 patients) = 80 patients

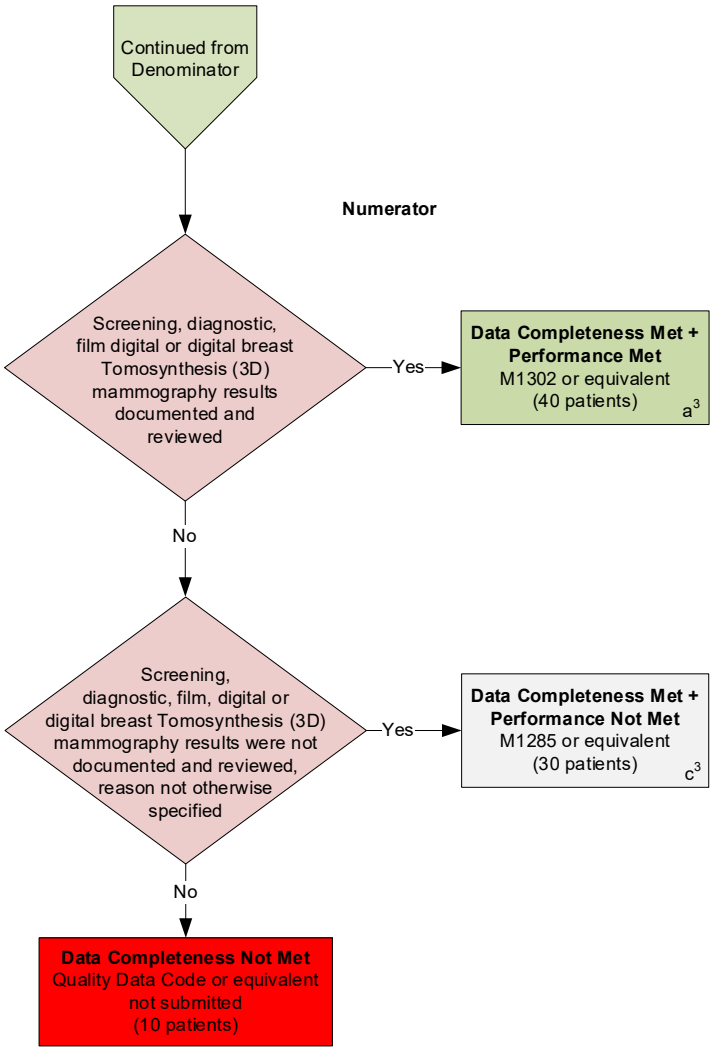
Performance Rate=
Performance Met (a^2=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

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

v8

Submission Criteria Three: All Patients Who Were Screened for Breast Cancer





SAMPLE CALCULATIONS: SUBMISSION CRITERIA THREE

Data Completeness =

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

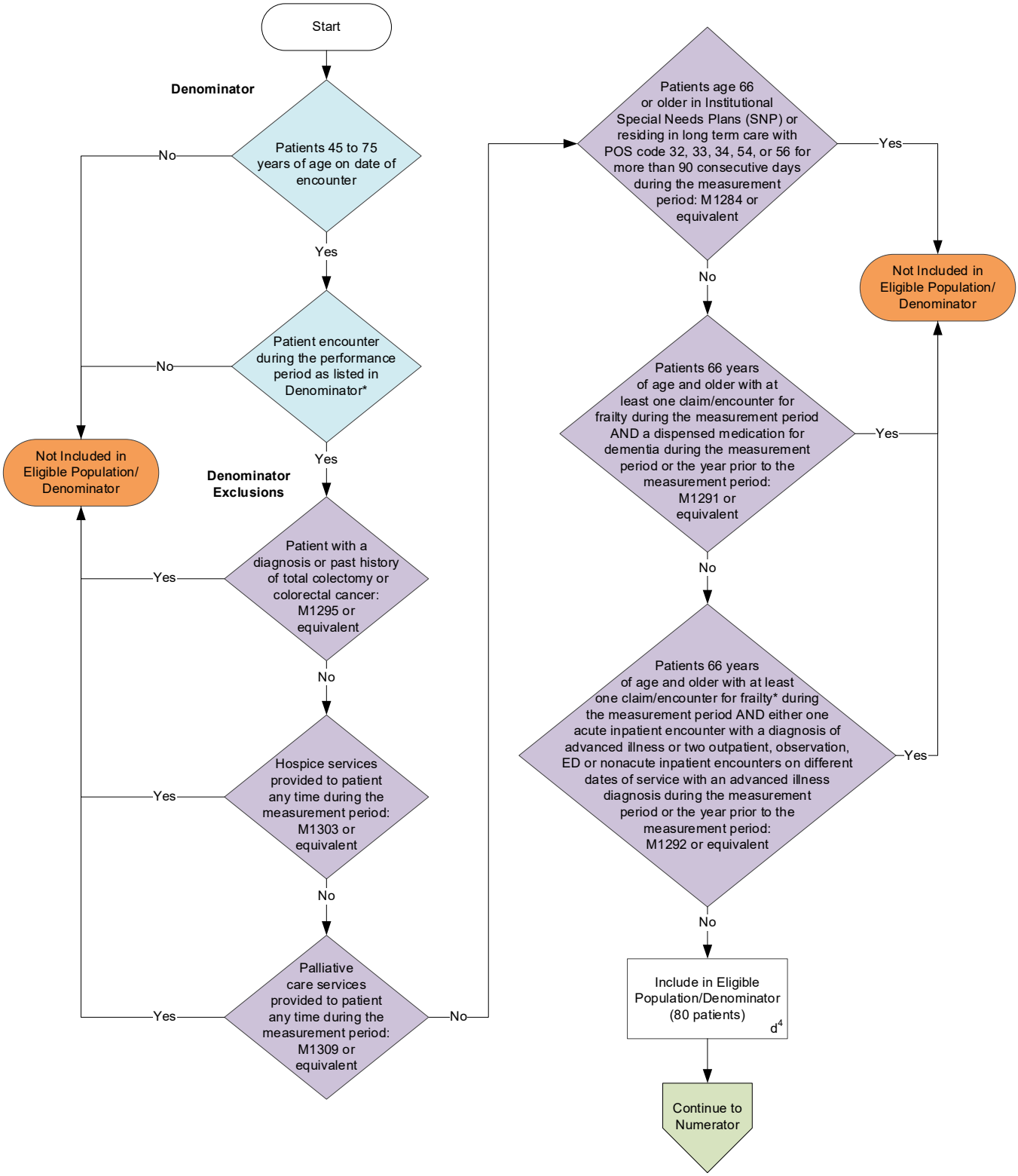
Performance Rate=

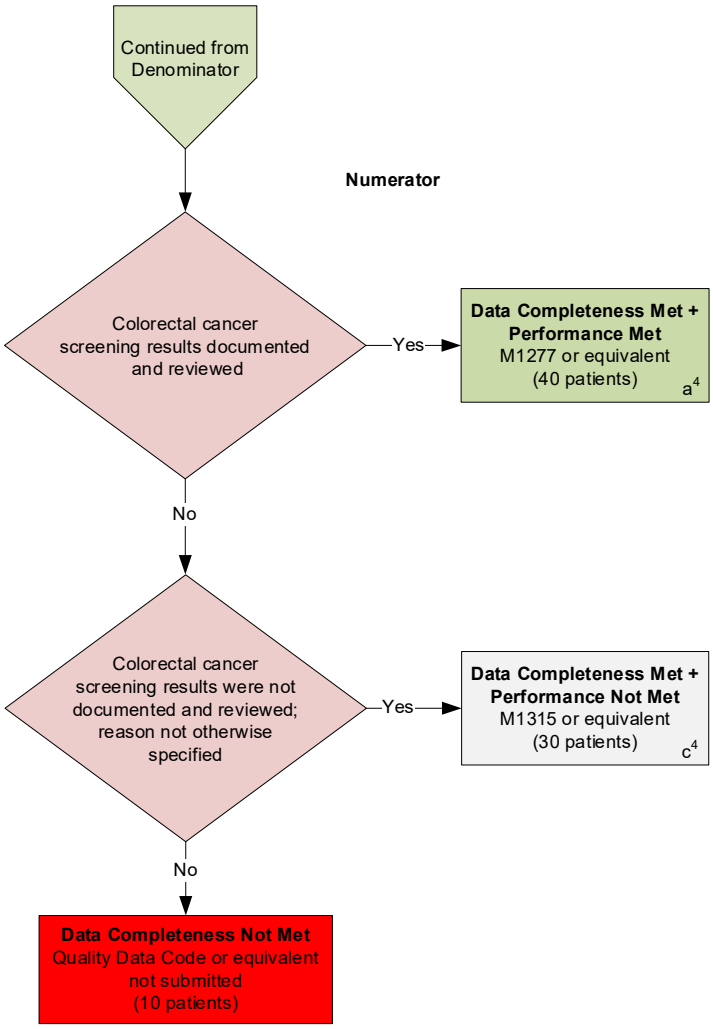
Performance Met (a^3=40 patients) / Data Completeness Numerator (70 patients) = 40 patients / 70 patients = **57.14%**

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

v8

Submission Criteria Four: All Patients Who Were Screened for Colorectal Cancer Screening





SAMPLE CALCULATIONS: SUBMISSION CRITERIA FOUR

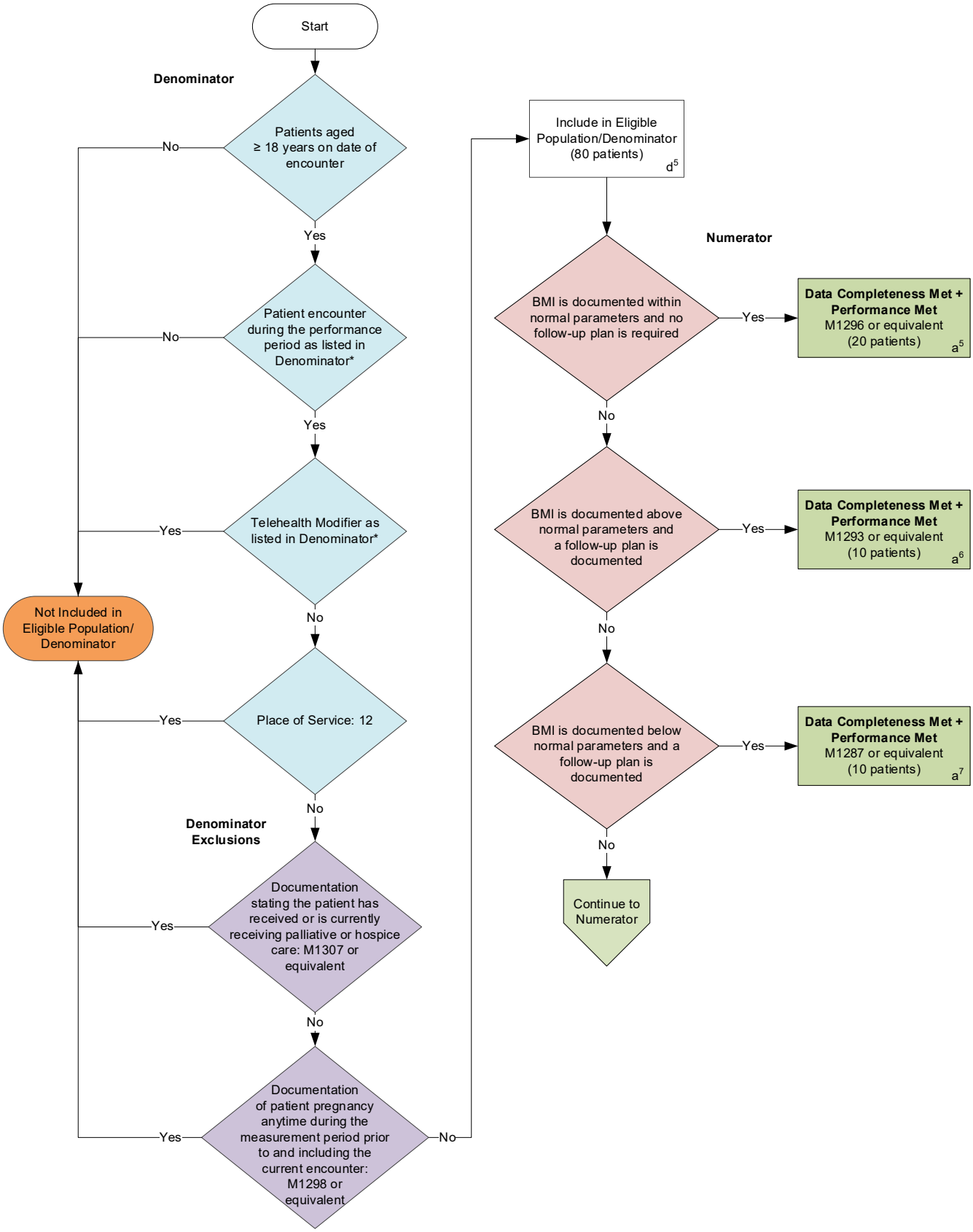
Data Completeness =
Performance Met (a^4=40 patients) + Performance Not Met (c^4=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d^4=80 patients) = 80 patients

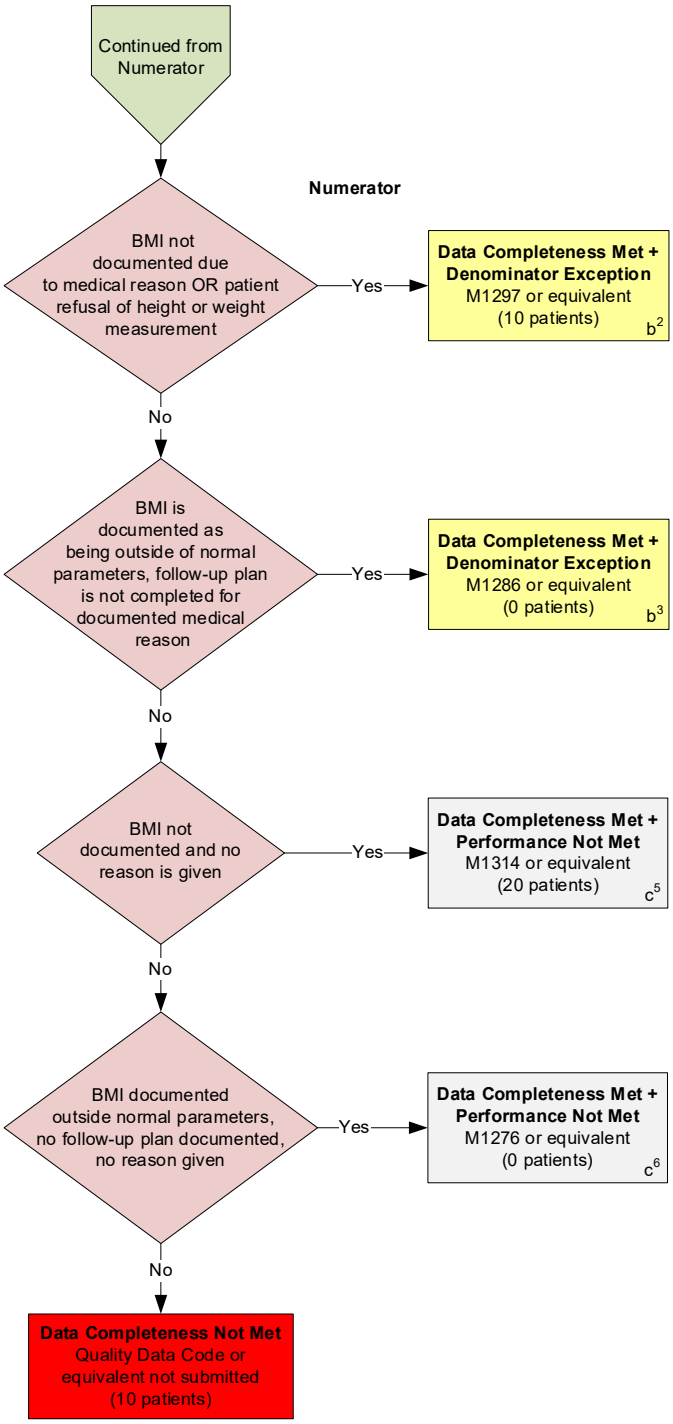
Performance Rate=
Performance Met (a^4=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

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

v8

Submission Criteria Five: All Patients Who Were Screened for Body Mass Index (BMI): Screening and Follow-Up Plan





SAMPLE CALCULATIONS: SUBMISSION CRITERIA FIVE

Data Completeness =

$$\frac{\text{Performance Met } (a^5+a^6+a^7=40) + \text{Denominator Exception } (b^2+b^3=10) + \text{Performance Not Met } (c^5+c^6=20)}{\text{Eligible Population / Denominator } (d^5=80 \text{ patients})} = \frac{70 \text{ patients}}{80 \text{ patients}} = \mathbf{87.50\%}$$

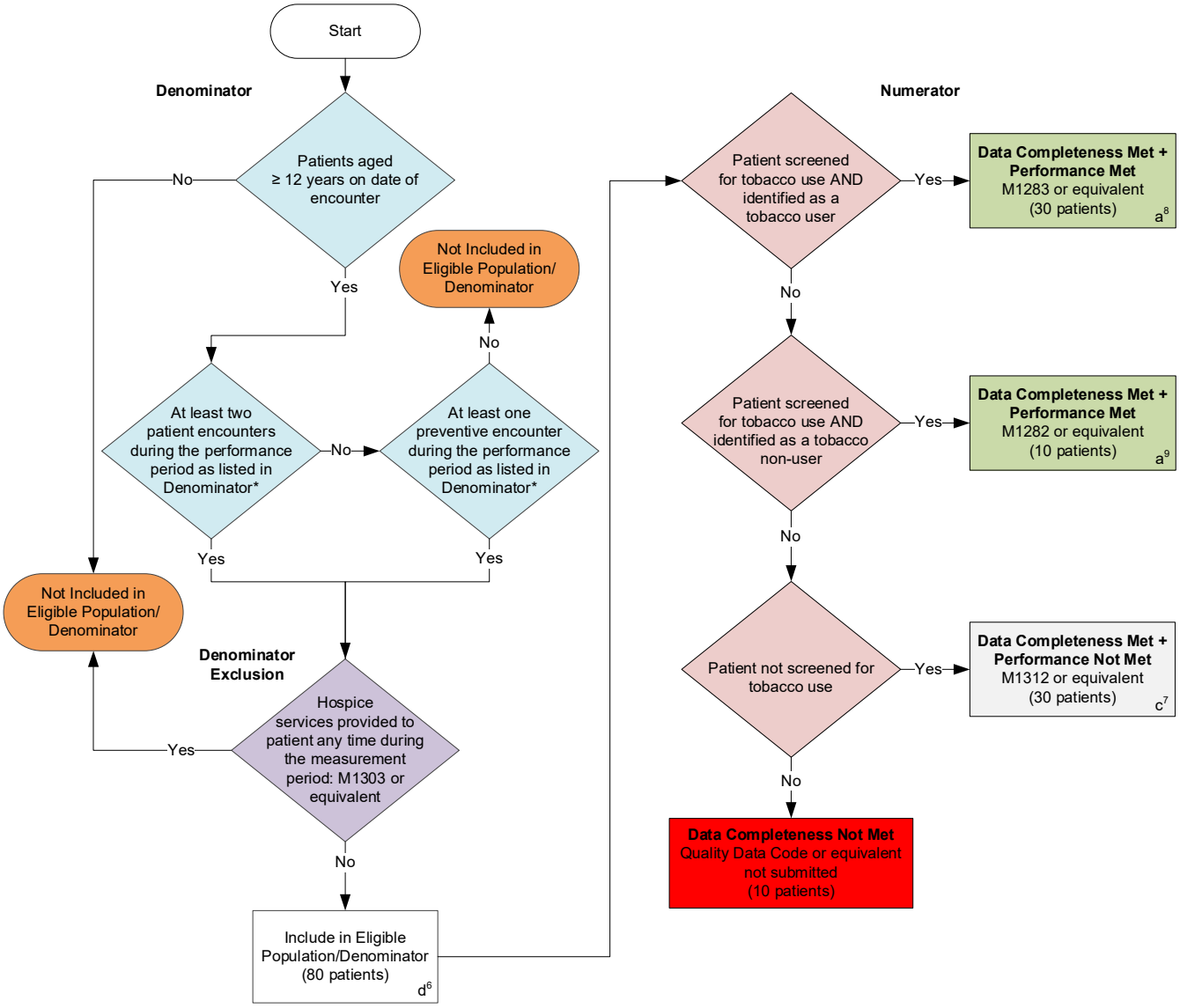
Performance Rate=

$$\frac{\text{Performance Met } (a^5+a^6+a^7=40)}{\text{Data Completeness Numerator (70 patients)} - \text{Denominator Exception } (b^2+b^3=10)} = \frac{40 \text{ patients}}{60 \text{ patients}} = \mathbf{66.67\%}$$

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

v8

Submission Criteria Six: All patients Who Were Screened for Tobacco Use: Screening and Cessation Intervention
Performance Rate A



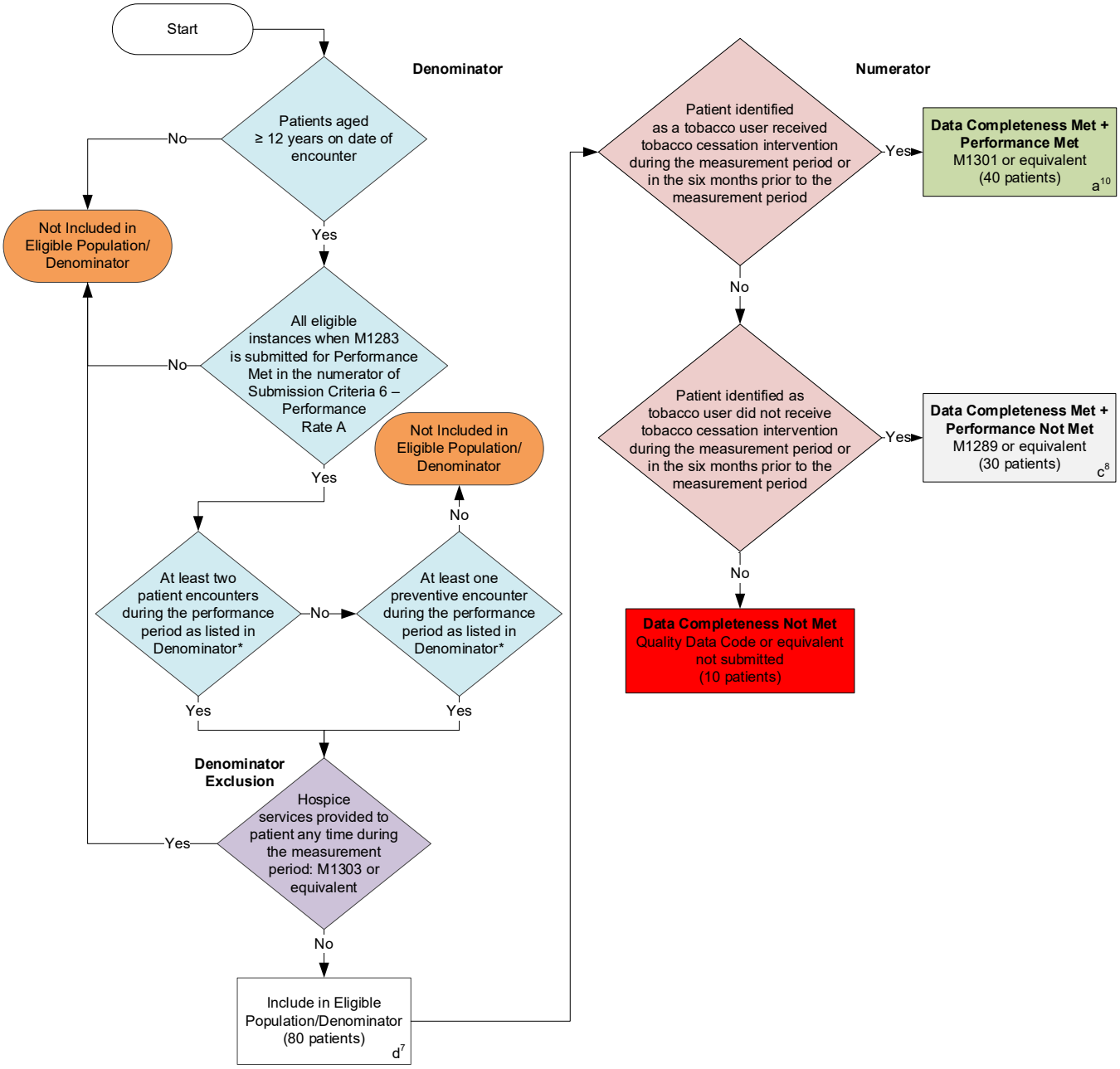
SAMPLE CALCULATIONS: SUBMISSION CRITERIA SIX-A

Data Completeness =
Performance Met (a^8+a^9=40 patients) + Performance Not Met (c^7=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d^6=80 patients) = 80 patients

Performance Rate=
Performance Met (a^8+a^9=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.
For accountability reporting in the CMS MIPS program, the rate for submission criteria 6b is used for the composite performance rate. For the purposes of submitting submission criteria 6, use the data completeness determined in submission criteria 6a.
NOTE: Submission Frequency: Patient-Process

Submission Criteria Six: All patients Who Were Screened for Tobacco Use: Screening and Cessation Intervention
Performance Rate B



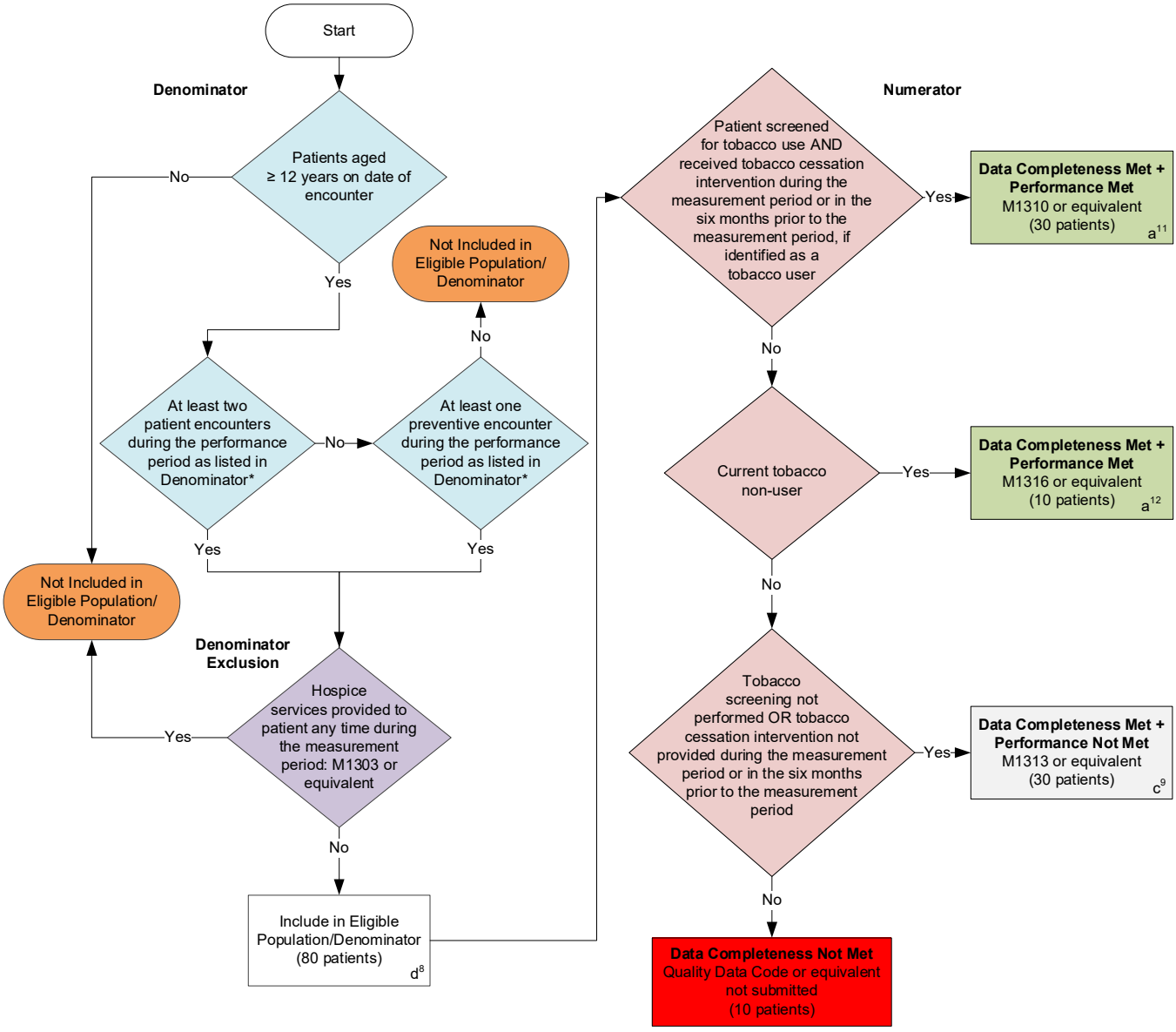
SAMPLE CALCULATIONS: SUBMISSION CRITERIA SIX-B

Data Completeness =
Performance Met (a^{10}=40 patients) + Performance Not Met (c^{8}=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d^{7}=80 patients) = 80 patients

Performance Rate=
Performance Met (a^{10}=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.
For accountability reporting in the CMS MIPS program, the rate for submission criteria 6b is used for the composite performance rate. For the purposes of submitting submission criteria 6, use the data completeness determined in submission criteria 6a.
NOTE: Submission Frequency: Patient-Process

Submission Criteria Six: All patients Who Were Screened for Tobacco Use: Screening and Cessation Intervention
Performance Rate C



SAMPLE CALCULATIONS: SUBMISSION CRITERIA SIX-C

Data Completeness =
Performance Met (a^{11}+a^{12}=40 patients) + Performance Not Met (c^{9}=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d^{8}=80 patients) = 80 patients

Performance Rate=
Performance Met (a^{11}+a^{12}=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.
For accountability reporting in the CMS MIPS program, the rate for submission criteria 6b is used for the composite performance rate. For the purposes of submitting submission criteria 6, use the data completeness determined in submission criteria 6a.
NOTE: Submission Frequency: Patient-Process

v8

Submission Criteria Seven: All Patients Who Were Screened for High Blood Pressure and Follow-Up Documented

SAMPLE CALCULATIONS: SUBMISSION CRITERIA SEVEN

Data Completeness =

Performance Met (a^{13}+a^{14}=40 visits) + Denominator Exception (b^{4}=10 visits) + Performance Not Met (c^{10}+c^{11}=20 visits) = 70 visits = **87.50%**

Eligible Population / Denominator (d^{9}=80 visits) = 80 visits

Performance Rate=

Performance Met (a^{13}+a^{14}=40 visits) = 40 visits = **66.67%**

Data Completeness Numerator (70 visits) – Denominator Exception (b^{4}=10 visits) = 60 visits

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

NOTE: Submission Frequency: Visit

v8

OVERALL SAMPLE CALCULATIONS:

Overall Data Completeness=

Performance Met (a^{1-9}+a^{13-14}=280) + Denominator Exception (b^{1-4}=30) + Performance Not Met (c^{1-7}+c^{10-11}=180) = 490 = **87.5%**

Eligible Population / Denominator (d^{1-6}+d^{9}=560) = 560

Overall Performance Rate=

Performance Met (a^{1-7}+a^{10}+a^{13-14}=280) = 280 = **60.87%**

Data Completeness Numerator (490) – Denominator Exception (b^{1-4}=30) = 460

*See the posted measure specification for specific coding and instructions to submit this measure.
For accountability reporting in the CMS MIPS program, the rate for submission criteria 6b is used for the composite performance rate. For the purposes of submitting submission criteria 6, use the data completeness determined in submission criteria 6a.
NOTE: Submission Frequency: Submission Criteria One: Patient-Periodic; Submission Criteria Two: Patient-Process; Submission Criteria Three: Patient-Process; Submission Criteria Four: Patient-Process; Submission Criteria Five: Patient-Intermediate; Submission Criteria Six: Patient-Process; Submission Criteria Seven: Visit

v8

2024 Clinical Quality Measure Flow Narrative for Quality ID #497: Preventive Care and Wellness (Composite)

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

Multiple Performance Rates

Submission Criteria One: All Patients Who Were Screened for Influenza Vaccination

1. Start with Denominator
2. Check *Patients aged greater than or equal to 6 months*:
    a. If *Patients aged greater than or equal to 6 months* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 6 months* equals Yes, proceed to check *Patient encounter during January thru March and/or October thru December as listed in Denominator**.
3. Check *Patient encounter during January thru March and/or October thru December as listed in Denominator**:
    a. If *Patient encounter during January thru March and/or October thru December as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during January thru March and/or October thru December as listed in Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during the measurement period*.
4. 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*. Stop processing.
    b. If *Hospice services provided to patient any time during the measurement period* equals No, proceed to check *Anaphylaxis due to the vaccine on or before the date of the encounter.*
5. Check *Anaphylaxis due to the vaccine on or before the date of the encounter:*
    a. If *Anaphylaxis due to the vaccine on or before the date of the encounter* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.
    b. If *Anaphylaxis due to the vaccine on or before the date of the encounter* equals No, include in *Eligible Population/Denominator*.
6. Denominator Population:
    - Denominator Population is all Eligible Patients in 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 *Influenza immunization administered or previously received*:

a. If *Influenza immunization administered or previously received* 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 *Influenza immunization administered or previously received* equals No, proceed to check *Influenza immunization was not administered for reasons documented by clinician*.

9. Check *Influenza immunization was not administered for reasons documented by clinician*:

a. If *Influenza immunization was not administered for reasons documented by clinician* equals Yes, include in *Data Completeness Met and Denominator Exception*.

- *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 patients in the Sample Calculation.

b. If *Influenza immunization was not administered for reasons documented by clinician* equals No, proceed to check *Influenza immunization was not administered, reason not given*.

10. Check *Influenza immunization was not administered, reason not given*:

a. If *Influenza immunization was not administered, 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 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 *Influenza immunization was not administered, reason not given* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

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

Sample Calculations - Submission Criteria One:

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

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

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

NOTE: Submission Frequency: Patient-Periodic

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

Submission Criteria Two: All Patients Who Were Screened for Pneumococcal Vaccination Status for Older Adults

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 the performance period as listed in Denominator** equals Yes, proceed to check *Patient had anaphylaxis due to the pneumococcal vaccine any time during or before the measurement period*.
4. Check *Patient had anaphylaxis due to the pneumococcal vaccine any time during or before the measurement period*:
    a. If *Patient had anaphylaxis due to the pneumococcal vaccine any time during or before the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient had anaphylaxis due to the pneumococcal vaccine any time during or before the measurement period* equals No, 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*. Stop processing.
    b. If *Hospice services provided to patient any time 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 *Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period*:
    a. If *Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period* equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* 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 the Sample Calculation.

b. If *Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period* equals No, proceed to check *Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period*.

9. Check *Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period*:

   a. If *Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period* equals Yes, include in *Data Completeness Met and Performance Not Met*.

      - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 30 patients in the Sample Calculation.

   b. If *Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period* equals No, proceed to check *Data Completeness Not Met.*

10. 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 - Submission Criteria Two:

Data Completeness equals Performance Met (a^2 equals 40 patients) plus Performance Not Met (c^2 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.

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: All Patients Who Were Screened for Breast Cancer

1. Start with Denominator

2. Check *Patients 41 to 74 years of age at the beginning of the measurement period*:

   a. If *Patients 41 to 74 years of age at the beginning of the measurement period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

b. If *Patients 41 to 74 years of age at the beginning of the measurement period* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.

3. Check *Patient encounter during the performance period as listed in Denominator**:

   a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy*.

4. Check *Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy*:

   a. If *Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy* equals No, 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*. 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 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 *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*:

   a. If *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* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *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* 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* No, proceed to check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period*.

9. Check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period*:

    a. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period* equals No, include in *Eligible Population/Denominator*.

    b. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

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^3 equals 80 patients in the Sample Calculation.

11. Start Numerator

12. Check *Screening, diagnostic, film, digital or digital breast Tomosynthesis (3D) mammography results documented and reviewed*:

    a. If *Screening, diagnostic, film, digital or digital breast Tomosynthesis (3D) mammography results documented and reviewed* 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 40 patients in the Sample Calculation.

    b. If *Screening, diagnostic, film, digital or digital breast Tomosynthesis (3D) mammography results documented and reviewed* equals No, proceed to check *Screening, diagnostic, film, digital or digital breast Tomosynthesis (3D) mammography results were not documented and reviewed, reason not otherwise specified*.

13. Check *Screening, diagnostic, film, digital or digital breast Tomosynthesis (3D) mammography results were not documented and reviewed, reason not otherwise specified*:

    a. If *Screening, diagnostic, film, digital or digital breast Tomosynthesis (3D) mammography results were not documented and reviewed, 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 as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^3 equals 30 patients in the Sample Calculation.

    b. If *Screening, diagnostic, film, digital or digital breast Tomosynthesis (3D) mammography results were not documented and reviewed, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

14. Check *Data Completeness Not Met*:

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

Sample Calculations - Submission Criteria Three:

Data Completeness equals Performance Met (a^3 equals 40 patients) plus Performance Not Met (c^3 equals 30 patients) divided by Eligible Population/Denominator (d^3 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^3 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

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

NOTE: Submission Frequency: Patient-Process

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

Submission Criteria Four: All Patients Who Were Screened for Colorectal Cancer Screening

1. Start with Denominator:

2. Check *Patients 45 to 75 years of age on date of encounter*:

    a. If *Patients 45 to 75 years of age on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients 45 to 75 years of age on date of encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.

3. Check *Patient encounter during the performance period as listed in Denominator**:

    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop Processing.

b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Patients with a diagnosis or past history of total colectomy or colorectal cancer*.

4. Check *Patients with a diagnosis or past history of total colectomy or colorectal cancer*:

    a. If *Patients with a diagnosis or past history of total colectomy or colorectal cancer* equals Yes, do not include *in Eligible Population/Denominator*. Stop processing.

    b. If *Patients with a diagnosis or past history of total colectomy or colorectal cancer* equals No, 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*. 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* No, proceed to check *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.*

7. Check *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*:

    a. If *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* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *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* equals No, proceed to check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period*.

8. Check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period*:

    a. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period* equals No, proceed to check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period*.

9. Check *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period*:

    a. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period* equals No, include in *Eligible Population/Denominator*.

10. Denominator Population:

    - Denominator Population is all Eligible Visits in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^4 equals 80 visits in the Sample Calculation.

11. Start Numerator

12. Check *Colorectal cancer screening results documented and reviewed*:

    a. If *Colorectal cancer screening results documented and reviewed* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^4 equals 40 patients in the Sample Calculation.

    b. If *Colorectal cancer screening results documented and reviewed* equals No, proceed to check *Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified*.

13. Check *Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified*:

    a. If *Colorectal cancer screening results were not documented and reviewed, 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 as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^4 equals 30 patients in the Sample Calculation.

    b. If *Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

14. Check *Data Completeness Not Met*:

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

Sample Calculations - Submission Criteria Four:

Data Completeness equals Performance Met (a^4 equals 40 patients) plus Performance Not Met (c^4 equals 30 patients) divided by Eligible Population/Denominator (d^4 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^4 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

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

NOTE: Submission Frequency: Patient-Process

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

Submission Criteria Five: All Patients Who Were Screened for Body Mass Index (BMI): Screening and Follow-Up Plan

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years on date of encounter*:
    a. If *Patients aged greater than or equal to 18 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years on date of encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Telehealth Modifier as listed in Denominator**.
4. Check *Telehealth Modifier as listed in Denominator**:
    a. If *Telehealth Modifier as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier as listed in Denominator** equals No, proceed to check *Place of Service (POS).*
5. Check *Place of Service (POS):*
    a. If *Place of Service (POS)* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Place of Service (POS)* equals No, proceed to check *Documentation stating the patient has received or is currently receiving palliative or hospice care.*
6. Check *Documentation stating the patient has received or is currently receiving palliative or hospice care:*
    a. If *Documentation stating the patient has received or is currently receiving palliative or hospice care* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

b. If *Documentation stating the patient has received or is currently receiving palliative or hospice care* equals No, proceed to check *Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter.*

7. Check *Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter*:

   a. If *Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.

   b. If *Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter* equals No, include in *Eligible Population/Denominator*.

8. Denominator Population

   - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^5 equals 80 patients in the Sample Calculation.

9. Start Numerator

10. Check *BMI is documented within normal parameters and no follow-up plan is required:*

    a. If *BMI is documented within normal parameters and no follow-up plan is required* equals Yes, include in *Data Completeness Met and Performance Met*.

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

    b. If *BMI is documented within normal parameters and no follow-up plan is required* equals No, proceed to check *BMI is documented above normal parameters and a follow-up plan is documented.*

11. Check *BMI is documented above normal parameters and a follow-up plan is documented:*

    a. If *BMI is documented above normal parameters and a follow-up plan is documented* equals Yes, include in *Data Completeness Met and Performance Met*.

       - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^6 equals 10 patients in the Sample Calculation.

    b. If *BMI is documented above normal parameters and a follow-up plan is documented* equals No, proceed to check *BMI is documented below normal parameters and a follow-up plan is documented.*

12. Check *BMI is documented below normal parameters and a follow-up plan is documented:*

    a. If *BMI is documented below normal parameters and a follow-up plan is documented* equals Yes, include in *Data Completeness Met and Performance Met*.

       - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^7 equals 10 patients in the Sample Calculation.

    b. If *BMI is documented below normal parameters and a follow-up plan is documented* equals No, proceed to check *BMI not documented due to medical reason OR patient refusal of height or weight measurement.*

13. Check *BMI not documented due to medical reason OR patient refusal of height or weight measurement:*

    a. If *BMI not documented due to medical reason OR patient refusal of height or weight measurement* equals Yes, include in *Data Completeness Met and Denominator Exception.*

        - *Data Completeness Met and Denominator Exception* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 10 patients in the Sample Calculation.

    b. If *BMI not documented due to medical reason OR patient refusal of height or weight measurement* equals No, proceed to check *BMI is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason.*

14. Check *BMI is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason:*

    a. If *BMI is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^3 equals 0 patients in the Sample Calculation.

    b. If *BMI is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason* equals No, proceed to check *BMI not documented and no reason is given*.

15. Check *BMI not documented and no reason is given:*

    a. If *BMI not documented and no reason is given* equals Yes, include in *Data Completeness Met and Performance Not Met*

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^5 equals 20 patients in the Sample Calculation.

    b. If *BMI not documented and no reason is given* equals No, proceed to check *BMI documented outside normal parameters, no follow-up plan documented, no reason given.*

16. Check *BMI documented outside normal parameters, no follow-up plan documented, no reason given*:

    a. If *BMI documented outside normal parameters, no follow-up plan documented, no reason given* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^6 equals 0 patients in the Sample Calculation.

    b. If *BMI documented outside normal parameters, no follow-up plan documented, no reason given* equals No, proceed to check *Data Completeness Not Met*.

17. Check *Data Completeness Not Met:*

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

Sample Calculations - Submission Criteria Five:

Data Completeness equals Performance Met (a^5 plus a^6 plus a^7 equals 40 patients) plus Denominator Exception (b^2 plus b^3 equals 10 patients) plus Performance Not Met (c^5 plus c^6 equals 20 patients) divided by Eligible Population / Denominator (d^5 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^5 plus a^6 plus a^7 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b^2 plus b^3 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

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

NOTE: Submission Frequency: Patient-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.

Submission Criteria Six: All patients Who Were Screened for Tobacco Use: Screening and Cessation Intervention Performance Rate A:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 12 years on date of encounter*:
    a. If *Patients aged greater than or equal to 12 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 12 years on date of encounter* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in the Denominator**.
3. Check *At least two patient encounters during the performance period as listed in the Denominator**:
    a. If *At least two patient encounters during the performance period as listed in the Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in the Denominator**.
    b. If *At least two patient encounters during the performance period as listed in the Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during the measurement period*.
4. Check *At least one preventive encounter during the performance period as listed in the Denominator**:
    a. If *At least one preventive encounter during the performance period as listed in the Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *At least one preventive encounter during the performance period as listed in the Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during the measurement period*.
5. Check *Hospice services provided to patient any time during the measurement period*:
    a. If *Hospice services provided to patient any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*.
    b. If *Hospice services provided to patient any time during the measurement period* equals No, include in *Eligible Population/Denominator*.
6. Denominator Population:

- 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^6 equals 80 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^8 equals 30 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^9 equals 10 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^7 equals 30 patients in the Sample Calculation.

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

11. Check *Data Completeness Not Met*:

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

Sample Calculations - Submission Criteria Six-A:

Data Completeness equals Performance Met (a^8 plus a^9 equals 40 patients) plus Performance Not Met (c^7 equals 30 patients) divided by Eligible Population/Denominator (d^6 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^8 plus a^9 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.

For accountability reporting in the CMS MIPS program, the rate for submission criteria 6b is used for the composite performance rate. For the purposes of submitting submission criteria 6, use the data completeness determined in submission criteria 6a.

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 Six: All patients Who Were Screened for Tobacco Use: Screening and Cessation Intervention Performance Rate B:

1. Start with Denominator

2. Check *Patient 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 M1283 is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 6 – Performance Rate A*.

3. Check *All eligible instances when M1283 is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 6 – Performance Rate A*:

    a. If *All eligible instances when M1283 is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 6 – Performance Rate A* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *All eligible instances when M1283 or equivalent is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 6 – Performance Rate A* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in the Denominator**.

4. Check *At least two patient encounters during the performance period as listed in the Denominator**:

    a. If *At least two patient encounters during the performance period as listed in Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in the Denominator**.

    b. If *At least two patient encounters during the performance period as listed in the Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during the measurement period*.

5. Check *At least one preventive encounter during the performance period as listed in the Denominator**:

    a. If *At least one preventive encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *At least one preventive encounter during the performance period as listed in the Denominator** equals Yes, proceed to check *Hospice services provided to patient any time during the measurement period*.

6. Check *Hospice services provided to patient any time during the measurement period*:

    a. If *Hospice services provided to patient any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*.

b. If *Hospice services provided to patient any time during the measurement period* equals No, include in *Eligible Population/Denominator*.

7. Denominator Population:

    - 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^{7} equals 80 patients in the Sample Calculation.

8. Start Numerator

9. Check *Patient identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to measurement period*:

    a. If *Patient identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to measurement 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 a^{10} equals 40 patients in the Sample Calculation.

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

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

    a. If *Patient identified as tobacco user did not receive tobacco cessation intervention during the measurement period or in the six months prior to 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^{8} equals 30 patients in the Sample Calculation.

    b. If *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)* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

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

Sample Calculations - Submission Criteria Six-B:

Data Completeness equals Performance Met (a^{10} equals 40 patients) plus Performance Not Met (c^{8} equals 30 patients) divided by Eligible Population/Denominator (d^{7}equals 70 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^{10} 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.

For accountability reporting in the CMS MIPS program, the rate for submission criteria 6b is used for the composite performance rate. For the purposes of submitting submission criteria 6, use the data completeness determined in submission criteria 6a.

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 Six: All patients Who Were Screened for Tobacco Use: Screening and Cessation Intervention Performance Rate C:

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*. Stop processing.
    b. If *Hospice services provided to patient any time 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^8 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, if identified as a tobacco user*:

    a. If *Patient screened for tobacco use AND received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period, 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^{11} equals 30 patients in the Sample Calculation.

    b. If *Patient screened for tobacco use AND received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period, 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^{12} equals 10 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^{9} equals 30 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*:

    - 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 Six-C:

Data Completeness equals Performance Met (a^{11} plus a^{12} equals 40 patients) plus Performance Not Met (c^{9} equals 30 patients) divided by Eligible Population/Denominator (d^{6} equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^{11} plus a^{12} 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.

For accountability reporting in the CMS MIPS program, the rate for submission criteria 6b is used for the composite performance rate. For the purposes of submitting submission criteria 6, use the data completeness determined in submission criteria 6a.

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 Seven: All Patients Who Were Screened for High Blood Pressure and Follow-Up Documented

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years at the beginning of the measurement period*:
    a. If *Patients aged greater than or equal to 18 years at the beginning of the measurement period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years at the beginning of the measurement period* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator*.*
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Telehealth Modifier as listed in Denominator**.
4. Check *Telehealth Modifier as listed in Denominator**:
    a. If *Telehealth Modifier as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier as listed in Denominator** 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^9 equals 80 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[13] equals 40 visits in the Sample Calculation.

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

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

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

      - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[14] equals 0 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[4] equals 10 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[10] equals 10 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[11] equals 10 visits in the Sample Calculation.

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

13. Check *Data Completeness Not Met:*

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

Sample Calculations - Submission Criteria Seven:

Data Completeness equals Performance Met (a^{13} plus a^{14} equals 40 visits) plus Denominator Exception (b^{4} equals 10 visits) plus Performance Not Met (c^{10} plus c^{11} equals 20 visits) divided by Eligible Population/Denominator (d^{9} equals 80 visits). All equals 70 visits divided by 80 visits. All equals 87.50 percent.

Performance Rate equals Performance Met (a^{13} plus a^{14} equals 40 visits) divided by Data Completeness Numerator (70 visits) minus Denominator Exception (b^{4} equals 10 visits). All equals 40 visits divided by 60 visits. All equals 66.67 percent.

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

NOTE: Submission Frequency: Visit

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

Sample Calculations – Overall Calculations:

Data Completeness equals Performance Met (a^{1-9} plus a^{13-14} equals 280) plus Denominator Exception (b^{1-4} equals 30) plus Performance Not Met (c^{1-7} plus c^{10-11} equals 180) divided by Eligible Population/Denominator (d^{1-6} plus d^{9} equals 560). All equals 490 divided by 560. All equals 87.50 percent.

Performance Rate equals Performance Met (a^{1-7} plus a^{10} plus a^{13-14} equals 280) divided by Data Completeness Numerator (490) minus Denominator Exception (b^{1-4} equals 30). All equals 280 divided by 460. All equals 60.87 percent.

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

For accountability reporting in the CMS MIPS program, the rate for Submission Criteria 6b is used for the composite performance rate. For the purposes of submitting Submission Criteria 6, use the data completeness determined in Submission Criteria 6a.

NOTE: Submission Frequency: Submission Criteria One: Patient-Periodic; Submission Criteria Two: Patient-Process; Submission Criteria Three: Patient-Process; Submission Criteria Four: Patient-Process; Submission Criteria Five: Patient-Intermediate; Submission Criteria Six: Patient-Process; Submission Criteria Seven: 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