Individual Quality Measures Applicable to Eligible OMS-MPFS Final Rule 2019

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
High Priority (Patient Safety	Measure #21:	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin – National Quality Strategy Domain: Patient Safety** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic who had an order	Claims, Registry	All surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic. **Denominator Instructions:** CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population, therefore both	Le Fort Fractures 21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436 Mandibular Fractures 21454, 21461, 21462, 21465, 21470 Glossectomy 41130, 41135, 41140, 41145, 41150, 41153, 41155	Surgical patients who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis	**Numerator Quality-Data Coding Options:** **Documentation of Order for First or Second Generation Cephalosporin for Antimicrobial Prophylaxis (written order, verbal order, or standing order/protocol)** ***Performance Met:*** **G9197:** Documentation of order for first OR second generation cephalosporin for antimicrobial prophylaxis ***Note:*** *G9197 is provided for antibiotic ordered or antibiotic given. Submit G9197 if a first or second generation cephalosporin was given for antimicrobial prophylaxis.* **OR** **Order for First or Second Generation Cephalosporin not ordered for Medical Reasons** ***Denominator Exception:*** **G9196*:*** Documentation of medical reason(s) for not ordering a first OR second generation cephalosporin for antimicrobial prophylaxis (e.g., patients enrolled in clinical trials, patients with documented infection prior to surgical procedure of interest, patients who were receiving antibiotics more than 24 hours prior to surgery [except colon surgery patients taking oral prophylactic antibiotics], patients who were receiving antibiotics within 24 hours prior to arrival [except colon surgery patients taking oral prophylactic antibiotics], other medical reason(s)) **OR**

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		for a first OR second generation cephalosporin for antimicrobial prophylaxis.		surgeons will be fully accountable for the clinical action described in the measure. **Denominator Criteria (Eligible Cases):** Patients aged ≥ 18 years on date of encounter **AND** **Patient procedure during the performance period (CPT):** Listed below are surgical procedures with indications for first or second generation cephalosporin prophylactic antibiotic.			**Order for First or Second Generation Cephalosporin not Ordered, Reason Not Given** ***Performance Not Met:*** **G9198:** Order for first OR second generation cephalosporin for antimicrobial prophylaxis was not documented, reason not given
High Priority (Patient Safety	Measure #23:	*Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis*	Claims, Registry	Patients aged ≥ 18 years on date of encounter **AND**	Le Fort Fractures 21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436	Surgical patients who had an order for LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical	**CPT II 4044F:** Documentation that an order was given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time

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		Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time		having one of the encounters listed in the next column to the right	Mandibular Fractures 21454, 21461, 21462, 21465, 21470 Glossectomy 41130, 41135, 41140, 41145, 41150, 41153, 41155	prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	**OR** **4044F with 1P:** Documentation of medical reason(s) for patient not receiving any form of VTE prophylaxis (LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis) within 24 hours prior to incision time or 24 hours after surgery end time **OR** **4044F with 8P:** Order was not given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time, reason not otherwise specified

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High Priority (Care Coordination) Core Quality Measure Collaborative (CQMC) core measure	Measure #46: Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications and removing the CMS Web Interface.	**Medication Reconciliation Post-Discharge – National Quality Strategy Domain: Communication and Care Coordination** **DESCRIPTION:** The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical	Claims, Registry	SUBMISSION CRITERIA 1: Patients 18-64 years of age on date of encounter SUBMISSION CRITERIA 2: Patients aged 65 years and older on date of encounter SUBMISSION CRITERIA 3: All Patients 18 years of age and older AND Patient encounter during the performance period (CPT or HCPCS) to the codes on the right column. AND Patient discharged from an inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) within the last 30 days	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacists or registered nurse on or within 30 days of discharge.	**NUMERATOR NOTE:** Medication reconciliation should be completed and documented on or within 30 days of discharge. If the patient has an eligible discharge but medication reconciliation is not performed and documented within 30 days, submit 1111F with 8P. **Numerator Quality-Data Coding Options:** **Patient receiving Hospice Services, Patient Not Eligible:** **Denominator Exclusion: G9691**: Patient had hospice services any time during the measurement period **OR** **Documentation of Reconciliation of Discharge Medication with Current Medication List in the Medical Record** **Performance Met: CPT II 1111F**: Discharge medications reconciled with the current medication list in outpatient medical record **OR** **Discharge Medication not Reconciled with Current Medication List in the Medical Record, Reason Not Otherwise Specified** Append a submission modifier (8P) to CPT Category II code 1111F to submit circumstances when the action described in the numerator is not performed and the reason is not otherwise specified. **Performance Not Met: 1111F with 8P**: Discharge medications not reconciled with the current medication list in outpatient

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		pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is submitted as three rates stratified by age group: • Submission Criteria 1: 18-64 years of age • Submission Criteria 2: 65 years and older • Total Rate: All patients 18 years of age and older					medical record, reason not otherwise specified
High Priority (Care Coordination)	Measure #47:	Care Plan – National Quality Strategy Domain: Communicatio	Claims, Registry	Patients aged ≥ 65 years on date of encounter **AND**	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220,	Patients who have an advance care plan or surrogate decision maker documented in	**Advance Care Planning Discussed and Documented** CPT II 1123F: Advance Care Planning discussed and documented; advance care

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		n and Care Coordination		Having one of the encounters (CPT or HCPCS codes) during the reporting period listed in the next column to the right	99221, 99222, 99223, 99231, 99232, 99234, 99235, 99236, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402	the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	plan or surrogate decision maker documented in the medical record **OR** CPT II 1124F: Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan **OR** Advance Care Planning not Documented, Reason not Otherwise Specified Append a reporting modifier (8P) to CPT Category II code 1123F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified. 1123F with 8P: Advance care planning not documented, reason not otherwise specified
High Priority (Patient Safety)	Measure #130:	*Documentation of Current Medications in the Medical Record:*	Claims, Registry	Patients aged ≥ 18 years on date of encounter	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	Eligible professional or eligible clinician attests to documenting, updating or	**Numerator Quality-Data Coding Options:** **Current Medications Documented Performance Met: G8427:** Eligible clinician attests to documenting in the

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		Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and		**AND** having one of the encounters (CPT or HCPCS codes) listed in the next column to the right		reviewing a patient's current medications using all immediate resources available on the date of encounter. This list **must** include ALL known prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosages, frequency and route of administration **NUMERATOR NOTE**: The eligible clinician must document in the medical record they obtained, updated, or reviewed a	medical record they obtained, updated, or reviewed the patient's current medications **OR** **Current Medications not Documented, Patient not Eligible** **Denominator Exception: G8430:** Eligible clinician attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible clinician **OR** **Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason not Given** **Performance Not Met: G8428:** Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given

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		route of administration				medication list on the date of the encounter. Eligible clinicians submitting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. By submitting the action described in this measure, the provider attests to having documented a list of current medications utilizing all immediate resources available at the time of the encounter. G8427 should be submitted if the eligible clinician	

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						documented that the patient is not currently taking any medications	
High Priority (Care Coordination)	Measure #131:	*Pain Assessment and Follow-Up:* Percentage of visits for patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Claims, Registry	Patients aged ≥ 18 years on date of encounter **AND** having one of the encounters (CPT or HCPCS codes) listed in the next column to the right	92526, 96116, 96150, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	Patient visits with a documented pain assessment using a standardized tool(s) AND documentation of a follow-up plan when pain is present	**G8730**: Pain assessment documented as positive utilizing a standardized tool and a follow-up plan is documented **OR** **G8731:** Pain assessment documented as negative, no follow-up plan required **OR** **G8442**: Documentation that patient is not eligible for a pain assessment **OR** **G8939:** Pain assessment documented, follow-up plan not documented, patient not eligible/appropriate **OR** **G8732**: No documentation of pain assessment, reason not given **OR** **G8509**: Documentation of positive pain assessment; no documentation of a follow-up plan, reason not given

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High Priority (Care Coordination)	Measure #137	**Melanoma: Continuity of Care – Recall System – National Quality Strategy Domain: Communication and Care Coordination** Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes: A target date for the next complete physical skin exam, AND	Registry	**Diagnosis for melanoma or history of melanoma having one of diagnosis and patient encounter during the performance period. (CPT/(ICD-10-CM codes) listed to the right.** **<u>WITHOUT</u> Telehealth Modifier:** GQ, GT, 95, POS 02	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245 C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, D03.30, D03.39, Z85.820	Patients whose information is entered, at least once within a 12 month period, into a recall system that includes: A target date for the next complete physical exam AND A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment	**<u>Numerator Options:</u>** ***Performance Met:*** Patient information entered into a recall system that includes: target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments **(7010F)** **<u>OR</u>** ***Denominator Exception:*** Documentation of system reason(s) for not entering patient's information into a recall system (e.g., melanoma being monitored by another physician provider) **(7010F *with* 3P)** **<u>OR</u>** ***Performance Not Met:*** Recall system not utilized, reason not otherwise specified **(7010F *with* 8P)**

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		A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment					
High Priority (Care Coordination)	Measure #138:	**Melanoma: Coordination of Care – National Quality Strategy Domain: Communication and Care Coordination** Percentage of patient visits, regardless of age, with a new occurrence of melanoma that have a treatment plan	Registry	**Denominator Criteria (Eligible Cases) 1: Diagnosis for melanoma (ICD-10-CM):** C43.10, C43.11, C43.20, C43.30, C43.31, D03.30, D03.39 **AND Patient encounter for excision of malignant melanoma (CPT):** 11640, 11641, 11642, 11643, 11644, 11646, , 14040, 14041, 14060, 14061, 14301,	(Eligible cases 1) C43.10, C43.11, C43.20, C43.30, C43.31, D03.30, D03.39 11640, 11641, 11642, 11643, 11644, 11646, 14040, 14041, 14060, 14061, 14301, 17311 (Eligible cases 2) C43.10, C43.11, C43.20, C43.30, C43.31, D03.30, D03.39	**NUMERATOR (SUBMISSION CRITERIA):** Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.	**NUMERATOR (SUBMISSION CRITERIA 1 & 2):** Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis ***Performance Met:*** Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis **(5050F OR** ***Denominator Exception:*** Documentation of patient reason(s) for not communicating treatment plan to the Primary Care Physician(s) (PCP) (s) (e.g., patient asks that treatment plan not be communicated to the physician(s) providing continuing care) **(5050F *with* 2P) OR** ***Denominator Exception:*** Documentation of system reason(s) for not communicating

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		documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis THERE ARE TWO SUBMISSION CRITERIA FOR THIS MEASURE: 1) All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma during excision of malignant lesion OR 2) All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma evaluated in an		17311 All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma **Denominator Criteria (Eligible Cases) 2: Diagnosis for melanoma (ICD-10-CM):** C43.10, C43.11, C43.20, C43.30, C43.31, D03.30, D03.39 **AND Patient encounter during the performance period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245* **WITHOUT Telehealth Modifier:** GQ, GT, 95, POS 02 **(CPT/(ICD-10-CM codes) listed to the right.**	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245*		treatment plan to the PCP(s) (e.g., patient does not have a primary care physician or referring physician) **(5050F *with* 3P)** **OR *Performance Not Met:*** Treatment plan not communicated, reason not otherwise specified **(5050F *with* 8P)**

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		outpatient setting					
High Priority (Outcome) Core Quality Measure Collaborative (CQMC) core measure	Measure # 226:	*Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention* Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Claims, Registry	Patients aged ≥ 18 years on date of encounter **AND** having one of the encounters (CPT or HCPCS codes) listed in the next column to the right	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user	**Patient Screened for Tobacco Use** **CPT II 4004F:** Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user **OR** **Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco** **CPT II 1036F:** Current tobacco non-user **OR** **Tobacco Screening not Performed for Medical Reasons** Append a modifier (**1P**) to CPT Category II code **4004F** to report documented circumstances that appropriately exclude patients from the denominator **4004F *with* 1P:** Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy) **OR**

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							Tobacco Screening not Performed Reason Not Specified Append a reporting modifier (**8P**) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified. **4004F *with* 8P:** Tobacco Screening not performed, reason not otherwise specified
High Priority (Patient Safety)	Measure #238:	*Use of High-Risk Medications in the Elderly* Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported: a. Percentage of patients who were ordered at least one high-risk medication b. Percentage of patients who were ordered at least two different high-risk medications.	Registry	Patients aged ≥ 65 years on date of encounter **AND** having one of the encounters listed in the next column to the right	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	Percentage of patients who were ordered at least one or two high-risk medication during the measurement period	**Drug Classifications applying to the OMS.** **Pain medication, skeletal relaxants:** Carisoprodol, Metaxalone, Chlorzoxazone, Methocarbamol, Cyclobenzaprine, Orphenadrine **Pain medications, other:** Indomethacin, Ketorolac, include parenteral, Meperidine, Pentazocine

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High Priority (Care Coordination)	Measure #265:	*Biopsy Follow-Up:* Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician	Registry	All patients undergoing a biopsy	11100, 20200, 20205, 20206, 20220, 20225, 20240, 20245, 30100, 31050, 31051, 38500, 38505, 40490, 40808, 41100, 41108, 42100, 42400, 42405, 42800, 42802, 42804, 42806, 64795, 99201, 99202, 99203, 99204, 99205	Patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and the patient by the physician performing the biopsy. The physician performing the biopsy must also acknowledge and/or document the communication in a biopsy tracking log and document in the patient's medical record.	**G8883:** Biopsy results reviewed, communicated, tracked and documented **OR** **G88884:**Clinician documented reason that patient's biopsy results were not reviewed, [e.g., patient asks that biopsy results not be communicated to the primary care/referring physician, patient does not have a primary care/referring physician or is a self-referred patient] **OR** **G8885:** Biopsy results NOT reviewed, communicated, tracked or documented
	Measure #277:	**Sleep Apnea: Severity Assessment at Initial Diagnosis:** Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an	Registry only	Patients aged ≥ 18 years on date of encounter **AND Diagnosis for sleep apnea (**		Patients who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis **Definitions:** **Apnea-Hypopnea Index (AHI)** for	**Numerator Options:** ***Performance Met:*** Apnea hypopnea index (AHI) or respiratory disturbance index (RDI) measured at the time of initial diagnosis **(G8842)** **OR** ***Denominator Exception:*** Documentation of reason(s) for not measuring an apneahypopnea index (AHI) or a respiratory disturbance index (RDI) at the time of initial diagnosis (e.g., psychiatric disease, dementia, patient declined, financial, insurance coverage, test ordered but not yet completed) **(G8843)**

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		apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis				polysomnography performed in a sleep lab is defined as (Total Apneas + Hypopneas per hour of sleep); Apnea-Hypopnea Index (AHI) for a home sleep study is defined as (Total Apneas + Hypopneas per hour of monitoring). **Respiratory Disturbance Index (RDI)** - is defined as (Total Apneas + Hypopneas + Respiratory Effort Related Arousals per hour of sleep).	**OR** ***Performance Not Met:*** Apnea hypopnea index (AHI) or respiratory disturbance index (RDI) not measured at the time of initial diagnosis, reason not given **(G8844)**
	Measure #279:	Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy – National Quality Strategy Domain: Effective Clinical Care	Registry	Patients aged ≥ 18 years on date of encounter **AND** **Diagnosis for sleep apnea (ICD-10-CM):** G47.30, G47.33 **WITHOUT** **Telehealth Modifier:** GQ,	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	Patient visits with documentation that adherence to positive airway pressure therapy was objectively measured	Patient visits with documentation that adherence to positive airway pressure therapy was objectively measured **Numerator options**:

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				GT, 95, POS 02 **AND** **Positive airway pressure therapy was prescribed:** G8852 **AND** having one of the encounters (CPT or HCPCS codes) listed in the next column to the right			Performance Met: Objective measurement of adherence to positive airway pressure therapy, documented (G8851) OR Denominator Exception: Documentation of reason(s) for not objectively measuring adherence to positive airway pressure therapy (e.g., patient didn't bring data from continuous positive airway pressure [CPAP], therapy not yet initiated not available on machine) (G8854) OR Performance not met: Objective measurement of adherence to positive airway pressure therapy not performed, reason not given (G8855)
	Measure #317:	*Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented*	Claims, Registry	Patients aged ≥ 18 years on date of encounter **AND**	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99224, 99225, 99226, 99234,	Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as	*****Screening for High Blood Pressure not Documented, Patient not Eligible *Denominator Exclusion:* G9744**:** Patient not eligible due to active diagnosis of hypertension

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		Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated		having one of the encounters (CPT or HCPCS codes) listed in the next column to the right <u>WITHOUT</u> Telehealth modifier: GQ, GT, 95, POS 02	99235, 99236, 99281, 99282, 99283, 99285, D7140, D7210, G0101, G0402, G0438, G0429	indicated if the blood pressure is pre-hypertensive or hypertensive ***NUMERATOR NOTE:*** *Although the recommended screening interval for a normal BP reading is every 2 years, to meet the intent of this measure, BP screening and follow-up must be performed once per performance period. For patients with Normal blood pressure, a follow-up plan is not required. If the blood pressure is pre-hypertensive (SBP > 120 and <139 OR DBP >80 and <89) at a Primary Care Provider (PCP) encounter follow up as directed by the PCP would meet the intent of*	**G8783:** Normal blood pressure reading documented, follow-up not required **OR** **G8950:** Pre-Hypertensive or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented **<u>OR</u>** **Screening or Follow-Up for High Blood Pressure not Completed, Documented Reason ***Denominator Exception:*** **G9745**: Documented reason for not screening or recommending a follow-up for high blood pressure **<u>OR</u>** **G8785:** Blood pressure reading **not** documented, reason not given OR **G8952:** Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up **not** documented, reason not given

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						*the measure **(G8783).***	
High Priority (Appropriate Use)	Measure #331:	Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse) Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms	Registry	**Denominator Criteria (Eligible Cases):** Patients aged ≥ 18 years on date of encounter **AND** **Diagnosis for acute sinusitis (ICD-10-CM):** J01.00, J01.01, J01.10, J01.11, J01.20, J01.21, J01.30, J01.31, J01.40, J01.41, J01.80, J01.90 **AND** having one of the encounters (CPT code) listed in the next column to the right	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285 WITHOUT Telehealth Modifier: GQ, GT, 95, POS 02	Patients prescribed any antibiotic within 10 days after onset of symptoms	Numerator Options: *Performance Met:* Antibiotic regimen prescribed within 10 days after onset of symptoms (G9286) OR *Denominator Exception:* Antibiotic regimen prescribed within 10 days after onset of symptoms for documented medical reason (G9505) OR *Performance Not Met:* Antibiotic regimen not prescribed within 10 days after onset of symptoms (G9287)
High Priority (Appropriate Use)	Measure #332:	Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis	Registry	**Denominator Criteria (Eligible Cases):** Patients aged ≥ 18 years on date of encounter **AND** **Diagnosis for acute sinusitis (ICD-10-CM):** J01.00, J01.01,	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285 WITHOUT	Patients who were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis	**G9315:** Amoxicillin, with or without clavulanate, prescribed as a first line antibiotic at the time of diagnosis **OR** **G9313:** Amoxicillin, with or without clavulanate, not prescribed as first line

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis		J01.10, J01.11, J01.20, J01.21, J01.30, J01.31, J01.40, J01.41, J01.80, J01.90 **AND** having one of the encounters (CPT code) listed in the next column to the right	Telehealth Modifier: GQ, GT, 95, POS 02 AND Sinusitis caused by, or presumed to be caused by, bacterial infection: G9364 AND Antibiotic regimen prescribed: G9498		antibiotic at the time of diagnosis for documented reason (e.g., cystic fibrosis, immotile cilia disorders, ciliary dyskinesia, immune deficiency, prior history of sinus surgery within the past 12 months, and anatomic abnormalities, such as deviated nasal septum, resistant organisms, allergy to medication, recurrent sinusitis, chronic sinusitis, or other reasons) **OR** **G9314:** Amoxicillin, with or without clavulanate, not prescribed as first line antibiotic at the time of diagnosis, reason not given
High Priority (Appropriate Use)	Measure #333:	*Adult Sinusitis: Computed Tomography (CT) for Acute Sinusitis (Overuse):* Percentage of patients aged 18 years and older with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of	Registry	Patients aged ≥ 18 years on date of encounter **AND** Diagnosis for acute sinusitis Diagnosis for acute sinusitis (ICD-10-CM) for J01.00, J01.10, J01.20, J01.30,	99201, 99202, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285 WITHOUT Telehealth Modifier: GQ, GT, 95, POS 02	Patients who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis	**G9349:** CT scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis **OR** **G9348:** CT scan of the paranasal sinuses ordered at the time of diagnosis for documented reasons (e.g., persons with sinusitis symptoms lasting at least 7 to 10 days, antibiotic resistance, immunocompromised, recurrent sinusitis, acute frontal sinusitis, acute sphenoid

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis		J01.40, J01.80, J01.90 AND having one of the encounters listed in the next column to the right			sinusitis, periorbital cellulitis, or other medical) **OR** **G9350:** CT scan of the paranasal sinuses not ordered at the time of diagnosis or received within 28 days after date of diagnosis
High Priority (Outcome)	Measure #342:	*Pain Brought Under Control Within 48 Hours:* Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) who report pain was	Registry	Patients aged ≥ 18 years AND having one of the encounters listed in the next column to the right AND	99324, 99325, 99326, 99327, 99328	Patients whose pain was brought to a comfortable level within 48 hours of initial assessment (after admission to palliative care services)	**G9250:** Documentation of patient pain brought to a comfortable level within 48 hours from initial assessment **OR** **G9251:** Documentation of patient with pain not brought to a comfortable level within 48 hours from initial assessment

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		brought to a comfortable level within 48 hours		Patient able to communicate and understand the language of the person asking AND Patient self-reported uncomfortable due to pain at the initial assessment			
	Measure #355:	*Unplanned Reoperation within the 30 day Postoperative Period* Percentage of patients aged 18 years or older who had any unplanned reoperation within the 30 day postoperative period	Registry	All patients aged 18 years and older AND Patient procedure during the performance period having one of the encounters listed in the next column to the right	20200, 20205, 21552, 21554, 21555, 21556.	Unplanned return to the operating room for a surgical procedure, for any reason, within 30 days of the principal operative procedure	Unplanned return to the operating room for a surgical procedure, for complications of the principal operative procedure, within 30 days of the principal operative procedure **(G9308) OR** Unplanned return to the operating room for a surgical procedure, for complications of the principal operative procedure, within 30 days of the principal operative procedure **(G9308)**

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
High Priority- Patient Experience	Measure #358:	**Patient-Centered Surgical Risk Assessment and Communication – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and	Registry	Patients aged ≥ 18 years on date of encounter **AND Patient encounter during the performance period (Multiple CPT codes apply)** **AND NOT DENOMINATOR EXCLUSION:** **Emergency surgery:** G9752	10121, 10140, 10160, 10180, 11000, 11001, 11010, 11011, 11042, 11043, 11044,11420, 11421, 14301, 15040, 15155, 15220, 15240, 15260, 15574, 15576, 21011, 21012, 21013, 21014, 21015, 21016, 21025, 21026, 21034, 21040, 21044, 21045, 21046, 21047, 21048, 21049, 21139, 21154, 21235, 21299, 21360, 40800, 40801, 40810, 40812, 40814, 40816, 41000, 41005, 41006, 41007, 41008, 41009, 41016, 41017, 41018, 41110, 41112, 41113, 41114, 41116, 41120, 41130, 41135, 41140, 41145, 41150, 41153, 41155	Documentation of empirical, personalized risk assessment based on the patient's risk factors with a validated risk calculator using multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient and/or family	***Numerator Options:*** ***Performance Met:*** *Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family* ***(G9316)*** ***Performance Not Met:*** *Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family not completed* ***(G9317)***

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		who received personal discussion of those risks with the surgeon					
	Measure #361:	**Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry – National Quality Strategy Domain: Patient Safety** Percentage of total computed tomography (CT) studies performed for all patients, regardless of age, that are submitted to a radiation dose index registry that is capable of collecting at a minimum	Registry	All patients regardless of age **AND** **Patient procedure during the performance period (based on CPT codes to the right)**	70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498	CT studies performed that are reported to a radiation dose index registry that is capable of collecting at a minimum all of the following data elements: Manufacturer Study description Manufacturer's model name Patient's weight Patient's size Patient's sex Patient's age Exposure time X-Ray tube current	**Numerator Options:** **Performance Met:** CT studies performed reported to a radiation dose index registry that is capable of collecting at a minimum all necessary data elements **(G9327)** **OR** **Performance Not Met:** CT studies performed not reported to a radiation dose index registry that is capable of collecting at a minimum all necessary data elements, reason not given **(G9326)**

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		selected data elements				Kilovoltage (kV) Mean Volume Computed tomography dose index (CTDIvol) Dose-length product (DLP)	
	Measure #362:	**Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-up and Comparison Purposes – National Quality Strategy Domain: Communication and Care Coordination** Percentage of final reports for	Registry	All patients regardless of age **AND** **Patient procedure during the performance period (based on CPT codes to the right)**	70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498	Final reports for CT studies which document that DICOM format image data are available to non-affiliated external healthcare facilities or entities on a secure, media-free, reciprocally searchable basis with patient authorization for at least a 12-month period after the study	***Performance Met:*** Final report documented that DICOM format image data available to non-affiliated external healthcare facilities or entities on a secure, media free, reciprocally searchable basis with patient authorization for at least a 12-month period after the study **(G9340)** **OR** ***Performance Not Met:*** DICOM format image data available to non-affiliated external healthcare facilities or entities on a secure, media free, reciprocally searchable basis with patient authorization for at least a 12-month period after the study not documented in final report, reason not given **(G9329)**

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		computed tomography (CT) studies performed for all patients, regardless of age, which document that Digital Imaging and Communications in Medicine (DICOM) format image data are available to non-affiliated external healthcare facilities or entities on a secure, media free, reciprocally searchable basis with patient authorization for at least a 12-month period after the study					

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
High Priority (Care Coordination)	Measure #374:	**Closing the Referral Loop: Receipt of Specialist Report – National Quality Strategy Domain: Effective Communication and Care Coordination** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred	Registry	Patients regardless of age on the date of the encounter **AND** **Patient encounter during the performance period (based on CPT codes to the right)** **WITHOUT Telehealth Modifier:** GQ, GT, 95, POS 02 **AND** **Patient was referred to another provider or specialist during the performance period: G9968**	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred	**Numerator Options:** **Performance Met:** Provider who referred the patient to another provider received a report from the provider to whom the patient was referred **G9969** **OR** **Performance Not Met:** Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred **G9970**

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
High Priority (Care Coordination)	Measure #397:	Melanoma Reporting – National Quality Strategy Domain: Communication and Care Coordination	Claims	Patients ≥ 18 years of age on date of encounter **AND** **Diagnosis for malignant cutaneous melanoma (ICD-10-CM):** C43.0, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9 **AND** **Patient procedure during performance period (CPT):** 88305		Pathology reports for primary malignant cutaneous melanoma that include the pT (primary tumor) category and a statement on thickness, ulceration and mitotic rate.	**Numerator Quality-Data Coding Options:** **If Patient is not Eligible for this Measure because the Specimen is not of Cutaneous Origin** ***Denominator Exclusion:*** **G9430:** Specimen site other than anatomic cutaneous location OR Pathology reports that include the pT (primary tumor) category and a statement on thickness and ulceration and for pT1, mitotic rate. Performance Met: G9428: Pathology report includes the pT Category and a statement on thickness and ulceration and for pT1, mitotic rate. OR **Pathology Reports that does not Include the pT category and a Statement on Thickness and Ulceration and for pT1, mitotic rate, not documented for Medical Reasons** ***Denominator Exception:*** **G9429:** Documentation of medical reason(s) for not including pT Category and a statement on thickness and ulceration and for pT1, mitotic rate (e.g., negative skin biopsies in

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
							a patient with a history of melanoma or other documented medical reasons) OR Pathology Reports that does not include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate, reason not given. Performance NOT met: G9431: Pathology report does not include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate.
	Measure #402:	*Tobacco Use and Help with Quitting Among Adolescents – National Quality Strategy Domain: Community / Population Health* The percentage of adolescents 12 to 20 years of age with a	Registry	Patients aged 12 to 20 years on the date of encounter **AND** having one of the encounters (CPT or HCPCS codes) listed in the next column to the right	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439	Patients who were screened for tobacco use at least once within 18 months (during the measurement period or the six months prior to the measurement period) **AND** who received tobacco cessation counseling	**G9458:** Patient documented as tobacco user AND received tobacco cessation intervention (must include at least one of the following: advice given to quit smoking or tobacco use, counseling on the benefits of quitting smoking or tobacco use, assistance with or referral to external smoking or tobacco cessation support programs, or current enrollment in smoking or tobacco use cessation program) if identified as a tobacco user **OR**

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user				intervention if identified as a tobacco user	**G9459**: Currently a tobacco non-user **OR** **G9460:** Tobacco assessment OR tobacco cessation intervention not performed, reason not otherwise specified
High Priority (Outcome)	Measure #404:	*Anesthesiology Smoking Abstinence: National Quality Strategy Domain: Effective Clinical Care* *The percentage of current smokers who abstain from cigarettes prior to anesthesia on the day of elective surgery or procedure*	Registry	Patients aged ≥ 18 years AND having one of the encounters (CPT or HCPCS codes) listed in the next column to the right AND Current cigarette smokers (G9642)	00100-00210	Current cigarette smokers and who abstained from smoking prior to anesthesia on the day of surgery or procedure.	**G9644:** Patients who abstained from smoking prior to anesthesia on the day of surgery or procedure **OR** **G9645:** Patients who did not abstain from smoking prior to anesthesia on the day of surgery or procedure

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
				AND Elective Surgery (G9643) AND Seen pre-operatively by anesthesiologist or proxy prior to day of surgery (G9497)			
High Priority (Opioid)	Measure #408:	**Opioid Therapy Follow-up Evaluation – National Quality Strategy Domain: Effective Clinical Care** All patients 18 and older prescribed opiates for longer than six weeks duration	Registry	Patients aged ≥ 18 years on date of encounter **AND** **Patient encounter during the performance period (CPT codes in the next column):** **WITHOUT**	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	Patients who had a follow-up evaluation conducted at least every three months during opioid therapy	**Numerator Options:** **Performance Met:** Patients who had a follow-up evaluation conducted at least every three months during opioid therapy **(G9562)** **OR** **Performance Not Met:** Patients who did not have a follow-up evaluation conducted at least every three months during opioid therapy **(G9563)**

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record		**Telehealth Modifier:** GQ, GT, 95, POS 02 **AND** **Patients prescribed opiates for longer than six weeks:** G9561			
High Priority (Opioid)	Measure #412:	*Documentation of Signed Opioid Treatment Agreement–National Quality Strategy Domain: Effective Clinical Care* All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid	Registry	Patients aged ≥ 18 years on date of encounter AND Having one of the encounters (CPT) listed in the next column to the right WITHOUT Telehealth Modifier: GQ, GT, 95, POS 02 AND	99201-99205, 99212-99215, 99304-99310, 99324-99328, 99334-99337, 99341-99350	Patients who signed an opioid treatment agreement at least once during opioid therapy	**G9578 (Performance Met):** Documentation of signed opioid treatment agreement at least once during opioid therapy **OR** **G9579 (Performance Not Met):** No documentation of signed an opioid treatment agreement at least once during opioid therapy

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		Therapy documented in the medical record		Patients prescribed opiates for longer than six weeks: G9577			
High Priority (Opioid)	Measure #414:	*Evaluation or Interview for Risk of Opioid Misuse – National Quality Strategy Domain: Effective Clinical Care* All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAAP-R) or patient interview documented at least once during Opioid	Registry	Patients aged ≥ 18 years on date of encounter AND Having one of the encounters (CPT) listed in the next column to the right **WITHOUT** **Telehealth Modifier:** GQ, GT, 95, POS 02 **AND** **Patients prescribed opiates for longer than six weeks:** G9583	99201-99205, 99212-99215, 99304-99310, 99324-99328, 99334-99337, 99341-99350 AND Patients prescribed opiates for longer than 6 weeks	Patients evaluated for risk of misuse of opiates by using a brief validated instrument (e.g., Opioid Risk Tool, SOAAP-R) or patient interview at least once during opioid therapy	**G9584 (Performance Met):** Patient evaluated for risk of misuse of opiates by using a brief validated instrument (e.g., Opioid Risk Tool, SOAAP-R) or patient interviewed at least once during opioid therapy **OR** **G9585 (Performance Not Met):** Patient not evaluated for risk of misuse of opiates by using a brief validated instrument (e.g., Opioid Risk Tool, SOAAP-R) or patient not interviewed at least once during opioid therapy

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		Therapy in the medical record					
High Priority (Efficiency)	Measure #415:	*Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older - National Quality Strategy Domain: Efficiency and Cost Reduction* Percentage of emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care clinician who have an	Claims, Registry	All emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider	Diagnosis for minor blunt head trauma within the code range- S00-S09 Patient encounter during the performance period: 99281-99285	Emergency department visits for patients who have an indication for a head CT	**Patient with Minor Blunt Head Trauma with a Valid Reason for a Head CT for Documented Reasons** *(Two G-codes [G9531 & G9530] are required on the claim form to submit this numerator option)* ***Denominator Exclusion:*** **G9531:** Patient has documentation of ventricular shunt, brain tumor, multisystem trauma, pregnancy, or is currently taking an antiplatelet medication including: ASA/dipyridamole, clopidogrel, prasugrel, ticlopidine, ticagrelor, or cilostazol **AND** **G9530:** Patient presented within 24 hours of a minor blunt head trauma with a GCS score of 15 and had a head CT ordered for trauma by an emergency care provider **OR** **If Patient is not Eligible for this Measure because of a Documented Reason as Indicated, Submit:** *(One G-code [G9532] is required on the claim form to submit this numerator option)* ***Denominator Exclusion:*** **G9532:** Patient's head injury occurred greater than 24 hours before presentation to the emergency department, OR has a GCS score less than 15 or does not have a GCS score documented, OR had a head CT for trauma ordered by someone other than an

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		indication for a head CT.					emergency care provider, OR was ordered for a reason other than trauma **OR** **Patient with Minor Blunt Head Trauma had an Appropriate Indication for a Head CT** *(Two G-codes [G9529 & G9530] are required on the claim form to submit this numerator option)* ***Performance Met:*** **G9529:** Patient with minor blunt head trauma had an appropriate indication(s) for a head CT **AND** **G9530:** Patient presented within 24 hours of a minor blunt head trauma with a GCS score of 15 and had a head CT ordered for trauma by an emergency care provider **OR** **Patient with Minor Blunt Head Trauma did not have an Appropriate Indication for a Head CT** *(Two G-codes [G9533 & G9530] are required on the claim form to submit this numerator option)* ***Performance Not Met:*** **G9533:** Patient with minor blunt head trauma did not have an appropriate indication(s) for a head CT **AND** **G9530:** Patient presented within 24 hours of a minor blunt head trauma with a GCS score of 15 and had a head CT ordered for trauma by an emergency care provider To indicate the GCS score less than 15 is an appropriate indication for a head CT.

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
High Priority (Efficiency	Measure #416:	*Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 through 17 Years - National Quality Strategy Domain: Efficiency and Cost Reduction* Percentage of emergency department visits for patients aged 2 through 17 years who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who are	Claims, Registry	Patients aged 2 through 17 years on date of encounter AND having one of the encounters (ICD-10-CM) listed in the next column to the right AND having one of the encounters (CPT codes) listed in the next column to the right	Diagnosis for minor blunt head trauma within the code range- S00-S09 Patient encounter during the performance period: 99281-99285	Emergency department visits for patients who are classified as low risk according to the Pediatric Emergency Care Applied Research Network (PECARN) prediction rules for traumatic brain injury	Pediatric Patient with Minor Blunt Head Trauma with a Valid Reason for Head CT for Documented Reasons *(Two G-codes [G9595 & G9594] are required on the claim form to submit this numerator option)* *Denominator Exclusion:* G9595: Patient has documentation of ventricular shunt, brain tumor, coagulopathy, including thrombocytopenia AND G9594: Patient presented within 24 hours of a minor blunt head trauma with a GCS score of 15 and had a head CT ordered for trauma by an emergency care provider OR If Patient is Not Eligible for this Measure because of a Documented Reason as Indicated, Submit: *(One G-code [G9596] is required on the claim form to submit this numerator option)* *Denominator Exclusion:* G9596: Pediatric patient's head injury occurred greater than 24 hours before presentation to the emergency department, OR has a GCS score less than 15 or does not have a GCS score documented, OR had a head CT for trauma ordered by someone other than an emergency care provider, OR was ordered for a reason other than trauma OR Pediatric Patient with Minor Blunt Head Trauma Classified as Low Risk According

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		classified as low risk according to the Pediatric Emergency Care Applied Research Network (PECARN) prediction rules for traumatic brain injury.					to the PECARN Prediction Rules with Order of Head CT *(Two G-codes [G9593 & G9594] are required on the claim form to submit this numerator option)* *Performance Met:* G9593: Pediatric patient with minor blunt head trauma classified as low risk according to the PECARN prediction rules AND G9594: Patient presented within 24 hours of a minor blunt head trauma with a GCS score of 15 and had a head CT ordered for trauma by an emergency care provider OR Pediatric Patient with Minor Blunt Head Trauma Not Classified as Low Risk According to the PECARN Prediction Rules with Order of Head CT *(Two G-codes [G9597 & G9594] are required on the claim form to submit this numerator option)* *Performance Not Met:* G9597: Pediatric patient with minor blunt head trauma not classified as low risk according to the PECARN prediction rules AND G9594: Patient presented within 24 hours of a minor blunt head trauma with a GCS score of 15 and had a head CT ordered for trauma by an emergency care provider To indicate the GCS score less than 15 is an appropriate indication for a head CT.

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
High Priority (Outcome)	Measure #424:	*Perioperative Temperature Management* – *National Quality Strategy Domain: Patient Safety* Percentage of patients, regardless of age, who undergo surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom at least one body temperature greater than or equal to 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) was recorded within the 30	Registry	All patients regardless of age AND having one of the encounters (CPT codes) listed in the next column to the right AND **Anesthesia of 60 minutes duration or longer:** 4255F **AND NOT** **DENOMINATOR EXCLUSIONS:** **Monitored Anesthesia Care (MAC):** G9654 **OR**	00100-00210	Patients for whom at least one body temperature greater than or equal to 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time	***Performance Met:*** At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time **(G9771)** **OR** ***Denominator Exception:*** Documentation of one of the following medical reason(s) for not achieving at least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time (e.g., Emergency cases, Intentional hypothermia, etc.) **(G9772)** **OR** ***Performance Not Met:*** At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) not achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time **(G9773)**

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		minutes immediately before or the 15 minutes immediately after anesthesia end time		**Peripheral Nerve Block (PNB):** G9770			
High Priority (Patient Safety)	Measure #430:	*Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy – National Quality Strategy Domain: Patient Safety* *Percentage of patients, aged 18 years and older, who undergo a procedure under an inhalational general anesthetic, AND who have three or more risk factors for post-operative nausea and vomiting (PONV), who*	Registry	Patients aged ≥ 18 years on date of encounter AND having one of the encounters (CPT codes) listed in the next column to the right AND Patient received inhalation anesthetic agent: 4554F AND	00100-00210	Patients who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively or intraoperatively	Performance Met: Patient received at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (G9775) OR Denominator Exception: Documentation of medical reason for not receiving at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason) (G9776) OR Performance Not Met: Patient did not receive at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (G9777)

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		receive combination therapy consisting of at least two prophylactic pharmacologic antiemetic agents of different classes preoperatively or intraoperatively		Patient exhibits 3 or more risk factors for post-operative nausea and vomiting: 4556F			
	Measure #431:	*Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling- National Quality Strategy Domain: Community/ Population Health* Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for	Registry	Patients aged ≥ 18 years AND having one of the encounters (CPT or HCPCS codes) listed in the next column to the right **WITHOUT** **Telehealth Modifier:** GQ, GT, 95, POS 02 **OR**	99201-99205, 99212-99215, G0270, G0271	Patients who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user	**G9621 (Performance Met):** Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling **OR** **Performance Met:** Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling **(G9621)** **G9622 (Performance Met):** Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user		**At Least One Preventive Visit during the performance period (CPT or HCPC):** 96160, 96161, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439 **WITHOUT** **Telehealth Modifier:** GQ, GT, 95, POS 02			**OR** **G9623 (Medical Performance Exclusion):** Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons) **OR** **G9624 (Performance Not Met):** Patient not screened for unhealthy alcohol screening using a systematic screening method OR patient did not receive brief counseling, reason not given
	Measure #436:	*Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques* Percentage of final reports for patients aged 18 years and older undergoing CT with documentation	Claims, Registry	Patients aged ≥ 18 years AND having one of the encounters (CPT or HCPCS codes) listed in the next column to the right	70450-70498, 0042T	Final reports with documentation that indicate an individualized dose optimization technique was used for the performed procedure, Dose optimization techniques	**G9637 Dose Reduction Techniques (Performance Met):** Final reports with documentation of one or more dose reduction techniques (e.g., Automated exposure control, adjustment of the mA and/or kV according to patient size, use of iterative reconstruction technique) **OR**

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		that one or more of the following dose reduction techniques were used: • Automated exposure control • Adjustment of the mA and/or kV according to patient size • Use of iterative reconstructio n technique				include the following: • Automated expose control • Adjustment of the mA and/or kV according to patient size • Use of iterative reconstruction techniqe	**G9638 Dose Reduction Techniques not Performed (Performance Not Met):** Final reports without documentation of one or more dose reduction techniques (e.g., Automated exposure control, adjustment of the mA and/or kV according to patient size, use of iterative reconstruction technique)
Care Coordinati on	Measure #440:	**Basal Cell Carcinoma (BCC)/Squam ous Cell Carcinoma: Biopsy Reporting Time - Pathologist to Clinician**: Basal Cell Carcinoma (BCC)/Squamo us Cell Carcinoma (SCC): Biopsy Reporting Time	Registry only	**Diagnosis for cutaneous basal carcinoma or squamous cell carcinoma AND Patient procedure during the** performance period **(CPT):** 88304, 88305 **AND NOT DENOMINATOR EXCLUSION: Pathologists/De**	**(ICD-10-CM):** C44.01, C44.02, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.41, C44.42, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629,	Number of final pathology reports diagnosing cutaneous basal cell carcinoma or squamous cell carcinoma (to include in situ disease) sent from the Pathologist/Dermatopathologist to the biopsying clinician for review within 7 business days from the time when the tissue	Pathology report diagnosing cutaneous basal cell carcinoma or squamous cell carcinoma (to include in situ disease) sent from the Pathologist/Dermatopathologist to the biopsying clinician for review within 7 business days from the time when the tissue specimen was received by the pathologist **(G9785)**

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		-Pathologist to Clinician: Percentage of biopsies with a diagnosis of cutaneous Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC) (including in situ disease) in which the pathologist communicates results to the clinician within 7 days from the time when the tissue specimen was received by the pathologist.		**rmatopathologists providing a second opinion on a biopsy:** G9784	C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.81, C44.82, C44.91, C44.92, D04.0, D04.10, D04.11, D04.12, D04.20, D04.21, D04.22, D04.30, D04.39, D04.4, D04.5, D04.60, D04.61, D04.62, D04.70, D04.71, D04.72, D04.8, D04.9	specimen was received by the pathologist	
	Measure #463:	**Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics) – National Quality Strategy Domain:**	Registry	Patients aged 3 through 17 years on date of encounter AND Patient procedure during the performance period (CPT	00170, 00190	Patients who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively	**Numerator Options:** ***Performance Met:*** Patient received combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively **(G9956)** **OR** ***Denominator Exception:*** Documentation of medical reason for not receiving combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively

Indicator*	Measure Number	Measure Description	Reporting Options/Methods	Denominator Criteria (Eligible Cases)	Possible Denominator Codes Applicable to OMS *	Numerator	Possible Numerator Codes
		Effective Clinical Care Percentage of patients aged 3 through 17 years, who undergo a procedure under general anesthesia in which an inhalational anesthetic is used for maintenance AND who have two or more risk factors for post-operative vomiting (POV), who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively		codes on the next column**)** **Patient received inhalational anesthetic agent:** 4554F **AND** **Patient exhibits 2 or more risk factors for post-operative vomiting:** G9954 **AND NOT DENOMINATOR EXCLUSION:** **Cases in which an inhalational anesthetic is used only for induction:** G9955		and/or intraoperatively	and/or intraoperatively (e.g., intolerance or other medical reason) **(G9957)** **OR** ***Performance Not Met:*** Patient did not receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively **(G9958)**