QUALITY ID	MEASURE NAME	MEASURE DESCRIPTION	PERFORMANCE MET CODES	EXCLUSION CODES	PERFORMANCE NOT MET CODES	NQS DOMAIN	MEASURE TYPE	HIGH PRIORITY MEASURE	DATA SUBMISSION METHOD
47	Care Plan	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	**1123F** - Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record **OR** **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	**G9692** - Hospice services received by patient any time during the measurement period	**1123F-8P** - Advance care planning not documented, reason not otherwise specified	Communication and Care Coordination	Process	Yes	Claims,Registry
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m2	**G8420** - BMI is documented within normal parameters and no follow-up plan is required **OR G8417** - BMI is documented above normal parameters and a follow-up plan is documented **OR G8418** - BMI is documented below normal parameters and a follow-up plan is documented.	**G8422** - BMI not documented, documentation the patient is not eligible for BMI calculation **OR G8938** - BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible **OR G9716** - BMI is documented as being outside of normal limits, follow-up plan is not completed for documented reason.	**G8421** - BMI not documented and no reason is given **OR** **G8419** - BMI documented outside normal parameters, no follow-up plan documented, no reason given	Community/ Population Health	Process	No	Claims, CMS Web Interface, EHR, Registry
130	Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	**G8427** - Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications	**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	**G8428** - Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given	Patient Safety	Process	Yes	Claims, EHR, Registry
185	Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use	Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings, which had an interval of 3 or more years since their last colonoscopy	**0529F** - Interval of 3 or more years since patient's last colonoscopy, documented	**0529F-1P** - Documentation of medical reason(s) for an intervalof less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, last colonoscopy found greater than 10 adenomas, or patient at high risk for colon cancer [Crohn's disease, ulcerative colitis, lower gastrointestinal bleeding, personal or family history of colon cancer]) **OR** **0529F-3P** - Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy+F127 report was incomplete)+F231	**0529F-8P** - Interval of less than 3 years since patient's last colonoscopy, reason not otherwise specified	Communication and Care Coordination	Process	Yes	Claims, Registry
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	**4004F** - Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user **OR** **1036F** - Current tobacco non-user	**4004F-1P** - Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)	**4004F-8P** - Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified	Community/ Population Health	Process	No	Claims, CMS Web Interface, EHR, Registry
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	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	**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	**G9744** - Patient not eligible due to active diagnosis of hypertension **OR** **G9745** - Documented reason for not screening or recommending a follow-up for high blood pressure	**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	Community/ Population Health	Process	No	Claims, EHR, Registry
320	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Percentage of patients aged 50 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report	**0528F** - Recommended follow-up interval for repeat colonoscopy of at least 10 years documented in colonoscopy report	**0528F-1P** - Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is ≥ 66 years old, or life expectancy < 10 years old, other medical reasons)	**0528F-8P** - At least 10 year follow-up interval for colonoscopy not recommended, reason not otherwise specified	Communication and Care Coordination	Process	Yes	Claims, Registry