Measure	CPTII	Code Description	Age	ICD.10	CPT I	Modifiers
117 (NQF 0055) Diabetes: Eye Exam **(Effective Clinical Care)** **NEW CODES FOR 2022!**	**2022F** or **2023F** or **2024F** or **2025F** or **2026F** or **2033F** or	Retinal or Dilated Eye Exam Performed by an ophthalmologist or optometrist, with evidence of retinopathy (documented and reviewed) Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist without evidence of retinopathy (documented and reviewed) 7 standard field stereoscopic photos with interpretation, with evidence of retinopathy (documented and reviewed) 7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist without evidence of retinopathy (documented and reviewed) Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos (documented and reviewed) Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos results without evidence of retinopathy (documented and reviewed) Low risk retinopathy	**18 - 75**	E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3219, E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, E11.3312, E11.3313, E11.3319, E11.3391, E11.3392, E11.3393, E11.3399, E11.3411, E11.3412, E11.3413, E11.3419, E11.3491, E11.3492, E11.3493, E11.3499, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533, E11.3539, E11.3541, E11.3542, E11.3543, E11.3549, E11.3551, E11.3552, E11.3553, E11.3559, E11.3591, E11.3592, E11.3593, E11.3593, E11.3599, E11.36, E11.37X1, E11.37X2, E11.37x3E11.37X9, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59,E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9	92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439	**8P**: Reason NOT Specified * Note: **8P** modifier NOT used with 3072F

Measure	CPTII	Code Description	Age	ICD.10	CPT I	Modifiers
	3072F *	(no retinopathy in previous year)*				
		* Note: This code can only be used if the claim/encounter was during the measurement period because it indicates that the patient had "no evidence of retinopathy in the prior year."				
	G9714	Not eligible due to Hospice status				
141 (NQF 0563)	**3284F**	**POAG**: Reduction of IOP >/= 15% Pre-Intervention Level	**18 +**	H40.1111, H40.1112, H40.1113, H40.1114, H40.1121, H40.1122, H40.1123, H40.1124, H40.1131, H40.1132, H40.1133, H40.1134, H40.1211, H40.1212, H40.1213, H40.1214, H40.1221, H40.1222, H40.1223, H40.1224, H40.1231, H40.1232, H40.1233, H40.1234, H40.151, H40.152, H40.153	92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337	**8P**: Reason NOT Specified
POAG: IOP Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% OR Documentation of a Plan of Care **(Communication and Care Coordination)**	**OR**					
	0517F	Glaucoma Plan of Care Documented				
	AND					
	3285F	Reduction of IOP < 15% Pre-Intervention Level				
	OR					
	0517F 8P	Glaucoma Plan of Care NOT Documented, Reason NOT Otherwise Specified				
	AND					
	3285F	Reduction of IOP < 15% Pre-Intervention Level				

Measure	CPT II	Code Description	CPT I	Modifiers
130 Documentation of Current Medications in the Medical Record **(Patient Safety)**	G8427 or G8430 or G8428	Attest to documenting in the medical record that physician obtained, updated, or reviewed the patient's current medications Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation) Current Medications with Name, Dosage, Frequency, Route NOT Documented, Reason NOT Specified/Given	92002, 92004, 92014, 92014, 92507, 92508, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92548, 92550, 92557, 92567, 92568, 92570, 92588, 92626, 96116, 97166, 97167, 97168, 97802, 97803, 97804, 98960, 98961, 98962, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221,99222, 99223, 99236, 99304, 99305, 99306, 99307, 99339, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99496, 99281, 99283, 99284, 99285, 99385, 99386, 99387, 99395, 99396, 99397	None
236 Controlling High Blood Pressure **Effective Clinical Care**	**G8752** **Or** **G8753** **AND** **G8754** **OR** **G8755** **OR** **G8756**	Most recent systolic blood pressure < 140 mmHg Most recent systolic blood pressure ≥ 140 mmHg Most recent diastolic blood pressure < 90 mmHg Most recent diastolic blood pressure ≥ 90 mmHg No documentation of blood pressure measurement, reason not given	99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, G0438, G0439	

Measure	CPT II	Code Description	CPT I	Modifiers
226(NQF 0028) Preventive Care & Screening: Tobacco Use: Screening and Cessation Intervention **(Community / Population Health)**	**Criteria 1** **G9903** Or **G9902** Or **G9904** Or **G9905** **Criteria 2** **G9906** or **G9907** or **G9908** **Criteria 3** **G0030:** or	**All patients** Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco Patient Screened for Tobacco Use and Identified as a Tobacco User Patient Not Screened for Tobacco Use, Medical Reason Patient Not Screened for Tobacco Use, No reason given **Tobacco Users (must report G9902 first plus one code below)** Patient identified as a tobacco user received tobacco cessation intervention on the date of the encounter or within the previous 12 months (counseling and/or pharmacotherapy) Documentation of medical reason(s) for not providing tobacco cessation intervention on the date of the encounter or within the previous 12 months (e.g., limited life expectancy, other medical reason) **Patient Identified as Tobacco User Did Not Receive Tobacco Cessation Intervention, Reason Not Given Screened Patients,** Patient screened for tobacco use AND received tobacco cessation intervention on the date of the encounter or within the previous 12 months (counseling, pharmacotherapy, or both), if identified as a tobacco user **Patient Screened for Tobacco Use and Identified as a Tobacco Non-User**	90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439 **Examples:** Tobacco Non-user: G9903 and 1036F Tobacco User Screened and Cessation Counselling: G9902, G9906, 4004F Tobacco User Screened NO Cessation Counselling, Medical: G9902, G9907, 9909F Tobacco User Screened NO Cessation Counselling, No Reason: G9902, G9908, 4004F-8P Tobacco User Not Screening+No Cessation Counselling, Medical: G9904, G9907, 4004F-1P Tobacco User Not Screening+No Cessation Counselling, No Reason: G9905, 4004F-8P	

	1036F or **G0028** or **G9909** Or **G0029**	Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason) Documentation of medical reason(s) for not providing tobacco cessation intervention on the date of the encounter or within the previous 12 months if identified as a tobacco user (e.g., limited life expectancy, other medical reason) Tobacco screening not performed OR tobacco cessation intervention not provided on the date of the encounter or within the previous 12 months, reason not otherwise specified		

Please note: For 2022, Quality ID #014: Age-Related Macular Degeneration (AMD): Dilated Macular Examination has been removed for claims based reporting.