

Measure	CPTII	Code Description	Age	ICD.10	CPT I	Modifiers
12 (NQF 0086) POAG: ON Evaluation Primary Open-Angle Glaucoma: Optic Nerve Evaluation (Effective Clinical Care)	2027F	POAG: Optic Nerve Evaluation Performed	18 +	H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.1110, H40.1111, H40.1112, H40.1113, H40.1114, H40.1120, H40.1121, H40.1122, H40.1123, H40.1124, H40.1130, H40.1131, H40.1132, H40.1133, H40.1134, H40.1190, H40.1191, H40.1192, H40.1193, H40.1194, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.151, H40.152, H40.153,	92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 <i>* Signifies that this CPT code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for claims-based measures.</i>	1P: Medical Reason 8P: Reason NOT Specified
14 (NQF 0087) AMD: DFE Age-Related Macular Degeneration : Dilated Macular Examination (Effective Clinical Care)	G9974 G9975 G9892 G9893	AMD: Dilated Macular Examination Performed including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity AMD: No Dilated Macular Examination Performed Medical Reason AMD: No Dilated Macular Examination, Patient reason AMD: No dilated Macular examination, No Reason	50 +	H35.3110, H35.3111, H35.3112, H35.3113, H35.3114, H35.3120, H35.3121, H35.3122, H35.3123, H35.3124, H35.3130, H35.3131, H35.3132, H35.3133, H35.3134, H35.3210, H35.3211, H35.3212, H35.3213, H35.3220, H35.3221, H35.3222, H35.3223, H35.3230, H35.3231, H35.3232, H35.3233	92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337	

Measure	CPTII	Code Description	Age	ICD.10	CPT I	Modifiers
19 (NQF 0089) DR: Diabetic Retinopathy: Communication with Physician Managing Ongoing Diabetes Care (Communication and Care Coordination)	G8398	Dilated Macular or Fundus Exam NOT Performed	18 +	E08, E09 and E10 series as well as the following: E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3219, E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, 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, E11.3593, E11.3599, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3219, E13.3291, E13.3292, E13.3293, E13.3299, E13.3311, E13.3312, E13.3313, E13.3319, E13.3391, E13.3392, E13.3393, E13.3399, E13.3411, E13.3412, E13.3413, E13.3419, E13.3491, E13.3492, E13.3493, E13.3499, E13.3511, E13.3512, E13.3513, E13.3519, E13.3521, E13.3522, E13.3523, E13.3529, E13.3531, E13.3532, E13.3533, E13.3539, E13.3541, E13.3542, E13.3543, E13.3549, E13.3551, E13.3552, E13.3553, E13.3559, E13.3591, E13.3592, E13.3593, E13.3599	92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337	1P: Medical Reason 2P: Patient Reason 8P: Reason NOT Specified
	OR 5010F Diabetic Retinopathy: Findings of dilated macular or fundus exam communicated with the physician or other qualified health care professional responsible for managing ongoing diabetes care and G8397 Dilated Macular or Fundus Exam Performed including documentation of the presence or absence of macular edema AND level of severity of retinopathy					
117 (NQF 0055) Diabetes: Eye Exam (Effective Clinical Care)	2022F or 2024F	Retinal or Dilated Eye Exam Performed by an Eye Care Professional (documented and reviewed)	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,	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

* Signifies that this CPT code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for claims-based measures.

	<p>or 2026F</p> <p>or 3072F *</p> <p>or G9714</p>	<p>7 standard field stereoscopic photos with interpretation (documented and reviewed)</p> <p>Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos results (documented and reviewed)</p> <p>Low risk retinopathy (no retinopathy in previous year)*</p> <p>* 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.”</p> <p>Not eligible due to Hospice status</p>		<p>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</p>		<p>* Note: 8P modifier NOT used with 3072F</p>
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Measure	CPTII	Code Description	Age	ICD.10	CPT I	Modifiers
141 (NQF 0563) POAG: IOP Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% OR Documentation of a Plan of Care (Communication and Care Coordination)	3284F	POAG: Reduction of IOP \geq 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
	OR					
	3285F	Reduction of IOP < 15% Pre-Intervention Level				
	and 0517F	Glaucoma Plan of Care Documented				
	OR					
	3285F	Reduction of IOP < 15% Pre-Intervention Level				
and 0517F	Glaucoma Plan of Care NOT Documented, Reason NOT Otherwise Specified					
OR						
3284F	IOP Measurement NOT Documented, Reason NOT Otherwise Specified					

Measure	CPT II	Code Description	CPT I	Modifiers
130 (NQF 0419) Documentation of Current Medications in the Medical Record (Patient Safety)	G8427 or G8430 or G8428	Current Medications Documented (with Name, Dosage, Frequency, or Route Documented) Current Medications NOT Documented, Patient not Eligible (emergency situations only) 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, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96151, 96152, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215,	None

226(NQF 0028) Preventive Care & Screening: Tobacco Use: Screening and Cessation Intervention (Community / Population Health)	Criteria 1 G9903 or G9902 or G9904 or G9905	<u>All patients</u> 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	90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99201, 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:	
	Criteria 2 G9906 or G9907 or G9908	<u>Tobacco Users</u> Patient Screened and Received Cessation Counselling Patient Screened, No Cessation Counselling, Medical Reason Patient Screened, No Cessation Counselling, No reason given	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	
	Criteria 3 4004F or 1036F or 4004F 1P Or G9909 Or 4004F 8P	Tobacco User Screened and Received Counselling Screened and Non-Tobacco User Tobacco Use Not Screened Medical Reason for Not Screening Tobacco User, Medical Reason for Not Providing Cessation Counselling No Tobacco Screening Performed No Cessation Counselling Provided, No Reason		

2019 AOA MORE SUPPORTED QUALITY MEASURE SPECIFICATIONS

130	CMS68	<u>Documentation of Current Medication</u>
117	CMS131	<u>Diabetes: Eye Exam</u>
374	CMS50	<u>Closing the Referral Loop: Receipt of Specialist Report</u>
019	CMS142	<u>Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</u>
012	CMS143	<u>Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation</u>
226	CMS 138	<u>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</u>
236	CMS 165	<u>Controlling High Blood Pressure</u>
001	CMS 122	<u>Diabetes: Hemoglobin A1c Poor</u>

For additional guidance on how to report quality measures via your EHR visit: <https://www.aoa.org/more/ehr-participants>