Measure	Measure Description	Protocol or Documentation Required	Coding
(AAB) Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Adults 18 – 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	Patients dispensed a prescription for antibiotic medication on or three days after the episode start date.	**ICD-10:** J20.3 – J20.9 **Antibiotic prescriptions:** Aminoglycosides, aminopenicillins, antipseudomonal, penicillins, beta-lactamase inhibitors, first-generation cephalosporins, fourth-generation cephalosporins, ketolides, lincomycin derivatives, macrolides, miscellaneous antibiotics, natural penicillins, penicillinase-resistant penicillins, quinolones, rifamycin derivatives, second-generation cephalosporin, sulfonamides, tetracyclines, third-generation cephalosporins, urinary anti-infectives
(ABA) Adult BMI Assessment	Patient ages 18 – 74 years who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior.	Weight and BMI value, dated during the measurement year or the year prior. The weight and BMI must be from the same data source. For patients younger than 21 years of age on the date of service, documentation in the medical record must indicate the height, weight and BMI percentile and must be from the same data source. BMI percentile must be documented as a value (e.g. 85th percentile) or BMI percentile plotted on an age-growth chart. **Exclusions**: Members with a diagnosis of pregnancy during the measurement year or the year prior.	**HCPS:** G0438, G0439, T1015, G0463, G0402 **ICD-10:** **BMI 19 or less, adult:** Z68.1 **BMI 20.0 - 29.9, adult:** Z68.20 - Z68.29 **BMI 30-39, adult:** Z68.30 – Z68.39 **BMI 40 or greater, adult:** Z68.40 – Z68.45 **Pediatric BMI Percentile:** Z68.51 – Z68.54

Measure	Measure Description	Protocol or Documentation Required	Coding
(CBP) Controlling High Blood Pressure *Note: Members are identified by claims indicating at least one outpatient visit with a hypertension diagnosis during the first six months of the measurement year*	Patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria: ▪ Patients 18–59 years of age whose BP was < 140/90 mm Hg. ▪ Patients 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. ▪ Patients 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.	Documentation for confirming diagnosis: Notation or problem list of diabetes, hypertension (HTN), high BP, elevated BP, borderline HTN, intermittent HTN, history of HTN, hypertensive vascular disease, hyperpiesia, or hyperpiesis on or before June 30 of the measurement year. **Most recent BP reading as long as it occurred after the diagnosis of hypertension as follows:** ▪ Patients 18–59 years of age whose BP was < 140/90 mm Hg. ▪ Patients 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. ▪ Patients 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. **Exclusions:** Documentation in the medical record that includes a dated note indicating evidence of end stage renal disease, kidney transplant on or prior to Dec. 31, or members with a diagnosis of pregnancy, or members who had a non-acute inpatient admission during the measurement year (identify the discharge date for the stay).	**Compliance:** Both a most recent systolic BP< 140mm Hg and a diastolic BP < 90 mm Hg identified in documentation via medical record review. **Outpatient Visit CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387. 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455-99456 **HCPCS:** G0438, G0439, T1015, G0463, G0402 **Hypertension diagnosis** **ICD-10:** I10
(CCS) Cervical Cancer Screening	Women 21–64 years of age who were screened for cervical cancer using either of the following criteria: ▪ Age 21–64 who had cervical cytology performed every three years. ▪ Age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.	Documentation in the medical record must include the following: ▪ Ages 24–64 (back three years): ▪ A note indicating the date the cervical cytology was performed. ▪ The result or finding. ▪ Ages 30–64, who do not meet first requirement (back 5 years). ▪ A note indicating the date the cervical cytology and the HPV test was performed. ▪ The result or finding. **Exclusions:** Evidence of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history. Documentation of complete, total or radical abdominal or vaginal hysterectomy. ***Note:*** *Documentation of hysterectomy alone does not meet criteria because it is not sufficient evidence that the cervix was removed.*	**(Pap) CPT:** 88141 –88143, 88147, 88148, 88150, 88152 – 88154, 88164 – 88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 **HPV CPT:** 87620 - 87622 ***Note:*** *NCQA does not intend to include ICD-10-CM (diagnosis) or ICD-10-PCS (procedure) codes to identify cervical cancer screening. ICD-10-CM Official Guidelines for Coding and Reporting state: Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe the procedure performed. Therefore, Z codes will not be used to identify encounters for cervical cancer screening. ICD-10- PCS is intended for coding procedures performed in inpatient settings. Therefore, ICD-10-PCS codes are inapplicable because cervical cancer screening typically occurs in an outpatient setting. The table currently includes CPT, HCPCS, UB Revenue and LOINC codes which are used in outpatient settings.*

Measure	Measure Description	Protocol or Documentation Required	Coding
(CDC) Comprehensive Diabetes Care	Members 18–75 years of age with diabetes (type 1 or type 2) who had each of the following: ▪ Hemoglobin A1c (HbA1c) testing ▪ HbA1c poor control (>9.0%) ▪ HbA1c control (<8%) ▪ HbA1c control (<7%) ▪ Retinal eye exam performed ▪ Medical attention for nephropathy ▪ BP control (<140/90 mm Hg)	See each individual measure below. Data reviewed to identify compliance with the measures include: ▪ Claims and encounters ▪ Vision claims ▪ Medical records ▪ Labs	**ICD-10:** E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41 – E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620 - E11.22, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.30 - E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620 – E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, O24.011 – O24.013, O24.019, O24.02, O24.03, O24.111 – O24.113, O24.119, O24.12, O24.13, O24.312, O24.313, O24.319, O24.32, O24.33, O24.811 – O24.813, O24.819, O24.82, O24.83
(CDC – HbA1c)	Patients 18–75 years of age with diabetes (type 1 or type 2) ▪ HbA1c testing ▪ HbA1c poor control (>9.0%) ▪ HbA1c control (<8.0%) ▪ HbA1c control (<7.0%)	Documentation with the most recent HbA1c test performed during the measurement year. Documentation must include the date and result. **Exclusions for HbA1c control <7% for a selected population**: ▪ 65 years of age and older as of Dec. 31 of the measurement year ▪ Coronary artery bypass graft (CABG). Members discharged for CABG during the measurement year or the year prior ▪ Percutaneous coronary intervention (PCI) during the measurement year or the year prior ▪ Ischemic vascular disease (IVD) - documentation of an IVD diagnosis – Ischemic heart disease – Angina – Coronary atherosclerosis – Coronary artery occlusion – Cardiovascular disease – Occlusion or stenosis of pre-cerebral arteries – Atherosclerosis of renal artery – Atherosclerosis of native arteries of the extremities ▪ Thoracoabdominal or thoracic aortic aneurysm ▪ Congestive heart failure (CHF) – documentation of CHF or diagnosis	**HbA1c/HbA1c level (Cat II) CPT:** 83036, 83037 **Cat II:** For HbA1c tests: 3044F – 3046F For A1c level <7%: 3044F For A1c level 7 - 9%: 3045F For A1c level >9%: 3046F **LOINC:** 17856-6, 4548-4, 4549-2

Measure	Measure Description	Protocol or Documentation Required	Coding
(CDC – Nephropathy)	Patients 18–75 years of age with diabetes (type 1 or type 2) who had the following during the measurement year: Medical attention for nephropathy (nephropathy test, evidence of nephropathy, urine macro albumin tests, or at least one angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) dispensing event).	Documentation during the measurement year indicating the date when the urine micro albumin test was performed and the results, documentation indicating evidence of nephropathy (i.e., renal transplant, end stage renal disease (ESRD), nephrologist visit or micro albumin test) or documentation with a note indicating that the member received a prescription for ACE inhibitors/ARBs in the measurement year. **Exclusions:** ▪ Gestational diabetes ▪ Steroid-induced diabetes	**Monitoring for nephropathy** **CPT:** 81000 – 81005, 82042 – 82044, 84156 **CAT II:** 3060F – 3062F, 3066F, 4010F **Evidence of Nephropathy Treatment** **ICD-10:** E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, N00.0 – N00.9, N01.0 – N01.9, N02.0 – N02.9, N02.0 – N02.9, N03 – N03.9, N04.0 – N04.9, N05.0 – N05.9, N06.0 – N06.9, N07.0 – N07.9, N08, N14.0 – N14.4, N15.0, N17.0 – N17.2, N17.8, N17.9, N18.1 – N18.6, N18.9, N19, N25.0, N25.1, N25.81, N25.89, N25.9, N26.1, N26.2, N26.9, Q60.0 – Q60.6, Q61.00 – Q60.02, Q61.11, Q61.19, Q61.2 – Q61.5, Q61.8, Q61.9, R80.0 – R80.3, R80.8, R80.9 **LOINC:** 11218-5, 12842-1, 13705-9, 13801-6, 14585-4, 14956-7, 14957-5, 14958-3, 14959-1, 1753-3, 1754-1, 1755-8, 1757-4, 18373-1, 20454-5, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 2887-8, 2888-6, 2889-4, 2890-2, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49023-5, 50561-0, 50949-7, 53121-0, 53525-2, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 57735-3, 5804-0, 58448-2, 58992-9, 59159-4, 60678-0, 63474-1, 9318-7
(CDC – BP Control <140/90 mm Hg)	Members 18–75 years of age with diabetes (type1or type 2) whose most recent BP level (taken during the measurement year) is <140/90 mm Hg	Documentation of the most recent blood pressure reading taken during the measurement year from the primary care provider (PCP) or specialist from whom the member receives care. **Exclusions:** ▪ Gestational diabetes ▪ Steroid- induced diabetes	**BP control <140/90 mm/Hg** **Diastolic: 80-89 CPT II:** 3079F **Diastolic greater than/equal to 90 CPT II:** 3080F **Diastolic less than 80 CPT II:** 3078F **Systolic greater than/equal to 140 CPT II:** 3077F **Systolic less than 140 CPT II:** 3074F, 3075F

Measure	Measure Description	Protocol or Documentation Required	Coding
(CDC – Retinal Eye Exam)	Members 18–75 years of age with diabetes (type 1 or type 2) who had the following during the measurement year: ▪ Retinal eye exam performed the year prior to the measurement year is acceptable if the exam was negative for retinopathy.	A note or letter during the measurement year prepared by an ophthalmologist, optometrist, primary care provider (PCP), or other healthcare provider indicating that an ophthalmoscopic exam was completed by an eye care provider, the date when the procedure was performed and the results. A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care provider reviewed the results during the measurement year. Documentation of a negative (or normal) retinal or dilated exam by an eye care provider in the year prior to the measurement year, where results indicate retinopathy was not present. **Exclusions:** ▪ Gestational diabetes ▪ Steroid- induced diabetes	**Retinal Eye Exam** **Optometrist or ophthalmologist CPT:** 67028, 67030, 67031, 67036, 67039–67043, 67101, 67105, 67107, 67108, 6710, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225, 99226, 92230, 92235, 92240, 92250, 92260, 99203–99205, 99213–99215,99243-99245 **HCPCS**: S3000, S0620, S0621, S0625 **Any provider type Cat II:** 3072F =negative for retinopathy, 2022F, 2024F, 2026F **ICD-10 PCS:** Z01.00, Z01.01 **ICD-10 CM:** E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
(COL) Colorectal Cancer Screening	Patients 50–75 years of age who had appropriate screening for colorectal cancer	Documentation needs to have one or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following: ▪ FOBT (fecal occult blood test) or FIT (fecal immunochemical test) during the measurement year ▪ Flexible sigmoidoscopy during measurement year or the four years prior to the measurement year ▪ Colonoscopy during the measurement year or the nine years prior to the measurement year **Exclusions:** ▪ Colorectal cancer ▪ Total colectomy	**FOBT CPT:** 82270, 82274 HCPCS: G0328 **Flex. Sig.** CPT: 45330 – 45335, 45337 – 45342, 45345 **HCPCS:** G0104 **Colonoscopy CPT:** 44388 – 44394, 44397, 44355, 45378 – 45387, 45391, 45392 G0105, G0121

Measure	Measure Description	Protocol or Documentation Required	Coding
(FUH) Follow-up After Hospitalization For Mental Health	Patients six years and older with a follow-up visit after hospitalization for mental illness.	The percentage of discharges for members who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner. The percentage of discharges for which the member received follow-up within seven days and 30 days of discharge.	**ICD-10:** F03.90, F03.91, F20 – F25, F28 – F34, F39, F42, F43, F44.89, F53, F60, F63, F68, F84, F90 – F94
(LBP) Use of Imaging Studies for Low Back Pain	Patients 18 – 50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI or CT Scan) within 28 days of the diagnosis.	This measure is reported as an inverted rate (1 – Numerator/eligible population), and a higher score indicates appropriate treatment of low back pain (the proportion for whom imaging studies did not occur). Jan. 1 – Dec. 3 of the measurement year is used to identify the first outpatient or ED encounter with a primary diagnosis of low back pain. **Exclusions**: ▪ Cancer ▪ Recent trauma ▪ Intravenous drug abuse ▪ Neurologic impairment	**ICD-10**: M46.46-M46.48, M47.26-M47.28, M47.816-M47.818, M47.896-M47.898, M48.06-M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.46, M51.47, M51.86, M51.87, M53.2X6 - M53.2X8. M53.3, M53.86 - M53.88, M54.30 - M54.32, M54.40- M54.42, M54.5, M54.89, M54.9, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33..130A, S33.130D, S33.130S, S33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.0012A, S39.012D, S39.012S, S39.029A, S39.029D, S39.029S, S39.82XA, S39.82XD, S39.82XS, S39.92XA, S39.92XD, S39.92XS **Imaging CPT:** 72010, 72020, 72052, 72100, 72110, 72114, 72120, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72158, 72200, 72202, 72220 **Out-patient visits/Observation** **CPT**: 99201-99205, 99211-99215. 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, 99455-99456 **HCPCS**: G0402, G0438, G0439, G0463, T1015 **ER Visit CPT:** 99281-99285

Measure	Measure Description	Protocol or Documentation Required	Coding
(PPC) Timeliness of Prenatal Care	Live births between Nov. 6 of the year prior to the measurement year and Nov. 5 of the measurement year. Prenatal care visit as a member of the organization in the first trimester or within 42 days of the enrollment in the organization	Prenatal care visit to an obstetrics and gynecology (OB/GYN) or other prenatal care practitioner or PCP. For visits to a primary care provider (PCP), a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following: ▪ A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height ▪ Evidence that a prenatal care procedure was performed (such as OB panel or ultrasound) ▪ Documentation of last menstrual period (LMP) or expected date of delivery (EDD) in conjunction with either a prenatal risk assessment and education and counseling, or a complete obstetrical history ▪ Visit does not apply if registered nurse (RN) conducts the visit.	**Prenatal visit during first trimester** **CPT:** 99201 – 99205, 99211 – 99215, 99241-99245, 99500 **Cat II:** 0500F-0502F **HCPCS:** T1015, G0463, H1000-H1004 **CPT:** Bundled 59400-59410, 59510, 59515, 59610, 59614, 59618, 59622 **Prenatal US CPT**: 76801, 76805, 76811, 76813, 76815-76821, 76825-76828 **Pregnancy ICD-10:** Z03.7, Z33, Z34, Z36, O09, O10.01, O10.011 – O10.013, O10.019, O10.111 – O10.113, O10.119, O10.21, O10.211 – O10.213, O10.219, O10.31, O10.311 – O10.313, O10.319, O10.41, O10.411 – O10.413, O10.419, O10.91, O10.911 – O10.913, O10.919, O11, O12, O13, O14, O15.00, O15.02, O15.03, O16, O20, O21 - O23, O24.01, O24.011 – O24.013, O24.019, O24.11, O24.111 - O24.113, O24.319, O24.4, O24.O24.41, O24.410, O24.414, O24.419, O24.81, O24.811 – O24.813, O24.819, O24.91, O24.911 – O24.913, O24.919, O25.1, O26.0 - O26.5, O26.61, O26.71, 26.8 - O36, O40 – O48, O60.0, O71, O88.01, O88.11, O88.21, O88.31, O91.01, O91.03, O91.11, O91.13, O91.21, O91.23, O92.01, O92.03, O92.11, O92.13, O92.3 - O92.7, O98.01, O98.11, O98.21, O98.31, O98.41, O98.51, O98.61, O98.71, O98.81, O98.91, O99.01, O99.11, O99.210 – O99.213, O99.280 – O99.283, O99.310 – O99.313, O99.320 – O99.323, O99.330 – O99.333, O99.340, O99.343, O99.350 – O99.353, O99.41, O99.51, O99.61, O99.71, O99.810, O99.820, O99.830, O99.840 – O99.843, O9A.11, O9A.21, O9A.31, O9A.41, O9A.51, BY4BZZZ, BY4CZZZ, BY4DZZZ, BY4FZZZ, BY4GZZZ

Measure	Measure Description	Protocol or Documentation Required	Coding
(PPC) Postpartum Care	Live births between Nov. 6 of the year prior to the measurement year and Nov. 5 of the measurement year. Postpartum visit on or between 21 and 56 days after delivery.	Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following: ▪ Pelvic exam ▪ Evaluation of weight, BP, breasts and abdomen ▪ Notation of "postpartum care," "PP care," "PP check," "6-week check," or preprinted "postpartum care" form	**Postpartum visit CPT**: 57170, 58300, 59430 , 99501 **CPTII**: 0503F **HCPCS**: G0101 **Cervical Cytology (PAP) CPT**: 88141 –88143, 88147, 88148, 88150, 88152 –88154, 88164 – 88167, 88174, 88175 **HCPCS**: G0123, G0124, G0141, G0143- G0145, G0147, G0148, P3000, P3001, Q0091 **ICD-10**: Z01.411, Z01.419, Z30.430, Z30.432, Z30.433, Z39.1, Z39.2 **Postpartum Bundled Visits CPT**: 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Patients ages 3–17 years of age who had an outpatient visit with a primary care provider (PCP) or OB/GYN and who had evidence of the following during the measurement year: ▪ BMI percentile documentation ▪ Counseling for nutrition ▪ Counseling for physical activity	**BMI percentile** Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI must be from the same data source. **Counseling for nutrition** Documentation of counseling for nutrition or referral for nutrition education during the measurement year. Documentation must include a note indicating the date and at least one of the following: ▪ Discussing current nutrition behaviors (e.g., eating habits, dieting behaviors) ▪ Addressing nutrition and indicating this on checklist ▪ Counseling or referral for nutrition education ▪ Giving the patient educational materials on nutrition during a face-to-face visit ▪ Giving anticipatory guidance for nutrition ▪ Counseling about weight or obesity **Counseling for physical activity** Documentation of counseling for physical activity or referral for physical activity during the measurement year. Documentation must include a note indicating the date and at least one of the following: ▪ Discussing current physical activity behaviors (e.g., exercise routine, participation in sports) ▪ Addressing physical activity and indicating this on checklist ▪ Counseling or referral for physical activity ▪ Giving the patient educational materials on physical activity during a face-to-face visit. ▪ Giving anticipatory guidance for physical activity. ▪ Counseling about weight or obesity. **Exclusions**: Members who've had a diagnosis of pregnancy during the measurement year.	**Annual Wellness Visit**: ICD-10: Z00.121, Z00.129, HCPS: G0438, G0439, T1015, G0463, G0402 **BMI Percentile**: **ICD-10**: Z68.51 – Z68.54 **Counseling for Nutrition**: **ICD-10**: Z71.3 **HCPCS**: G0270, G0271, S9452, S9470, S9449 **CPT**: 97802 – 97804 **Counseling for Physical Activity**: **HCPS**: S9451, G0447