

MSSP Quality Codes to Close

(Measurement Period/Year Jan.1 – Dec. 31, 2025) MY=Measurement year

Quality Measure Overview and Exclusion & Exception Codes	Measure Description and Code to Close the Quality Measure	How to Meet the Measure and Recommended Best Practices
<p>Prev – 5 Breast Cancer Screening – (BCS)</p> <p>Percentage of female patient ages 40-74 who had a mammogram screening for breast cancer in the 27 months prior to the end of the MY.</p> <p>Denominator: Women ages 41-74 on date of the encounter with a visit during the MY.</p> <p>Exclusions G9708 – women who had bilateral mastectomy or history of or for whom there is evidence of RT and LT unilateral Mastectomies G9687 – Hospice services provided any time during the MY. G9988 – palliative care services provided any time during MY. G2081 – Age \geq 66 in SNP or long-term care with POS 32,33,34,54, or 56 for \geq 90 consecutive days during MY. G2090 – Age \geq 66 with at least one claim for frailty & a dispensed medication for dementia within the MY or year prior. G2091 – Age \geq 66 with at least one claim for frailty & an advanced illness diagnosis during the MY or year prior.</p>	<p>Women who had a mammogram to screen for breast cancer during the 27-month window (Oct.1, 2023 - Dec. 31, 2025) And is billed through a claim.</p> <p>CPT codes: G9899 – Screening, diagnostic, film, or 3D mammography results reviewed & documented. G9900 – Screening, diagnostic, film, digital or 3D mammography results NOT reviewed & documented. 3014F – Screening mammography results have been documented & reviewed (MA ONLY)</p> <p>Documentation Requirements Date breast cancer screening was performed. Result of test (“normal” or Abnormal is sufficient Add appropriate codes if applicable.</p>	<ul style="list-style-type: none"> • Determine if the patient qualifies for any of the measure specific exclusions. • If the patient qualifies for the measure, review EHR for the most recent breast cancer screening result. • If documentation of result is in the chart and meets MY timeframe, follow documentation requirements below. • If no breast cancer screening or last screening is outside of the MP. • Ask patient if they have completed the screening. • Document test name, date, and result as patient reported in the EHR. • Contact outside entity to obtain results. • Order breast cancer screening per protocol or obtain order from provider.
<p>Prev- 6 Colorectal Cancer Screening- (COL-E)</p> <p>Percent of patients ages 45-75 who had an appropriate screening for colorectal cancer within the specified timeframe.</p> <p>Denominator: Patients ages 45-75 as Dec. 31 of the MY.</p> <p>Exclusions G9687 – Hospice services provided any time during the MY. G9988 – palliative care services provided any time during MY. G2081 – Age \geq 66 in SNP or long-term care with POS 32,33,34,54, or 56 for \geq 90 consecutive days during MY. G2090 – Age \geq 66 with at least one claim for frailty & a dispensed medication for dementia within the MY or year prior. G2091 – Age \geq 66 with at least one claim for frailty & an advanced illness diagnosis during the MY or year prior. Note: Partial colectomy is not an exclusion.</p>	<p>Patients who have completed the appropriate screening for colorectal cancer during the specified timeframe(procedural claim will close measure) 3017F – Colorectal cancer screening documented and reviewed.</p> <p>Colorectal Cancer Screenings services & time frames</p> <ul style="list-style-type: none"> • FOBT test within MY. (must not be obtained in the office setting) • sDNA with FIT test within MY or previous 2 years • Flex Sigmoidoscopy within the MY or previous 4 years • Colonoscopy within the MY or previous 9 years • CT Colonography during the MY or previous 4 years <p>Documentation Requirements</p> <ul style="list-style-type: none"> • Date colorectal cancer screening was performed • Screening name and result (“normal” or “abnormal” is sufficient) • Add appropriate code if applicable 	<p>Determine if the patient qualifies for any of the measure specific denominator exclusions.</p> <ul style="list-style-type: none"> • If a patient qualifies for the measure, review EHR for most colorectal cancer screening result. • If documentation of result is in the chart and meets MY timeframe, follow documentation requirements. <p>If no colorectal cancer screening or last screening is outside of the measurement period:</p> <ol style="list-style-type: none"> 1. Ask patient if they have completed screening. 2. Obtain test results from outside entity. Document within chart when received. 3. Order colorectal cancer screening per protocol or obtain order from Provider. 4. Encourage patients to complete FIT test Kits sent to the from payor if applicable
<p>HTN 2 - Controlling Blood Pressure (CBP)</p> <p>Controlling High Blood Pressure (CBP) - Percent of patients 18-85 who had a diagnosis of essential hypertension starting before and</p>	<p>Patients whose most recent Blood pressure is adequately controlled (systolic BP less than 140mmHg and diastolic BP less than 90 mmHg) during the MY.</p>	<p>Determine if the patient qualifies for any of the measure specific denominator exclusions.</p> <p>If a patient qualifies for the measure, obtain BP measurement.</p>



<p>continuing into or starting during the first 6 months of the MY, and whose most recent blood pressure (BP) was adequately controlled (>140/90 mmHg) during the MY.</p> <p>Denominator: Patients 18-85 years of age who had a visit during the MY and a diagnosis of essential hypertension starting before and continuing into or starting during the first 6 months of the MY. Diagnosis present between Jan 1, 2024 – June 30, 2025.</p> <p>Exclusions G9687 – Hospice services provided any time during the MY. G9988 – palliative care services provided any time during MY. G2081 – Age ≥ 66 in SNP or long-term care with POS 32,33,34,54, or 56 for ≥ 90 consecutive days during MY. G2115 – Age 66-80 with at least one claim for frailty & a dispensed medication for dementia within the MY or year prior. G2116 – Ages 66-80 with at least one claim for frailty & an advanced illness diagnosis during the MY or year prior. G2118 – Patients ages 81 and older with at least one claim visit for frailty during the MY or year prior. G9231 – Patients with evidence of ESRD, dialysis, or renal transplant before or during the MY. G9997 – patients with a diagnosis of pregnancy during the MY.</p>	<ul style="list-style-type: none"> • G8752 – Most recent systolic BP <140mmHg • G8754 – most recent diastolic BP >90mmHg • 3074F – Most recent systolic BP less than 130mmHg • 3075F – Most recent systolic BP 130-139mmHg • 3078F – most recent diastolic BP less than 80mmHg • 3079F – Most recent diastolic BP 80-89mmHg <p>Documentation Requirements</p> <ul style="list-style-type: none"> • Diagnosis of essential hypertension starting before or overlapping the first 6 months of the MY. • Date and value of the most recent BP measurement (numeric value) <p>Add appropriate codes if applicable</p> <p>Other codes to document out of compliance. These will NOT Close the measure: G8753 – Most recent systolic BP greater than or equal to 140mmHg G8755 – Most recent diastolic BP greater than or equal to 90mmHg G8756 – No documentation of BP, reason not given 3077F – Most recent systolic BP greater than or equal to 140mmHg 3080F – Most recent diastolic blood pressure greater than or equal to 90mmHg</p>	<ul style="list-style-type: none"> • IF BP is <140/90, document, result in HER. • IF BP is >140/90, recheck BP is 5 minutes, notify provider as appropriate and/or follow established protocol. • If Multiple BPs are taken on the same day, report all in EHR system but can use lowest diastolic and systolic for reporting purposes. • Patient reported blood pressures from an automated blood pressure monitor or device are acceptable. <p>Blood pressure obtained on the same day as a diagnostic test/procedure, during an acute inpatient stay or ED visit do NOT meet the measure.</p> <p>Recommended Best Practices</p> <ul style="list-style-type: none"> • Obtain BP at each visit • Perform medication reconciliation. • Review Hypertension medication regimen and plan of care • Educate patient to disease process and at home care. • Schedule follow-up per clinical guidelines. • Order home testing device and frequency for testing Home BP • Enroll in care Management or other programs as applicable
<p>DM- 2 Diabetes: glycemic Status Assessment >9% (GSD) Percentage of diabetic patients ages 18-75 who had a hemoglobin A1c result or GMI value greater than 9.0% during the MY. This is an inverse measure. Lower is Better.</p> <p>Denominator: Diabetic patients age 18-75 with a visit during the MY.</p> <p>Exclusions: G9687 – Hospice services provided any time during the MY. G9988 – palliative care services provided any time during MY. G2081 – Age ≥ 66 in SNP or long-term care with POS 32,33,34,54, or 56 for ≥ 90 consecutive days during MY. G2090 – Age ≥ 66 with at least one claim for frailty & a dispensed medication for dementia within the MY or year prior. G2091 – Age ≥ 66 with at least one claim for frailty & an advanced illness diagnosis during the MY or year prior.</p>	<p>Patients whose most recent glycemic status assessment (HbA1c or GMI) is more than 9.0%, missing, or was not performed during the measurement period.</p> <ul style="list-style-type: none"> • M1211 – Most recent glycemic Status assessment (HbA1c or GMI) level >9.0% • M1212 – glycemic Status assessment (HbA1c or GMI) level is missing, or was NOT performed during the MY • M1371 – Most recent glycemic status assessment (HbA1c or GMI) Level < 7.0% • M1372 – Most recent glycemic status assessment (HbA1c or GMI) Level $\geq 7.0\%$ and < 8.0% • M1373 - Most recent glycemic status assessment (HbA1c or GMI) Level $\geq 8.0\%$ and $\leq 9.0\%$ • 3044F – Most recent hemoglobin A1c level less than 7.0% • 3045F – Most recent hemoglobin A1c level 7.0% to 9.0% • 3051F – Most recent hemoglobin A1c level greater than or equal to 7.0% and Less than 8.0% • 3052F - Most recent hemoglobin A1c level greater than or equal to 8.0% and Less than or equal to 9.0% • 3046F – Most recent hemoglobin A1c level greater than 9.0% 	<p>Determine if the patient qualifies for any of the measures specific denominator exclusions.</p> <p>Screen all patients ages 18-75 with a diagnosis of diabetes for adequate glucose control.</p> <p>For patients who qualify for the measure:</p> <ul style="list-style-type: none"> • If there is no HbA1c or GMI result for the MY OR the most recent HbA1c or GMI result is 9 or greater, notify clinician, order HbA1c or GMI labs and schedule a follow-up visit. • If HbA1c or GMI is less than 9, continue to check HbA1c every 3 months and refill diabetic medication as appropriate. <p>Special considerations</p> <ul style="list-style-type: none"> • Patient reported data will not close measure • Office fingerstick HbA1c can be used to close measure. • GMI values should be collected over a 10–14-day period from patient’s continuous glucose monitor, and practice EHR system must be able to directly download and calculate GMI. • GMI must be reported as a numeric digit, not a range.

	<p>Documentation Requirements</p> <ul style="list-style-type: none"> Any diabetes diagnosis during the MY Visit note or lab result with the Date (MM/DD/YYYY) and distinct value of the most recent HbA1c result or GMI value Add appropriate HCPCS & CPT codes as applicable. 	
<p>Prev- 12 Depression Screening & Follow-up</p> <p>Percent of patient ages 12 and older screened for depression on the DOS or up to 14 days prior to the DOS using an age-appropriate standardized screening tool AND if positive, a follow-up plan is documented on the DOS or up to 2 days after, the date of the qualifying visit.</p> <p>Denominator: Patients 12+ at the beginning of the MY with at least one qualifying encounter during the MY</p> <p>Exclusion: G9717 – patient has diagnosis of bipolar disorder</p> <p>Exceptions:</p> <ul style="list-style-type: none"> * Patient reasons (i.e., patient refusal to participate) * Medical reasons <ul style="list-style-type: none"> ---Patient in urgent or emergent situation where delay to treatment would jeopardize patient's health status. ---Situation where patient's cognitive or functional capacity, or motivational limitations to improve may impact accuracy of results. <p>CPT Codes to Use if Screening is NOT performed:</p> <p>G8432 – Depression screening is not documented, reason not given</p> <p>G8433 – Depression screening is not completed, documented reason.</p> <p>G8511 – Screening for depression documented as positive, follow-up plan is not documented, reason not given.</p>	<p>Patients screened for depression on the DOS or up to 14 days prior to the DOS using an age-appropriate standardized tool. AND If screening is positive, a follow-up plan is documented on the DOS or up to 2 days after, the date of the qualifying visit.</p> <p>G8510 – Screening for depression is documented as negative, a follow up plan is not required.</p> <p>G8431 – Screening for depression is documented as positive AND a follow up plan is documented.</p> <p>Documentation Requirements:</p> <ul style="list-style-type: none"> Name of age-appropriate standardized screening tool used and results with a score or clinician interpretation of positive /negative. If screening was positive, document follow-up plan and actions taken. If unable to perform the screening, document reason why screening was not performed. 	<p>Determine if the patient qualifies for any of the measure-specific exclusions. Screen all patients 12+ with age-appropriate standardized depression screening tool at least once per year. If depression screening is negative, no further actions is needed. If depression screening is positive:</p> <ul style="list-style-type: none"> And patient is not suicidal, document depression screening as positive and review/inform clinician. And patient is suicidal, activate organizations' mental health emergency policy. Notify clinician <p>Clinician must create a follow up plan to include at least one or more of the following:</p> <ul style="list-style-type: none"> Referral to a provider or program for additional evaluation and assessment. Pharmacological interventions Other interventions or follow-up for the diagnosis and treatment of depression. <p>Recommended Best Practices: Schedule follow-up and/or begin treatment therapy</p> <ul style="list-style-type: none"> Patients 5-8 (mild depression) – schedule follow-up for re-screen in 2 weeks with clinician visit, flag for same-day clinician validation. Patients 9+ or with concerning presentation – escalate to clinician for same-day results validation and management, and schedule follow-up visit for PHQ-9 > 9(to achieve depression remission). <p>-Refer to BHI/Care Management as appropriate for patient – reported data will not close measure.</p>
<p>Care 2 – Fall Risk</p> <p>Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.</p> <p>Denominator: All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year). Documentation of patient reported history of falls is sufficient</p>	<p>Patients with a plan of care for falls documented within 12 months All components do not need to be completed during one patient visit but should be documented in the medical record as having been performed within the past 12 months.</p> <ul style="list-style-type: none"> 1100F- Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year. 0518F – Falls plan of care documented 	<p>The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.</p> <p>Balance, Strength, and Gait Training – Medical record must include documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three</p>

<p>Exclusions: G9720– Hospice services provided any time during the MY.</p> <p>0518F with 1P – Patient not ambulatory, bedridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair.</p>	<ul style="list-style-type: none"> • 0518F with 8P – Falls plan of care not documented, reason not otherwise specified 	<p>components: balance, strength or gait OR referral to physical therapy.</p>
<p>Prev 7 – Influenza Immunization – Percentage of patients age 6 months and older seen for a visit during the MY who received and influenza immunization OR who reported previous receipt of an influenza immunization.</p> <p>Denominator: All patients age 6 months and older seen for a visit during the MY.</p> <p>Exclusions: G9687 – Hospice services provided any time during the MY.</p> <ul style="list-style-type: none"> • Moved out of the county • Deceased 	<p>Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization</p> <ul style="list-style-type: none"> • Receipt of the current season’s influenza immunization from another provider or the same provider prior to the visit to which the measure is applied. <p>Documentation Requirements: Clearly document in the record the name of immunization with a date.</p>	<p>Determine if patient qualifies for any of the measure-specific exclusions.</p> <p>If patient qualifies to have the Influenza shot. Administer the flu shot to the patient.</p> <p>If they refuse, please documented clearly the refusal in the record.</p>
<p>Prev 10 – Tobacco Use – Percent of patients age 12 years and older who were screened for tobacco use one or more times within the MY AND who received cessation intervention during the MY or in the 6 months prior to the MY if identified as a tobacco user.</p> <p>Denominator:</p> <ul style="list-style-type: none"> • All patients 12 years and older seen for at least 2 visits or at least one preventive visit during the measurement period. • Plus, those who were screened for tobacco use during the MY period and identified as tobacco users. <p>Exclusions. G9687 – Hospice services provided any time during the MY.</p> <ul style="list-style-type: none"> • Moved out of the county • Deceased 	<ul style="list-style-type: none"> • Patients who were screened for tobacco use at least once during the MY. • Patients who received tobacco cessation intervention during the MY or in the 6 months prior to the MY. • Patients who were screened for tobacco use at least once during the MY AND who received tobacco cessation intervention during the MY if identified as a tobacco user. 	<p>Determine if the patient has been screened for tobacco use during this MY.</p> <p>To satisfy the intent of this measure; a patient must have at least one tobacco use screening during the MY. If a patient has multiple tobacco screenings during the MY, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will satisfy the measure requirements.</p> <p>If the patient uses any type of tobacco (EX. Smokes or uses smokeless tobacco), the expectation is that they should received tobacco cessation intervention: with counseling and/or pharmacotherapy.</p>
<p>Prev 13 – Statin Therapy for CVD - SPC The percent of patients with Atherosclerotic Cardiovascular Disease (ASCVD) who get the right type of cholesterol-lowering drugs.</p> <p>Denominator: Male patients ages 21-75 and female patients 40-75 during the MY who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD)</p>	<p>Patients who were dispensed at least one high or moderate-intensity statin medication during the MY.</p> <p>Pharmacy claim</p>	<p>Determine if the patient qualifies for any of the measure specific denominator exclusions. If a patient qualifies for the measure:</p> <ul style="list-style-type: none"> • Screen patients age 21-75 with ASCVD, personal or family history of elevated cholesterol, or diabetes for appropriateness of statin therapy. • If patient needs a statin prescription, call in at least 30-day refill to bridge gap in adherence, make outreach to patient to educate, and schedule follow-up visit (if appropriate) within 30 days.

<p>Exclusions: G9687 – hospice services provided any time during measurement period G9988 – palliative care services provided any time during measurement period G2081 – Age ≥ 66 in SNP or long-term care with POS code 32, 33, 34, 54, or 56 for ≥ 90 consecutive days during measurement period G2091 – Age ≥ 66 with at least one claim for frailty & an advanced illness diagnosis during the measurement period or year prior G9231 – patients with evidence of ESRD, dialysis, or renal transplant before or during the measurement period G9997 – patients with a diagnosis of pregnancy during the measurement period</p> <ul style="list-style-type: none"> • Patients who were dispensed clomiphene medication during the MY • Patients with myalgia, myositis, myopathy, or rhabdomyolysis during the current measurement year. 		<ul style="list-style-type: none"> • Prescribe moderate to high intensity statin medication to patients with diabetes. • Draw labs to determine LDL and document lab results once returned appropriately in the EHR. <p>For patients with a current statin prescription, document the qualifying diagnosis and initiation or continuation of statin therapy in the EHR.</p> <p>For qualifying patient without a current statin prescription, document the qualifying diagnosis and reason why statin therapy was or was not initiated or continued (ex. Allergy, pregnancy) in the EHR.</p> <p>Documentation Requirements:</p> <ul style="list-style-type: none"> • Document ASCVD and medication therapy within the EHR. • Add CPT codes as appropriate.
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