Graphium

2026 EDITION · PART THREE

Quality Measures

2026 Specifications for Anesthesia Reporting

One of four volumes covering the Quality Payment Program (qpp.cms.gov) for anesthesia: **Program Mechanics**, **Improvement Activities**, **Quality Measures**, and **How Graphium QCDR Works**.

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12	6	75%	10
MEASURES SPECIFIED	COUNTED BY CMS	DATA COMPLETENESS	MAX POINTS PER MEASURE

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CMS sources for the 2026 performance year:

- CMS MIPS eligibility and participation
- CMS 2026 Quality Guide
- CMS 2026 Small Practices Guide
- CMS 2026 Improvement Activities Guide

I. Reading a 2026 Quality Measure

How to Read This Section

CMS defines a small practice as 15 or fewer clinicians billing under a TIN. For small practices reporting traditional MIPS or an MVP, the standard weights with Promoting Interoperability reweighted to zero are Quality 40%, Cost 30%, and Improvement Activities 30%. If Cost is also reweighted to zero, the weights are Quality 50% and Improvement Activities 50%. Confirm your CMS small-practice designation and applicable weights in the QPP Participation Status Tool. Source: CMS 2026 Small Practices Guide.

Every measure in Section II follows the same template so readers can compare eligibility, reporting requirements, and scoring considerations.

This volume is a reference, not a syllabus. If you are learning how the program works, start with the companion volume, *QPP Program Mechanics*, which explains scoring, pathways, and payment adjustment and summarizes every measure in a page. Come here when you are building capture workflow, auditing a rate you do not believe, or answering a clinician who wants to know exactly what a measure counts.

A note on conflicting sources. Measure metadata occasionally differs between the CMS specification, the AQI NACOR measure book, and ASA's published summaries. **Where sources conflict, the CMS specification governs.** CMS scores the submission, so its classification is the one that determines how a measure is treated. Secondary sources are useful for clinical context and workflow guidance, not for measure type, high priority status, or benchmark treatment. QID 477 is the current example: ASA and AQI describe it as an Outcome measure, CMS classifies it as **Process**, and this volume follows CMS.

A note on CPT code lists. Each measure's denominator is anchored to an enumerated list of CPT codes, in most cases several hundred entries. **Every measure in this volume ends with its complete list**, under the heading *Denominator CPT Codes*, so a monograph can be read or handed over without a second document.

Three things are worth knowing before you use them. A matching code makes a case *eligible for consideration*, not automatically countable - age, elective status, diagnosis, anesthetic type and the other denominator criteria all still apply. The lists **change annually**, so a list carried over from a prior year is a source of silent error. And **AQI 18 is the one measure that requires two codes**: a CABG surgical code *and* the related anesthesia code, not either alone.

The lists here are generated from a structured data file, `measure-cpt-2026.json`, rather than typed. The same file drives the code lookup on the Graphium QCDR site, so the manual and the site cannot disagree. CPT is copyright the American Medical Association; see Section III.

Our 2026 measure set at a glance:

Measure	Steward	Type	High Priority	2026 Benchmark Status	Scoring Considerations
ABG 44	ABG QCDR	Efficiency	Yes	Historical benchmark, not topped out	Up to 10, subject to CMS rules

Measure	Steward	Type	High Priority	2026 Benchmark Status	Scoring Considerations
ABG 45	ABG QCDR	Process	Yes	No historical benchmark; **5-point floor**	Floor requires data completeness
AQI 18	ASA/AQI	Outcome (inverse)	Yes	No historical benchmark	Performance-period benchmark may be established
AQI 48	ASA/AQI	PRO-PM	Yes	Historical benchmark, not topped out	Up to 10, subject to CMS rules
AQI 65	ASA/AQI	Outcome	Yes	Historical benchmark, not topped out	Up to 10, subject to CMS rules
AQI 71	ASA/AQI	Composite	Yes	No historical benchmark	Performance-period benchmark may be established
AQI 80	ASA/AQI	Process	Yes	No historical benchmark; **7-point floor**	Floor requires data completeness
ePreop 31	Provation / Cleveland Clinic	Intermediate Outcome (inverse)	Yes	No historical benchmark	Performance-period benchmark may be established
QID 404	CMS	Intermediate Outcome	Yes	Historical benchmark, not topped out	Up to 10, subject to CMS rules
QID 430	CMS	Process	Yes	Historical benchmark, **topped out** (not yet capped)	Up to 10, subject to CMS rules
QID 463	CMS	Process	Yes	Historical benchmark, **topped out** (not yet capped)	Up to 10, subject to CMS rules
QID 477	CMS	Process	Yes	Historical benchmark, **topped out** (not yet capped)	Up to 10, subject to CMS rules

How Quality Measures Are Scored

This section is worth reading closely. Measure selection, not just measure performance, drives the Quality score.

Category Maximum Points

Under Traditional MIPS, each of your top 6 measures is worth a maximum of 10 points, giving the category a maximum of 60 points. If you earn 25 points across your top 6 measures, you have earned 41.7% (25/60) of the Quality category.

In an example where Quality has a 55% weight, that 41.7% contributes 22.9 points to the MIPS final score. The contribution differs when category weights change, including for small practices.

Points per Measure

Each measure is scored from 0 to 10 based on how your performance rate compares to that measure's **national benchmark**. CMS divides the national distribution of performance rates into deciles. Points can vary within a decile and are subject to data completeness, case minimums, applicable floors and caps, and other CMS scoring rules.

Historical benchmarks are the norm. They are built from data submitted two years before the performance year, so the 2026 benchmarks published by CMS were calculated from **2024** submissions. This means the benchmark is known before the performance year begins, which is what makes measure selection a planning exercise rather than a guess.

Worked example using the real 2026 benchmark for **QID 430 (Prevention of PONV, Combination Therapy)**:

Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
84.00 to 85.99	86.00 to 87.99	88.00 to 89.99	90.00 to 91.99	92.00 to 93.99	94.00 to 95.99	96.00 to 97.99	98.00 to 98.99	99.00 to 99.99	100.00

A performance rate of 98.6% falls in Decile 8. A rate of 92.5% falls in Decile 5. Note how tight this benchmark is: the entire scoring range spans only 16 percentage points, because nearly everyone performs well on this measure.

This is the single most important thing to understand about MIPS scoring: a performance rate of 69% on Measure A may be worth more CPS points than a 98% rate on Measure B. Points are a function of **both** your rate **and** the national distribution. Chasing a high raw percentage on a topped-out measure is often a worse use of effort than a moderate percentage on a measure with a wide benchmark.

Topped Out Measures and the 7-Point Cap

A measure is **topped out** when the national distribution is so compressed at the high end that the measure no longer meaningfully discriminates between clinicians. CMS flags these.

A topped-out measure that has been flagged for multiple consecutive years becomes subject to a **7-point cap**: no matter how well you perform, the measure cannot earn more than 7 of the 10 available points.

For 2026, **QID 430, QID 463, and QID 477 are all flagged as topped out but are NOT yet 7-point capped**. They can still earn a full 10 points this year. Plan for the cap to arrive in a future year and diversify accordingly. CMS also continues a policy introduced in 2025 that allows a selection of topped-out, point-capped measures drawn from certain specialty sets to still reach 10 points.

Scoring Floors for New Measures

First- and second-year measures have **scoring floors** when data completeness is met. These floors can apply even when a benchmark is unavailable or the case minimum is not met:

- Measures added in **PY 2025** carry a **5-point floor**.
- Measures added in **PY 2026** carry a **7-point floor**.

For 2026, **AQI 80, AQI 81, and AQI 82 have 7-point floors; ABG 45 and AQI 79 have 5-point floors**, subject to data completeness. Higher scores may be available when CMS can score performance against a benchmark. These measure-level floors do not guarantee a final MIPS score or payment adjustment.

Measures with No Benchmark and No Floor

A missing historical benchmark does not settle the final score. CMS attempts to establish a performance-period benchmark from that year's submissions. **AQI 18, AQI 71, and ePreop 31** lack historical benchmarks for 2026. If no performance-period benchmark can be established, CMS applies the applicable scoring rules, including small-practice exceptions. Choose clinically relevant measures and review CMS's final benchmark and scoring guidance rather than assuming these measures will score poorly.

Source: CMS 2026 Quality Benchmarks User Guide.

> **How Graphium handles this.** We report Performance Met percentage per measure and stop there. We do not project deciles or estimate a final Composite Performance Score, for the reasons set out in the companion volume, *How Graphium QCDR Works*. The benchmark tables reproduced throughout Section II are provided so you can interpret your own rates against the published distribution. They are reference material, not a scoring engine.

Performance Rate Calculation

For each measure, every anesthesia case in the reporting period is evaluated against the measure's criteria and assigned one of the following states:

Performance Met: The case is eligible (meets denominator criteria) and the numerator criteria were satisfied.

Performance Not Met: The case is eligible but the numerator criteria were not satisfied.

Data Completeness Not Met: The case is eligible but is missing data required to evaluate the numerator.

Ineligible: The case does not meet denominator criteria, or falls under a **Denominator Exclusion**. Exclusions are defined per measure. Your Performance Met rate is unaffected by these cases.

Denominator Exception: The case was eligible but was removed because it met additional criteria defined by the measure. Your Performance Met rate is unaffected by these cases, but they *do* count toward data completeness.

Performance Rate = Performance Met ÷ (Performance Met + Performance Not Met)

Data Completeness Rate = (Performance Met + Performance Not Met + Denominator Exceptions) ÷ (Performance Met + Performance Not Met + Denominator Exceptions + Data Completeness Not Met)

For 2026, a measure below 75% data completeness generally earns **0 points**. Small practices receive **3 points** for a submitted measure that does not meet the data completeness requirement. Missing documentation affects completeness; it is not the same as documenting that performance was not met. See the CMS 2026 Quality Guide.

II. The 2026 Measures

ABG 44: Low Flow Inhalational General Anesthesia**

Steward: ABG QCDR | **Collection Type:** QCDR Measure | **First Performance Year:** 2023 **2026 Status:** Approved by CMS for the 2026 MIPS performance period.

MEASURE DESCRIPTION Percentage of patients aged 18 years or older who undergo an elective procedure lasting 30 minutes or longer requiring inhalational general anesthesia and who, during the maintenance phase of the anesthetic, have a total fresh gas flow less than or equal to 1 L/min (less than or equal to 2 L/min for sevoflurane).

NQS DOMAIN / MEANINGFUL MEASURES AREA Efficient Use of Healthcare Resources / Clinical Process and Effectiveness

MEASURE TYPE: Process (classified as Efficiency in the CMS benchmark file) **HIGH PRIORITY STATUS:** Yes | **HIGH PRIORITY TYPE:** Efficiency **INVERSE MEASURE:** No | **RISK ADJUSTED:** No **NUMBER OF PERFORMANCE RATES:** 1 **CARE SETTING:** All settings **TELEHEALTH:** No **REPORTING OPTIONS:** MVP and Traditional MIPS

2026 BENCHMARK

National average performance rate: **95.52%**. Historical benchmark. Not topped out. Not 7-point capped.

D1	D2	D3	D4	D5	D6	D7	D8	D9	D10
32.19 – 86.86	86.87 – 95.99	96.00 – 98.57	98.58 – 99.23	99.24 – 99.33	99.34 – 99.59	99.60 – 99.81	99.82 – 99.99	--	100.00

Reading this benchmark: the top half of the distribution is compressed into less than one percentage point. Moving from 99.2% to 99.6% is worth three deciles. This is a measure where marginal effort pays disproportionately, and where a small number of high-flow cases costs real points.

INSTRUCTIONS Report each time a patient undergoes an elective procedure in which inhalational general anesthesia is used. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure reporting via the QCDR: CPT codes, patient demographics, and registry codes identify patients in the denominator. The measure must capture both the surgical and the related anesthesia CPT code. G-codes and registry codes capture the numerator.

DENOMINATOR All patients aged 18 years or older who undergo an elective procedure lasting 30 minutes or longer requiring inhalational general anesthesia. (ABG code **1095**)

Denominator Criteria (Eligible Cases): - Patients aged 18 years and older - **AND** Elective procedure (**G9643**) - **AND** Patient receives inhalational general anesthesia (**11A96**) - **AND** Procedure lasts 30 minutes or longer (**11A97**) - **AND** Patient encounter during the reporting period matching the measure's ASA anesthesia CPT list (251 codes; the full list appears at the end of this measure)

DENOMINATOR EXCEPTIONS Patient or technical reason exists for not providing low flow inhalational anesthesia, for example a flow meter not capable of generating low flows, a hypermetabolic patient, or lack of CO2 absorbents without KOH and low concentrations of NaOH. (AQI code **12A00**; ABG code **1096**)

NUMERATOR Patients who, during the maintenance phase of the anesthetic, have a total fresh gas flow less than or equal to 1 L/min (less than or equal to 2 L/min for sevoflurane).

Numerator Definitions: - **Inhalational general anesthesia** is the use of at least one inhalational anesthetic gas (halothane, isoflurane, desflurane, sevoflurane, nitrous oxide) as the primary mode of anesthesia for the procedure. - **Maintenance phase** is the portion of the case in which Stage III surgical anesthesia (unconsciousness, amnesia, immobility, unresponsiveness to surgical stimulation) is achieved at a safe anesthetic depth while maintaining respiratory and hemodynamic stability. It falls between induction and emergence. - **Fresh gas flow (FGF)** is the combined admixture of medical gases (air, oxygen, nitrous oxide) and volatile anesthetics as set by the anesthesia provider.

Numerator Quality-Data Coding Options:

Performance Met: Total FGF reduced to ≤ 1 L/min (≤ 2 L/min for sevoflurane) for the duration of the maintenance phase (AQI **11A98**; ABG **1097**)

OR

Performance Not Met: Total FGF greater than 1 L/min (greater than 2 L/min for sevoflurane) for the duration of the maintenance phase (AQI **11A99**; ABG **1098**)

RATIONALE

Managing fresh gas flow to reduce environmental contamination. In a circle anesthesia system, any anesthetic gases and vapors entering the scavenging system flow through the hospital vacuum system and are ultimately vented to the atmosphere. Total fresh gas flow determines the volume entering the scavenging system per minute. Whenever fresh gas flow exceeds the patient's requirement, gases and vapors enter the scavenging system and contaminate the atmosphere. Choosing the minimal total fresh gas flow minimizes that impact. The effect of a single case is small, but every practitioner can make a meaningful difference across the thousands of procedures in a career.

Described by Foldes in 1952, reducing fresh gas flow below 1 L/min during an anesthetic is both safe and effective, and delivers benefits to the patient, cost savings to the facility, and reduced environmental harm:

- Sevoflurane, isoflurane, and desflurane have global warming potentials two to three orders of magnitude higher than CO2.
- Nitrous oxide contributes significantly to both global warming and ozone depletion.
- Roughly 5% of the carbon footprint of the British National Health Service is attributable to exhaled anesthetic agents.
- Atmospheric lifetimes vary widely: 1 to 5 years for sevoflurane, 3 to 6 years for isoflurane, 9 to 21 years for desflurane, and 114 years for nitrous oxide.
- Conservation of heat and moisture within the breathing system is an added patient benefit, particularly when humidifier connection filters are not used.
- Low flow anesthesia produces cost savings even after accounting for increased CO2 absorber consumption, especially with sevoflurane and desflurane. One simulation of 1 L/min FGF across all agents predicted a 48% reduction in volatile anesthetic costs at a tertiary hospital.

Clinical recommendation: Set fresh gas flow during inhalational anesthesia to less than 1 L/min (less than 2 L/min for sevoflurane) during the maintenance phase of a general anesthetic case greater than 30 minutes in duration.

Reference: Greening the Operating Room and Perioperative Arena: Environmental Sustainability for Anesthesia Practice. Task Force on Environmental Sustainability, Committee on Equipment and Facilities, American Society of

Anesthesiologists.

RELEVANT FIELDS (Graphium capture) - ASA CPT code - Date of birth / patient age - Inhalational agent used - Anesthesia start and end time - Emergency status - Fresh gas flow during maintenance

REPORTING CODES

Code	Definition
1095	All patients aged 18 years or older who undergo an elective procedure lasting 30 minutes or longer requiring inhalational general anesthesia
G9643	Elective procedure
11A96	Patient receives inhalational general anesthesia
11A97	Procedure lasts 30 minutes or longer
12A00 / 1096	Patient or technical reason exists for not providing low flow inhalational anesthesia
11A98 / 1097	Total FGF reduced to ≤ 1 L/min (≤ 2 L/min for sevoflurane) for the duration of the maintenance phase
11A99 / 1098	Total FGF greater than 1 L/min (greater than 2 L/min for sevoflurane) for the duration of the maintenance phase

DENOMINATOR CPT CODES

A case must carry one of the codes below to enter this measure's denominator. **The other denominator criteria above still apply** - a matching code makes a case eligible for consideration, not automatically countable.

251 anesthesia CPT codes:

> 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00566, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01961, 01962, 01963, 01965, 01966

Source: 2026 AQI NACOR QCDR Measure Book. CPT copyright American Medical Association.

ABG 45: Aspiration Prevention in Patients with Gastric Distension**

Steward: ABG QCDR | **Collection Type:** QCDR Measure | **First Performance Year:** 2025 **2026 Status:** Approved by CMS for the 2026 MIPS performance period. Added in PY 2025, so it carries a **5-point scoring floor** if data completeness is met.

MEASURE DESCRIPTION Percentage of patients 18 years and older with a current diagnosis of gastrointestinal obstruction, ileus, or incarcerated hernia, or patients taking GLP-1 receptor agonists, or patients with gastroparesis, who undergo a surgical procedure under anesthesia and are treated preoperatively with a mitigation strategy that reduces the risk of aspiration during the surgical procedure.

NQS DOMAIN / MEANINGFUL MEASURES AREA Patient Safety

MEASURE TYPE: Process **HIGH PRIORITY STATUS:** Yes | **HIGH PRIORITY TYPE:** Patient Safety **INVERSE MEASURE:** No | **RISK ADJUSTED:** No **NUMBER OF PERFORMANCE RATES:** 1 **CARE SETTING:** All settings **TELEHEALTH:** No **DATA SOURCE:** EHR, Registry, Claims, Other

2026 BENCHMARK

No historical benchmark. Measure added in PY 2025. **Subject to a 5-point scoring floor if data completeness is met.**

Practical implication: the second-year scoring floor depends on data completeness. Review eligible case capture and the final CMS scoring rules when selecting this measure; the floor is not a guarantee of the overall Quality score.

INSTRUCTIONS Report each time an adult patient with one or more of the following conditions undergoes a surgical procedure under anesthesia: a) has gastrointestinal obstruction, ileus, or an incarcerated hernia b) is taking a GLP-1 receptor agonist c) has gastroparesis

Measure reporting via the QCDR: CPT codes, patient demographics, and registry codes identify patients in the denominator. The measure must capture both the surgical and the related anesthesia CPT code. G-codes and registry codes capture the numerator.

DENOMINATOR All patients aged 18 years or older who undergo a surgical procedure under anesthesia and have one or more of the listed conditions.

Denominator Criteria (Eligible Cases): - Patients aged 18 years and older - **AND** Current diagnosis of gastrointestinal obstruction, ileus, or incarcerated hernia (**12A49**) **OR** Has gastroparesis (**12A50**) **OR** Is taking a GLP-1 agonist, last dose less than 4 half-lives ago (**12A51**) - **AND** Receives anesthesia (MAC, regional, general, or neuraxial) (**12A57**) - **AND** Any patient encounter during the reporting period. **This measure applies to all cases regardless of CPT code**, which is unusual and makes it broadly applicable across a practice.

DENOMINATOR EXCEPTIONS - Local anesthesia only, no sedation (**12A52**) - Patient already intubated (**12A53**)

NUMERATOR Patients in the denominator who, prior to the surgical procedure under anesthesia, have one of the following mitigation strategies applied:

1. Clinical imaging demonstrating empty stomach contents (less than 1.5 mL/kg of fluid and no solids) within one hour of the procedure, by MRI, CT, or gastric ultrasound
2. Evacuation of stomach contents by nasogastric or orogastric tube within one hour of the procedure
3. Awake intubation
4. Maintenance of airway reflexes throughout the case

Numerator Quality-Data Coding Options:

Performance Met: **12A54** One or more of the four mitigation strategies applied prior to the procedure

OR

Denominator Exception: **12A55** Patient is taking GLP-1 receptor agonists or has gastroparesis but does not display symptoms of gastric distension. Symptomatic gastric distension is defined as a patient exhibiting two of the three following symptoms: 1) nausea and/or vomiting 2) dyspepsia or abdominal pain 3) abdominal bloating or distension

OR

Performance Not Met: **12A56** None of the four mitigation strategies applied prior to the procedure

RATIONALE

A 2021 anesthesia closed claims analysis identified that patients with gastrointestinal obstruction or other acute intraabdominal process are at high risk for pulmonary aspiration. In a majority of these closed claim aspiration cases, the anesthetic management was judged to be substandard. The most common reason cited was failure to place a nasogastric tube prior to the aspiration event. Rapid sequence induction and intubation with cricoid pressure as the sole preventative measure may not be sufficient to prevent massive aspiration.

Gastric distension, as seen in patients with gastrointestinal obstruction, ileus, incarcerated hernias, and symptomatic gastroparesis (drug-induced or otherwise), places the patient at highest risk. Four mitigation strategies have been identified that may reduce aspiration risk in such patients: placement of an NG or OG tube with evacuation of stomach contents, awake intubation, and maintenance of airway reflexes. If recent clinical imaging demonstrates a lack of high gastric content (less than 1.5 mL/kg of fluid and no solids), aspiration risk is reduced and none of the other three strategies is required.

CONCLUSION Pulmonary aspiration remains a major perioperative patient safety issue and can be fatal. Patients in the closed claims series had many factors previously identified as high-risk for aspiration of gastric contents, especially existing gastrointestinal obstruction. Anesthetic management of patients who experienced perioperative pulmonary aspiration was often judged to be substandard. These findings suggest that clinical practice modifications to preoperative assessment and anesthetic management of at-risk patients may improve perioperative outcomes.

REFERENCES 1. Warner MA, Meyerhoff KL, Warner ME, Posner KL, Stephens L, Domino KB. Pulmonary Aspiration of Gastric Contents: A Closed Claims Analysis. *Anesthesiology* 2021;135:284-291. doi:10.1097/ALN.0000000000003831 2. Salem MR, Khorasani A, Saatee S, Crystal GJ, El-Orbany M. Gastric tubes and airway management in patients at risk of aspiration: history, current concepts, and proposal of an algorithm. *Anesth Analg* 2014;118(3):569-79. PMID: 23757470 3. Silveira SQ, et al. Relationship between perioperative semaglutide use and residual gastric content: A retrospective analysis of patients undergoing elective upper endoscopy. *J Clin Anesth* 2023;87:111091. PMID: 36870274 4. Joshi GP, Abdelmalak BB, Weigel WA, et al., ASA Task Force on Preoperative Fasting. American Society of Anesthesiologists Consensus-Based Guidance on Preoperative Management of Patients (Adults and Children) on Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists. June 29, 2023 5. Kindel TL, Wang AY, Wadhwa A, et al. Multi-society clinical practice guidance for the safe use of glucagon-like peptide-1 receptor agonists in the perioperative period. *Surg Obes Relat Dis* 2024. doi:10.1016/j.soard.2024.08.033 6. Yeo YH, Gaddam S, Ng WH, et al. Increased risk of aspiration pneumonia associated with endoscopic procedures among patients with Glucagon-like peptide-1 receptor agonist use. *Gastroenterology* 2024. doi:10.1053/j.gastro.2024.03.015 7. Van de Putte P, Perlas A. The link between gastric volume and aspiration risk. In search of the Holy Grail? *Anaesthesia* 2018;73:274-279. doi:10.1111/anae.14164

RELEVANT FIELDS (Graphium capture) - Date of birth / patient age - Diagnosis of GI obstruction, ileus, or incarcerated hernia - Gastroparesis diagnosis - GLP-1 receptor agonist use and timing of last dose - Symptoms of

gastric distension (nausea/vomiting, dyspepsia/abdominal pain, bloating/distension) - Anesthesia type - Mitigation strategy applied and which one - Already intubated on arrival

REPORTING CODES

Code	Definition
12A49	Current diagnosis of gastrointestinal obstruction, ileus, or incarcerated hernia
12A50	Has gastroparesis
12A51	Is taking GLP-1 agonists (last dose less than 4 half-lives)
12A57	Receives anesthesia (MAC, regional, general, neuraxial)
12A52	Local anesthesia only, no sedation
12A53	Patient already intubated
12A54	One or more of the four mitigation strategies applied prior to the procedure
12A55	Patient taking GLP-1 RAs or with gastroparesis but not displaying symptoms of gastric distension
12A56	None of the four mitigation strategies applied prior to the procedure

DENOMINATOR CPT CODES

No CPT gate. The denominator is any patient receiving anesthesia (MAC, regional, general, or neuraxial) who has one of the listed conditions, so every anesthetized case is in scope regardless of procedure code.

Source: 2026 AQI NACOR QCDR Measure Book.

AQI 18: Coronary Artery Bypass Graft (CABG), Prolonged Intubation, Inverse Measure***

Steward: American Society of Anesthesiologists / Anesthesia Quality Institute | **First Performance Year:** 2016 **2026 Status:** Approved by CMS for the 2026 MIPS performance period.

MEASURE DESCRIPTION Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require postoperative intubation greater than 24 hours.

NQS DOMAIN / MEANINGFUL MEASURES AREA Effective Clinical Care / Preventable Healthcare Harm

MEASURE TYPE: Outcome **HIGH PRIORITY STATUS:** Yes **INVERSE MEASURE: Yes.** A lower rate indicates better quality. **RISK ADJUSTED:** No **NUMBER OF PERFORMANCE RATES:** 1 **CARE SETTING:** Hospital Inpatient **TELEHEALTH:** No **DATA SOURCE:** Claims, paper medical record, EHR, hybrid, registry **CBE NUMBER:** Not applicable | **eCQM:** Not applicable

2026 BENCHMARK

No historical benchmark. CMS may establish a performance-period benchmark using 2026 submissions. This is not a new measure, so new-measure floors do not apply; other CMS rules, including small-practice exceptions, may affect scoring.

Practical implication: the final scoring treatment remains uncertain until CMS determines whether a performance-period benchmark can be established. Consider the measure's clinical relevance and applicable scoring exceptions when planning your submission.

CHANGE FOR 2026 A new denominator exclusion was added: transcatheter aortic valve replacement (TAVR) and transcatheter aortic valve implantation (TAVI) cases.

INSTRUCTIONS Report each time an isolated CABG procedure is performed during the reporting period. It is anticipated that qualified anesthesia providers and eligible clinicians who provide services for isolated CABG will submit this measure. The measure is intended to reflect the quality of services provided for isolated CABG or isolated reoperation CABG patients.

Measure reporting via the QCDR: CPT codes and patient demographics identify patients in the denominator. The measure must capture both the surgical and the related anesthesia code. G-codes report the numerator.

DENOMINATOR All patients aged 18 years and older undergoing isolated CABG surgery.

Definition: Isolated CABG refers to CABG using arterial and/or venous grafts only.

Denominator Criteria (Eligible Cases): - Patient aged 18 years and older on date of encounter - **AND** Surgical CPT: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536 **AND** Anesthesia CPT: 00566, 00567 - **OR** Surgical CPT: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536 **AND** CPT 33530 **AND** Anesthesia CPT: 00562

DENOMINATOR EXCLUSIONS - Organ donors as designated by ASA Physical Status 6 - Procedure reduced or discontinued prior to initiation of cardiopulmonary bypass, as indicated on the claim by Modifier 52 or Modifier 53 - **NEW FOR 2026:** Transcatheter aortic valve replacement (TAVR) or transcatheter aortic valve implantation (TAVI) cases, CPT codes 33361, 33362, 33363, 33364, 33365, 33366, 33367, 33368, 33369, 93355 (**12A38**)

NUMERATOR Patients who require intubation greater than 24 hours following exit from the operating room.

Numerator Quality-Data Coding Options:

Performance Met: **G8569** Prolonged postoperative intubation (greater than 24 hours) required

OR

Performance Not Met: **G8570** Prolonged postoperative intubation (greater than 24 hours) not required

Note on inverse scoring: because this is an inverse measure, "Performance Met" records the undesirable outcome. A high performance rate is bad. Deciles run in the opposite direction from a standard measure.

RATIONALE

Prolonged intubation or prolonged ventilation following CABG surgery is associated with increased mortality and morbidity. A review of the literature suggests several predictors of prolonged ventilation following CABG, including increased incidence of pneumonia and pulmonary atelectasis, history of hypertension, COPD, kidney disease, and endocarditis. Most of these complications were associated with prolonged ICU and hospital length of stay and increased resource use.

Physician anesthesiologists and other qualified anesthesia providers maintain respiratory function throughout the perioperative period and play a critical role in respiratory care. Because they control the patient's breathing function, their decision-making around airway management substantially affects outcomes related to prolonged intubation and ventilation. Research shows that aortic aneurysm procedures, combined and valve procedures, preoperative renal dysfunction, and stroke are strong predictors of prolonged ventilation. Changes to care and procedures that reduce adverse respiratory outcomes require the engagement of anesthesia expertise.

REFERENCES 1. Ji Q, Duan Q, Wang X, et al. Risk factors for ventilator dependency following coronary artery bypass grafting. *Int J Med Sci* 2012;9(4):306-310. doi:10.7150/ijms.4340 2. Totonchi Z, Baazm F, Chitsazan M, Seifi S, Chitsazan M. Predictors of prolonged mechanical ventilation after open heart surgery. *J Cardiovasc Thorac Res* 2014;6(4):211-216. doi:10.15171/jcvtr.2014.014

RELEVANT FIELDS (Graphium capture) - Date of service - Date of birth - ASA CPT code and surgical CPT code - Isolated CABG surgery flag - ASA physical status - Modifier 52 / 53 - TAVR or TAVI case flag - Intubation greater than 24 hours after OR exit

REPORTING CODES

Code	Definition
12A38	TAVR or TAVI case (denominator exclusion, new for 2026)
G8569	Prolonged postoperative intubation (greater than 24 hours) required
G8570	Prolonged postoperative intubation (greater than 24 hours) not required

DENOMINATOR CPT CODES

A case must carry one of the codes below to enter this measure's denominator. **The other denominator criteria above still apply** - a matching code makes a case eligible for consideration, not automatically countable.

Procedure codes (17) - the case must carry one of these **and** one of the anesthesia codes that follow:

33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536

Anesthesia codes (3):

00562, 00566, 00567

Excluded by CPT (10) - a case carrying one of these is taken back out of the denominator:

33361, 33362, 33363, 33364, 33365, 33366, 33367, 33368, 33369, 93355

Requires a CABG surgical code AND the related anesthesia code. A surgical code alone does not place the case in the denominator.

Source: 2026 AQI NACOR QCDR Measure Book. CPT copyright American Medical Association.

AQI 48: Patient-Reported Experience with Anesthesia***

Steward: American Society of Anesthesiologists / Anesthesia Quality Institute | **First Performance Year:** 2017 **2026 Status:** Approved by CMS for the 2026 MIPS performance period. **Available in the Anesthesia MVP.**

MEASURE DESCRIPTION Percentage of patients aged 18 and older who were surveyed on their patient experience and satisfaction with anesthesia care and who reported a positive experience.

This measure consists of two performance rates:

AQI 48a: Percentage of patients aged 18 and older who were surveyed on their patient experience and satisfaction with anesthesia care.

AQI 48b: Percentage of patients aged 18 and older who completed a survey on their patient experience and satisfaction with anesthesia care and who report a positive experience **within 60 days of receipt of the survey**.

NOTE: A valid survey, as defined in the numerator of AQI 48a, must be sent to patients between discharge from the facility and within 30 days of facility discharge. To report AQI 48b, a minimum of **20 surveys** with the mandatory question completed must be reported. **To be scored on this measure, clinicians must report BOTH AQI 48a AND AQI 48b.**

NQS DOMAIN / MEANINGFUL MEASURES AREA Person and Caregiver-Centered Experience and Outcomes / Patient's Experience of Care

MEASURE TYPE: Patient-Reported Outcome-based Performance Measure (PRO-PM) **HIGH PRIORITY STATUS:** Yes | **HIGH PRIORITY TYPE:** Outcome **INVERSE MEASURE:** No | **RISK ADJUSTED:** No **NUMBER OF PERFORMANCE RATES:** 2 **OVERALL PERFORMANCE RATE FOR SCORING: AQI 48b CARE SETTING:** Ambulatory Care (Clinician Office/Clinic), Ambulatory Care (Hospital), Hospital, Hospital Inpatient, Outpatient Services **TELEHEALTH:** No **DATA SOURCE:** Claims, EHR, hybrid, registry, survey **REPORTING OPTIONS:** MVP and Traditional MIPS

2026 BENCHMARK

National average performance rate: **94.73%**. Historical benchmark. Not topped out. Not capped.

D1	D2	D3	D4	D5	D6	D7	D8	D9	D10
83.33 – 89.71	89.72 – 92.83	92.84 – 94.19	94.20 – 94.74	94.75 – 95.67	95.68 – 95.96	95.97 – 96.46	96.47 – 97.13	97.14 – 97.77	≥ 97.78

Reading this benchmark: the entire scoring range spans about 14 points, and deciles 4 through 8 are separated by roughly half a point each. This measure rewards a genuinely good patient experience program and punishes a mediocre one sharply. It is also one of the few measures in our set where the top decile is achievable without perfection, since Decile 10 begins at 97.78% rather than 100%.

Operational note: the 20-survey minimum and the 60-day response window are the two most common failure points. Groups that send surveys but do not chase responses often clear AQI 48a and then fail to reach 20 completed surveys for AQI 48b, which zeroes the measure since 48b is the scored rate.

INSTRUCTIONS AQI 48a should be reported each time a patient undergoes a procedure under anesthesia. AQI 48b should be reported every time a completed survey is returned by the patient within 60 days of receipt. To be scored on AQI 48b, the provider must collect the individual scores received on the survey as described in AQI 48a.

Measure reporting via the QCDR: CPT codes and patient demographics identify patients in the denominator. Registry codes report the numerator.

AQI 48a

DESCRIPTION Percentage of patients aged 18 and older who were surveyed on their patient experience and satisfaction with anesthesia care.

DENOMINATOR Patients aged 18 and older who undergo a procedure* under anesthesia.

Definition: *Any procedure including surgical, therapeutic, or diagnostic.

Denominator Criteria (Eligible Cases): - Patient aged 18 years or older on date of encounter - **AND** Patient encounter during the reporting period matching the measure's CPT list. This is the broadest code list in our set: 376 codes spanning the full ASA anesthesia range plus pain management, injection, catheter, and neurostimulator codes. The full list appears at the end of this measure.

DENOMINATOR EXCLUSIONS - Organ donors as designated by ASA Physical Status 6 - Patient died within 30 days of the procedure (**10A11**)

NUMERATOR Patients who received a survey within 30 days of the procedure to assess their experience and satisfaction with anesthesia.

Numerator Note: The survey should be administered shortly following discharge from the facility.

Definition of a valid survey: Practices and eligible clinicians may customize their surveys to meet local needs, but at a minimum a valid survey must include a core set of questions addressing **three of the four** following criteria, plus **one mandatory question**:

1. Preoperative education and preparation
2. Patient and/or family communication
3. Care team response to comfort and well-being
4. Postoperative pain control and/or management

Mandatory question (practices must also include a "Not Applicable" option):

> On a scale of 1 to 5, where 1 indicates the worst anesthesia experience and 5 indicates the best anesthesia experience, how would you rate your anesthesia experience?

Numerator Note: Practices may wish to supplement these questions using the ASA Committee on Performance and Outcomes Measurement work product "Patient Satisfaction with Anesthesia White Paper," and the five-component Perioperative Surgical Home framework: preoperative education and preparation; check-in and pre-procedure experience; caregiver and family communication during surgery; care team response to comfort and well-being; and postoperative pain management. See https://www.asahq.org/psh.

Numerator Quality-Data Coding Options:

Performance Met: **10A12** Patient provided with a survey within 30 days of the procedure

OR

Denominator Exception: **10A13** Documentation of patient, process, or medical reasons for not receiving a survey. This covers patients who are non-verbal, unable to be surveyed for a medical or psychiatric reason, unable to be surveyed due to a language barrier, who have not provided contact information, who are discharged to assisted living, a skilled nursing facility, or a similar location where direct access is unavailable, or who decline to be surveyed.

OR

Performance Not Met: **10A14** Patient was not provided with a survey within 30 days of the procedure

OR

11A93 The patient did not respond within 60 days of receipt of the survey.

> *Important:* 11A93 exists to remove unreturned surveys from the calculation. **Reporting it is essential for the data completeness calculation and does NOT indicate negative performance.** Performance is calculated on AQI 48b. Groups that omit this code damage their data completeness for no reason.

AQI 48b

DESCRIPTION Percentage of patients who complete the survey from AQI 48a and report a positive experience within 60 days of receipt of the survey.

DENOMINATOR All patients from the numerator of AQI 48a who complete a survey on their patient experience and satisfaction with anesthesia care within 60 days of receipt of the survey.

DENOMINATOR NOTE: The denominator must include a minimum of **20 returned surveys**.

Denominator Criteria (Eligible Cases): - Patient completed a survey on their patient experience and satisfaction with anesthesia care within 60 days of receipt (**11A94**)

DENOMINATOR EXCLUSIONS - Patient did not complete the mandatory anesthesia satisfaction question within 60 days of receipt of the survey (**11A95**)

NUMERATOR Patients who reported a positive experience with anesthesia care.

Definition: A positive experience is a response of **4 or 5** on the mandatory survey question.

Reporting note: To report this measure, the provider must submit the individual patient scores. The percentage reporting a positive experience is calculated on the provider's behalf.

Numerator Quality-Data Coding Options:

Performance Met: **10A70** Patient reported a positive anesthesia experience (a 4 or 5 on the mandatory survey question)

OR

Performance Not Met: **10A71** Patient did NOT report a positive anesthesia experience (a 1, 2, or 3 on the mandatory survey question)

RATIONALE

Despite the implementation of CAHPS and H-CAHPS, there remains a persistent gap in the ability to adequately measure patient experience for performance-based payment programs. To provide high quality, patient-centered care, anesthesiologists and other qualified anesthesia providers should measure and respond to patients'

perception of the degree to which they felt treated as individuals and empowered to engage in decision-making about their care. Assessment of patient satisfaction with anesthesia care provides feedback that enables providers to improve care delivery and quality. A wide array of tools is available for practices to implement based on local patient populations and quality improvement initiatives.

RELEVANT FIELDS (Graphium capture) - Date of procedure - Date of birth - ASA CPT code - ASA physical status - Survey sent, and date sent - Survey received, and date received - Response to mandatory question (1 to 5, or Not Applicable) - Reason for not surveying, if applicable

REPORTING CODES

Code	Definition
10A11	Patient died within 30 days of the procedure (AQI 48a exclusion)
10A12	Patient provided with a survey within 30 days of the procedure
10A13	Documentation of patient, process, or medical reason for not receiving survey
10A14	Patient was not provided with a survey within 30 days of the procedure
11A93	The patient did not respond within 60 days of receipt of the survey
11A94	Patient completed a survey within 60 days of receipt (AQI 48b denominator)
11A95	Patient did not complete the mandatory anesthesia satisfaction question within 60 days (AQI 48b exclusion)
10A70	Patient reported a positive anesthesia experience (4 or 5)
10A71	Patient did NOT report a positive anesthesia experience (1, 2, or 3)

CHANGES FOR 2026 The AQI 48b denominator and exclusion codes changed. The denominator code is now **11A94** (previously 10A72) and the exclusion is now **11A95** (previously 10A69). The 60-day response window is now stated explicitly in both.

DENOMINATOR CPT CODES

A case must carry one of the codes below to enter this measure's denominator. **The other denominator criteria above still apply** - a matching code makes a case eligible for consideration, not automatically countable.

AQI 48a

Procedure codes (110). AQI 48 uses one combined eligible CPT list. A qualifying code may come from this group **or** the anesthesia-code group below; one from each group is not required. All other denominator criteria still apply:

20526, 20550, 20551, 20552, 20553, 20600, 20604, 20605, 20606, 20610, 20611, 27096, 36555, 36556, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 62263, 62264, 62270, 62272, 62273, 62280, 62281, 62282, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 62328, 62329, 62350, 62355, 62360, 62361, 62362, 62365, 62370, 63650, 63661, 63662, 63663, 63664, 63685, 63688, 64400, 64405, 64408, 64415, 64416, 64417, 64418, 64420, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, 64450, 64451, 64454, 64461, 64463, 64466, 64467, 64468, 64469, 64473, 64474, 64479, 64483, 64486, 64487, 64488, 64489, 64490, 64493, 64505, 64510, 64517, 64520, 64530, 64600, 64605, 64610, 64620, 64624, 64625, 64630, 64633, 64635, 64640, 64680, 64681, 93503, 95990, 95991

Anesthesia codes (266):

00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01937, 01938, 01939, 01940, 01941, 01942, 01951, 01952, 01958, 01960, 01961, 01962, 01963, 01965, 01966, 01967, 01991, 01992

Codes apply to AQI 48a. AQI 48b's denominator is drawn from the AQI 48a numerator and has no separate code list.

Source: 2026 AQI NACOR QCDR Measure Book. CPT copyright American Medical Association.

AQI 65: Avoidance of Cerebral Hyperthermia for Procedures Involving Cardiopulmonary Bypass***

Steward: American Society of Anesthesiologists / Anesthesia Quality Institute | **First Performance Year:** 2019 **2026 Status:** Approved by CMS for the 2026 MIPS performance period.

MEASURE DESCRIPTION Percentage of patients aged 18 years and older undergoing a procedure using cardiopulmonary bypass who did not have a documented intraoperative pulmonary artery, oropharyngeal, or nasopharyngeal temperature greater than or equal to 37.0 degrees Celsius during the period of cardiopulmonary bypass.

NQS DOMAIN / MEANINGFUL MEASURES AREA Patient Safety / Preventable Healthcare Harm

MEASURE TYPE: Outcome **HIGH PRIORITY STATUS:** Yes | **HIGH PRIORITY TYPE:** Outcome **INVERSE MEASURE:** No | **RISK ADJUSTED:** No **NUMBER OF PERFORMANCE RATES:** 1 **CARE SETTING:** Hospital, Hospital Inpatient **TELEHEALTH:** No **DATA SOURCE:** Claims, paper medical record, EHR, hybrid, registry **CBE NUMBER:** Not applicable | **eCQM:** Not applicable

2026 BENCHMARK

National average performance rate: **93.52%**. Historical benchmark. Not topped out. Not capped.

D1	D2	D3	D4	D5	D6	D7	D8	D9	D10
48.08 – 75.87	75.88 – 88.35	88.36 – 96.90	96.91 – 99.99	--	--	--	--	--	100.00

Reading this benchmark: the distribution collapses above Decile 4. Anything short of a perfect 100% caps out at Decile 4 (roughly 4 points), and 100% jumps straight to 10. This is a binary-feeling measure in practice. For a cardiac group with reliable temperature documentation it is a strong 10-point measure. For a group with any documentation gaps it is worth 4 points at best, because **11A13 (no documented temperatures) counts as Performance Not Met**, not as an exclusion.

CHANGE FOR 2026 A new denominator exclusion was added: TAVR and TAVI cases.

INSTRUCTIONS Report each time a patient undergoes a cardiac operation using cardiopulmonary bypass during the reporting period. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure reporting via the QCDR: CPT codes and patient demographics identify patients in the denominator. Registry codes report the numerator.

DENOMINATOR All patients aged 18 years or older who undergo a procedure using cardiopulmonary bypass.

Denominator Criteria (Eligible Cases): - Patient aged 18 years and older - **AND** Patient encounter during the reporting period (CPT): **00562, 00563, 00567, 00580**

DENOMINATOR EXCLUSIONS - Procedure reduced or discontinued prior to initiation of cardiopulmonary bypass, as indicated on the claim by Modifier 52 or Modifier 53 - **NEW FOR 2026:** Transcatheter aortic valve replacement (TAVR) or transcatheter aortic valve implantation (TAVI) cases, CPT codes 33361, 33362, 33363, 33364, 33365, 33366, 33367, 33368, 33369, 93355 (**12A38**)

NUMERATOR Patients who did not have an intraoperative pulmonary artery, oropharyngeal, or nasopharyngeal temperature greater than or equal to 37.0 degrees Celsius during cardiopulmonary bypass.

Numerator Quality-Data Coding Options:

Performance Met: **11A11** All intraoperative pulmonary artery, oropharyngeal, or nasopharyngeal temperatures less than 37.0 degrees Celsius during cardiopulmonary bypass

OR

Performance Not Met: **11A12** At least one intraoperative pulmonary artery, oropharyngeal, or nasopharyngeal temperature greater than or equal to 37.0 degrees Celsius

OR

Performance Not Met: **11A13** No documented pulmonary artery, oropharyngeal, or nasopharyngeal temperatures during cardiopulmonary bypass

RATIONALE

Appropriate temperature management during cardiopulmonary bypass is important to avoid cerebral hyperthermia and associated cerebral injury. Studies have associated cerebral hyperthermia with complications including cognitive dysfunction, mediastinitis, and acute kidney injury. Through careful monitoring, good communication with perfusionists, and appropriate rewarming strategies, anesthesiologists can prevent cerebral hyperthermia.

CLINICAL RECOMMENDATION STATEMENTS 2015 STS/SCA/ASECT Guidelines on Temperature Management During Cardiopulmonary Bypass: - "Surgical teams should limit arterial outlet blood temperature to less than 37 degrees Celsius to avoid cerebral hyperthermia." (Class I, Level C) - "Pulmonary artery or nasopharyngeal temperature recording is reasonable for core temperature measurement." (Class IIa, Level C)

REFERENCE Engelman R, Baker RA, Likosky DS, et al. The Society of Thoracic Surgeons, The Society of Cardiovascular Anesthesiologists, and The American Society of ExtraCorporeal Technology: Clinical Practice Guidelines for Cardiopulmonary Bypass, Temperature Management during Cardiopulmonary Bypass. *J Extra Corpor Technol* 2015;47(3):145-154.

RELEVANT FIELDS (Graphium capture) - Date of service - Date of birth - ASA CPT code - CPB performed flag - Intraoperative PA, oropharyngeal, or nasopharyngeal temperatures during CPB (all values) - Modifier 52 / 53 - TAVR or TAVI case flag

REPORTING CODES

Code	Definition
12A38	TAVR or TAVI case (denominator exclusion, new for 2026)
11A11	All intraoperative PA, oropharyngeal, or nasopharyngeal temperatures less than 37.0 degrees Celsius during CPB
11A12	At least one intraoperative PA, oropharyngeal, or nasopharyngeal temperature greater than or equal to 37.0 degrees Celsius
11A13	No documented PA, oropharyngeal, or nasopharyngeal temperatures during CPB

DENOMINATOR CPT CODES

A case must carry one of the codes below to enter this measure's denominator. **The other denominator criteria above still apply** - a matching code makes a case eligible for consideration, not automatically countable.

4 anesthesia CPT codes:

> 00562, 00563, 00567, 00580

Excluded by CPT (10) - a case carrying one of these is taken back out of the denominator:

> 33361, 33362, 33363, 33364, 33365, 33366, 33367, 33368, 33369, 93355

Source: 2026 AQI NACOR QCDR Measure Book. CPT copyright American Medical Association.

AQI 71: Ambulatory Glucose Management***

Steward: American Society of Anesthesiologists / Anesthesia Quality Institute | **First Performance Year:** 2021 **2026 Status:** Approved by CMS for the 2026 MIPS performance period.

MEASURE DESCRIPTION Percentage of diabetic patients aged 18 years and older who receive an office-based or ambulatory surgery whose blood glucose level is appropriately managed throughout the perioperative period.

This measure consists of four performance rates:

AQI 71a: Percentage of patients with a current diagnosis of diabetes mellitus receiving anesthesia services for office-based or ambulatory surgery whose blood glucose level is tested prior to the start of anesthesia.

AQI 71b: Percentage of patients with diabetes mellitus receiving anesthesia services for office-based or ambulatory surgery who experienced a blood glucose level greater than 180 mg/dL (10.0 mmol/L) and who received insulin prior to anesthesia end time.

AQI 71c: Percentage of patients with diabetes mellitus receiving anesthesia services for office-based or ambulatory surgery who received insulin perioperatively and who received a follow-up blood glucose level check following administration of insulin and prior to discharge.

AQI 71d: Percentage of patients with diabetes mellitus receiving anesthesia services for office-based or ambulatory surgery who experienced a blood glucose level greater than 180 mg/dL (10.0 mmol/L) and who received education on managing their glucose in the postoperative period prior to discharge.

NOTE: The overall measure score is calculated as an **average of the performance rates of parts a, b, c, and d**. To be scored on this measure, clinicians must have **at least one eligible case reported for each of the four sub-metrics**. Missing any one of them zeroes the composite.

CHANGES FOR 2026 - **Measure Type changed from Process to Composite.** - **High Priority Status changed from No to Yes.** - ICD-10 code list for diabetes mellitus expanded to add E10.A0, E10.A1, and E10.A2 across all four sub-measures.

NQS DOMAIN / MEANINGFUL MEASURES AREA Effective Clinical Care / Healthcare Associated Infections

MEASURE TYPE: Composite *(changed for 2026)* **HIGH PRIORITY STATUS:** Yes *(changed for 2026)* **INVERSE MEASURE:** No | **RISK ADJUSTED:** No **NUMBER OF PERFORMANCE RATES:** 5 (the composite plus four sub-rates) **OVERALL PERFORMANCE RATE FOR SCORING:** 1st Performance Rate (the composite average) **CARE SETTING:** Ambulatory Care (Hospital), Ambulatory Surgical Center **TELEHEALTH:** No **DATA SOURCE:** Claims, EHR, hybrid, registry **CBE NUMBER:** Not applicable | **eCQM:** Not applicable

2026 BENCHMARK

No historical benchmark. CMS may establish a performance-period benchmark using 2026 submissions. This is not a new measure, so new-measure floors do not apply; other CMS rules, including small-practice exceptions, may affect scoring.

Practical implication: review the requirements for all four sub-metrics and your eligible case population. Clinical relevance and complete reporting matter; the absence of a historical benchmark does not establish the measure's final scoring potential.

INSTRUCTIONS Each sub-measure should be reported, as appropriate, each time a patient undergoes a procedure in an office-based or ambulatory setting during the reporting period. All four sub-metrics are required to be reported

during the performance period.

Measure reporting via the QCDR: CPT codes and patient demographics identify patients in the denominator. Registry codes report the numerator.

SHARED DENOMINATOR ELEMENTS (all four sub-measures)

Denominator Definition: Office-based and ambulatory surgery is a therapeutic or diagnostic procedure performed in a healthcare facility that does not require an overnight stay (less than 24 hours of care).

- All patients aged 18 years and older
- **AND** Diagnosis of diabetes mellitus (**11A41**) **OR** an ICD-10-CM code from the measure's diabetes list. The list spans the E10, E11, and E13 families, roughly 250 codes, and was expanded for 2026 to include E10.A0, E10.A1, and E10.A2. See the AQI NACOR 2026 QCDR Measure Specifications for the enumerated list.
- **AND** Place of Service Code **11, 19, 22, or 24** (Office, Off Campus Outpatient Hospital, On Campus Outpatient Hospital, Ambulatory Surgical Center)
- **AND** Patient encounter during the reporting period matching the measure's ambulatory anesthesia CPT list (a narrower ambulatory subset; 143 codes for AQI 71a, 71b and 71d, and 137 for AQI 71c. The full lists appear at the end of this measure.)

SHARED DENOMINATOR EXCLUSION (all four sub-measures) - Procedure less than 30 minutes duration (**11A45**)

AQI 71a: Ambulatory Point-of-Care Glucose Testing

DENOMINATOR: Shared elements above.

NUMERATOR: Patients who received a blood glucose test prior to the start of anesthesia.

Performance Met: **11A51** Patient received a blood glucose test prior to start of anesthesia **OR** ***Performance Not Met:*** **11A52** Patient did NOT receive a glucose test prior to start of anesthesia

AQI 71b: Ambulatory Hyperglycemia Control

DENOMINATOR: Shared elements above, **AND** experienced a blood glucose level greater than 180 mg/dL (10.0 mmol/L) prior to anesthesia end time (**11A44**).

NUMERATOR: Patients who received insulin prior to anesthesia end time.

Performance Met: **11A53** Patient received insulin prior to anesthesia end time **OR** ***Denominator Exception:*** **11A82** Documentation that insulin was not given because the patient had severe comorbidities and glucose concentrations between 180 mg/dL and 250 mg/dL (10 to 13.9 mmol/L) **OR** ***Performance Not Met:*** **11A54** Patient did NOT receive insulin prior to anesthesia end time

AQI 71c: Follow-Up Glucose Check for Patients Receiving Insulin

DENOMINATOR: Shared elements above, **AND** patient received insulin perioperatively (**11A55**).

NUMERATOR: Patients who received a follow-up blood glucose level check following the administration of insulin and prior to discharge.

Performance Met: **11A56** Patient received a follow-up blood glucose level check following the administration of insulin and prior to discharge **OR** ***Performance Not Met:*** **11A57** Patient did NOT receive a follow-up blood glucose level check following the administration of insulin and prior to discharge

AQI 71d: Hyperglycemia Management Patient Education

DENOMINATOR: Shared elements above, **AND** experienced a blood glucose level greater than 180 mg/dL (10.0 mmol/L) prior to anesthesia end time (**11A44**).

NUMERATOR: Patients who received education on managing their glucose in the postoperative period prior to discharge.

Numerator Note: To meet this measure, the anesthesiologist or another member of the care team must provide **both oral and written education**. ***Provision of written materials alone is not sufficient.***

Performance Met: **11A58** Patient received education on managing their glucose in the postoperative period prior to discharge **OR** ***Performance Not Met:*** **11A59** Patient did NOT receive education on managing their glucose in the postoperative period prior to discharge

RATIONALE

Diabetes mellitus is an important risk factor for surgical site infection and other surgical complications. With increasingly complex procedures being performed in ambulatory settings, perioperative glucose management is an important aspect of ambulatory anesthesia care. For diabetic patients, preoperative testing of blood glucose provides an important indicator of intraoperative insulin and care management needs. Despite this, evidence shows glucose testing is not consistently performed in the ambulatory setting. Improved preoperative glucose testing helps anesthesia providers anticipate and manage the needs of diabetic patients throughout the perioperative period.

Perioperative administration of insulin to hyperglycemic patients improves clinical outcomes by decreasing surgical site infections and hyperglycemia in the PACU. Blood glucose values of 180 mg/dL (10 mmol/L) or higher are treated with insulin. The target range for the perioperative period is 140 to 180 mg/dL (7.7 to 10 mmol/L).

CLINICAL RECOMMENDATION STATEMENTS

2010 SAMBA Consensus Statement on Perioperative Blood Glucose Management in Diabetic Patients Undergoing Ambulatory Surgery: "Ambulatory surgical facilities taking care of diabetic patients must have glucose monitoring capabilities such as point-of-care monitors. Adequate monitoring of blood glucose levels is critical in maintaining patient safety and should facilitate insulin titration to achieve optimal blood glucose levels as well as allow for early detection of hypoglycemia. It has been suggested that blood glucose levels should be checked on the patient's arrival to the facility before surgery and before discharge home." (LoE category 2A)

SAMBA recommends intraoperative blood glucose levels below 180 mg/dL. The AACE Task Force and the American Diabetes Association recommend target glucose levels between 140 and 180 mg/dL in critically ill patients. The Society of Critical Care Medicine advises treatment triggered at blood glucose levels at or above 150 mg/dL, with a goal of maintaining glucose below that level and absolutely below 180 mg/dL. The Society of Thoracic Surgeons recommends maintaining serum glucose at or below 180 mg/dL for at least 24 hours after cardiac surgery.

RELEVANT FIELDS (Graphium capture) - Date of procedure, date of birth - Diabetes diagnosis and ICD-10 code - Place of service code - ASA CPT code - Procedure duration - Preoperative blood glucose value and timing - Any blood glucose value greater than 180 mg/dL and timing - Insulin administered, and timing relative to anesthesia end - Follow-up glucose check after insulin, prior to discharge - Postoperative glucose management education, oral and written

REPORTING CODES

Code	Definition
11A41	Diagnosis of diabetes mellitus
11A44	Experienced a blood glucose level greater than 180 mg/dL (10.0 mmol/L) prior to anesthesia end time
11A45	Procedure less than 30 minutes duration (denominator exclusion, all sub-measures)
11A55	Patient received insulin perioperatively (71c denominator)
11A51	Patient received a blood glucose test prior to start of anesthesia
11A52	Patient did NOT receive a glucose test prior to start of anesthesia
11A53	Patient received insulin prior to anesthesia end time
11A82	Documentation that insulin was not given due to severe comorbidities with glucose 180 to 250 mg/dL
11A54	Patient did NOT receive insulin prior to anesthesia end time
11A56	Patient received a follow-up blood glucose check following insulin and prior to discharge
11A57	Patient did NOT receive a follow-up blood glucose check following insulin and prior to discharge
11A58	Patient received education on managing glucose in the postoperative period prior to discharge
11A59	Patient did NOT receive education on managing glucose in the postoperative period prior to discharge

DENOMINATOR CPT CODES

A case must carry one of the codes below to enter this measure's denominator. **The other denominator criteria above still apply** - a matching code makes a case eligible for consideration, not automatically countable.

AQI 71a, AQI 71b and AQI 71d

143 anesthesia CPT codes:

> 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00164, 00170, 00172, 00174, 00176, 00300, 00320, 00322, 00400, 00402, 00404, 00410, 00450, 00454, 00520, 00522, 00524, 00530, 00532, 00534, 00537, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00790, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00851, 00870, 00872, 00873, 00902, 00906, 00910, 00912, 00914, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01202, 01250, 01260, 01320, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01464, 01470, 01472, 01474, 01480, 01520, 01610, 01620, 01622, 01630, 01634, 01638, 01670, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01758, 01760, 01810, 01820, 01829, 01830, 01832, 01840, 01842,

01844, 01850, 01852, 01860, 01916, 01920, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01937, 01938, 01939, 01940, 01941, 01942, 01965, 01966, 01991, 01992

AQI 71c

137 anesthesia CPT codes:

00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00164, 00170, 00172, 00174, 00176, 00300, 00320, 00322, 00400, 00402, 00404, 00410, 00450, 00454, 00520, 00522, 00524, 00530, 00532, 00534, 00537, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00790, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00851, 00870, 00872, 00873, 00902, 00906, 00910, 00912, 00914, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01202, 01250, 01260, 01320, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01464, 01470, 01472, 01474, 01480, 01520, 01610, 01620, 01622, 01630, 01634, 01638, 01670, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01758, 01760, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01930, 01937, 01938, 01939, 01940, 01941, 01942, 01965, 01966, 01991, 01992

Four sub-measures. AQI 71a, 71b and 71d share one list; 71c is slightly narrower.

Source: 2026 AQI NACOR QCDR Measure Book. CPT copyright American Medical Association.

AQI 80: Continuation of Buprenorphine for Inpatient Surgical Patients, or Methadone Therapy during the Perioperative Period***

Steward: American Society of Anesthesiologists / Anesthesia Quality Institute | **First Performance Year:** 2026 **2026 Status: NEW.** Approved by CMS as a new QCDR measure for the 2026 MIPS performance period. Replaces the retired AQI 74 (methadone) and AQI 75 (buprenorphine), which were combined into this single measure.

MEASURE DESCRIPTION Percentage of patients age 13 and older undergoing an inpatient surgical procedure who have an outpatient prescription for buprenorphine/naloxone or suboxone in their admissions documentation and who are continued on buprenorphine for the duration of their inpatient stay; **or** undergoing an inpatient or ambulatory surgical procedure who are taking methadone as outpatients or who have a prescription for methadone in their admittance documentation, and where methadone is either continued or changed to an equivalent IV dose to maintain the therapeutic level regimen during the perioperative period. For patients receiving care in an ambulatory surgical setting, methadone medication was provided as scheduled before surgery.

This measure consists of two performance rates:

Measure A: Percentage of patients age 13 and older undergoing an inpatient surgical procedure who have an outpatient prescription for buprenorphine/naloxone or suboxone in their admissions documentation and are continued on buprenorphine for the duration of their inpatient stay.

Measure B: Percentage of patients age 13 and older undergoing an inpatient or ambulatory surgical procedure who are taking methadone as outpatients or have a prescription for methadone in their admittance documentation, and where methadone is either continued or changed to an equivalent IV dose to maintain the therapeutic level regimen during the perioperative period. In an ambulatory setting, methadone was provided as scheduled before surgery.

NOTE: The overall measure score is calculated as a **simple average of the performance rates of A and B**. To be scored, clinicians must have **at least one eligible case reported for each sub-metric**.

NQS DOMAIN / MEANINGFUL MEASURES AREA Opioid Related

MEASURE TYPE: Process **HIGH PRIORITY STATUS:** Yes | **HIGH PRIORITY TYPE:** Opioid-related **INVERSE MEASURE:** No | **RISK ADJUSTED:** No **NUMBER OF PERFORMANCE RATES:** 2, simple average **CARE SETTING:** Ambulatory, Ambulatory Surgical Center, Hospital, Hospital Inpatient, Hospital Outpatient, Office Based Surgery Center **TELEHEALTH:** No **DATA SOURCE:** Administrative claims data, claims, EHR, paper medical record, record review, registry

2026 BENCHMARK

No historical benchmark. Measure added in PY 2026. **Subject to a 7-point scoring floor if data completeness is met.**

Practical implication: AQI 80's first-year scoring floor is subject to data completeness. Confirm that the measure fits your case population and that both sub-metrics meet their reporting requirements before including it in your submission.

Testing requirement note: CMS approved this measure conditionally. For the 2027 self-nomination, empirical validity, measure score reliability, feasibility, and patient/encounter-level data element testing will be required.

INSTRUCTIONS Submit data on one of the submission criteria depending on the clinical findings and surgical setting. If the patient has an outpatient prescription for buprenorphine/naloxone in their admissions documentation for an inpatient surgical procedure, use Measure A. If the patient is taking methadone as an outpatient, has a prescription

for methadone in their admittance documentation, or methadone is provided as scheduled before an ambulatory surgical procedure, use Measure B.

There is no diagnosis associated with this measure.

Measure A: Buprenorphine Continuation (Inpatient)

DENOMINATOR Patients aged 13 years and older undergoing any inpatient surgical procedure who have a prescription for buprenorphine/naloxone or suboxone in their admitting documentation.

Denominator Criteria (Eligible Cases): - Patients aged 13 years and older - **AND** Patient encounter during the reporting period matching the measure's ASA anesthesia CPT list (266 codes; the full list appears at the end of this measure) - **AND** Place of service code **21** (Inpatient Hospital) - **AND** Patient has a prescription for buprenorphine/naloxone or suboxone in their admitting documentation (**12A17**)

DENOMINATOR EXCLUSIONS - Patient has a chronic pain diagnosis (ICD **G89.4**, or registry code **12A18**)

NUMERATOR All patients who receive a continuation of buprenorphine during their inpatient stay.

Performance Met: **12A19** The patient received a continuation of buprenorphine during their inpatient stay **OR** ***Denominator Exception:*** **12A20** Documentation that the inpatient is unable to tolerate buprenorphine, received instruction from their surgical, anesthesia, and/or addiction treatment provider to stop buprenorphine prior to the inpatient procedure, refused continuation of buprenorphine treatment, or received methadone in lieu of buprenorphine **OR** ***Performance Not Met:*** **12A21** The patient did NOT receive a continuation of buprenorphine during their inpatient stay

Measure B: Methadone Continuation (Inpatient or Ambulatory)

DENOMINATOR Patients aged 13 years and older undergoing an inpatient or ambulatory surgical procedure who are taking methadone as outpatients or who have a prescription for methadone in their admittance or ambulatory surgical documentation.

Denominator Criteria (Eligible Cases): - Patients aged 13 years and older - **AND** Patient encounter during the reporting period matching the measure's ASA anesthesia CPT list (266 codes; the full list appears at the end of this measure) - **AND** Place of service code **19, 21, 22, or 24** - **AND** Patient is taking methadone as an outpatient or has a prescription for methadone in their admittance documentation (**12A27**)

DENOMINATOR EXCLUSIONS None.

NUMERATOR All patients where methadone is either continued or changed to an equivalent IV dose to maintain the therapeutic level regimen during the perioperative period, or, if in an ambulatory setting, was provided as scheduled prior to surgery.

Numerator Note: In the inpatient setting, methadone may either be continued or changed to an equivalent IV dose to maintain therapeutic levels. Documentation of methadone provided as scheduled prior to surgery in the ambulatory setting is acceptable.

Numerator Note: For this measure, the perioperative period includes the preoperative, intraoperative, and postoperative periods. The postoperative period ends when the patient is discharged from the PACU or recovery location.

Performance Met: **12A28** Methadone therapy is continued or changed to an equivalent IV dose to maintain the therapeutic level regimen during the perioperative period, or in an ambulatory setting methadone was provided as

scheduled prior to surgery **OR** ***Denominator Exception:*** **12A29** Documentation that the patient received instruction from their surgical, anesthesia, and addiction treatment provider to stop methadone prior to the procedure; or documentation of medical reasons for not continuing or changing to an equivalent IV dose during the perioperative period, or for methadone not being provided as scheduled in an ambulatory setting. Medical reasons may include patient transfer to intensive care, a diagnosis of hypotension or shock, unstable plasma levels, or inability to tolerate the daily methadone regimen **OR** ***Performance Not Met:*** **12A30** Methadone therapy is NOT continued or changed to an equivalent IV dose during the perioperative period, or in an ambulatory setting methadone was NOT provided as scheduled prior to surgery

RATIONALE

According to multiple studies and guidelines, buprenorphine should not be routinely discontinued in the perioperative setting. Hospitalization presents an opportunity for anesthesiologists and pain medicine physicians to ensure patients already under opioid use disorder treatment have their therapy continued during their inpatient stay. Surgeons, anesthesiologists, and addiction medicine providers may also use the opportunity to identify patients at risk for opioid use disorder. Recommendations developed by a multispecialty expert panel including representatives from ASRA, ASA, the American Academy of Pain Medicine, the American Society of Addiction Medicine, and the American Society of Health System Pharmacists note that anesthesiologists and pain physicians can recommend and consider initiating medication treatment of opioid use disorder in patients with suspected OUD at the point of care, which can serve as a bridge to comprehensive treatment.

Barreveld describes hospitalization as a patient-centered opportunity for shared decision-making and expectation discussions, calling it essential to all medication-for-OUD strategies when managing acute surgical pain, and notes that prevailing consensus-based recommendations advise continuation of methadone and buprenorphine without interruption throughout the perioperative period.

CLINICAL PRACTICE RECOMMENDATIONS

American Society of Addiction Medicine, National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update: Discontinuation of methadone or buprenorphine before surgery is not required. Higher potency intravenous full agonist opioids can be used perioperatively for analgesia. If it is decided that buprenorphine or methadone should be discontinued before a planned surgery, this may occur the day before or the day of surgery based on surgical and anesthesia team recommendations. Methadone or buprenorphine can be resumed postoperatively when the need for full opioid agonist analgesia has resolved. In general, pre-surgery daily doses can be resumed if withheld for less than 2 to 3 days.

Buprenorphine Management in the Perioperative Period: Educational Review and Recommendations from a Multisociety Expert Panel, 2021: Continuation of buprenorphine in the perioperative period is supported by evidence that discontinuation is harmful, and for some patients discontinuation may be fatal. The likelihood of harm is increased in patients prescribed buprenorphine for OUD as opposed to chronic pain.

REFERENCES 1. Barreveld AM, Mendelson A, Deiling B, Armstrong CA, Viscusi ER, Kohan LR. Caring for Our Patients With Opioid Use Disorder in the Perioperative Period: A Guide for the Anesthesiologist. *Anesth Analg* 2023;137(3):488-507. PMID: 37590794 2. Jimenez Ruiz F, Warner NS, Acampora G, Coleman JR, Kohan L. Substance Use Disorders: Basic Overview for the Anesthesiologist. *Anesth Analg* 2023;137(3):508-520. PMID: 37590795 3. Kohan L, Potru S, Barreveld AM, et al. Buprenorphine management in the perioperative period: educational review and recommendations from a multisociety expert panel. *Reg Anesth Pain Med* 2021;46(10):840-859. PMID: 34385292 4. Moran S, Isa J, Steinemann S. Perioperative management in the patient with substance abuse. *Surg Clin North Am* 2015;95(2):417-28. PMID: 25814115 5. Sutherland AM, Clarke HA. The role of anesthesiologists in reducing opioid harm. *Can J Anaesth* 2022;69(8):917-922. PMID: 35773601

RELEVANT FIELDS (Graphium capture) - Date of procedure, date of birth (note: age 13 and older, not 18) - ASA CPT code - Place of service code - Buprenorphine/naloxone or suboxone prescription in admitting documentation - Methadone use or prescription in admittance documentation - Chronic pain diagnosis (G89.4) - Buprenorphine continued during inpatient stay - Methadone continued or converted to equivalent IV dose - Methadone provided as scheduled prior to ambulatory surgery - Documented reason for discontinuation

REPORTING CODES

Code	Definition
12A17	Patient has a prescription for buprenorphine/naloxone or suboxone in admitting documentation
12A18	Patient has a chronic pain diagnosis (Measure A exclusion)
12A19	The patient received a continuation of buprenorphine during their inpatient stay
12A20	Documentation of inability to tolerate, instruction to stop, refusal, or methadone in lieu of buprenorphine
12A21	The patient did NOT receive a continuation of buprenorphine during their inpatient stay
12A27	Patient is taking methadone as an outpatient or has a methadone prescription in admittance documentation
12A28	Methadone continued or changed to an equivalent IV dose, or provided as scheduled prior to ambulatory surgery
12A29	Documentation of instruction to stop methadone, or medical reason for not continuing
12A30	Methadone NOT continued or converted, or NOT provided as scheduled prior to ambulatory surgery

DENOMINATOR CPT CODES

A case must carry one of the codes below to enter this measure's denominator. **The other denominator criteria above still apply** - a matching code makes a case eligible for consideration, not automatically countable.

266 anesthesia CPT codes:

> 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620,

01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01937, 01938, 01939, 01940, 01941, 01942, 01951, 01952, 01958, 01960, 01961, 01962, 01963, 01965, 01966, 01967, 01991, 01992

Source: 2026 AQI NACOR QCDR Measure Book. CPT copyright American Medical Association.

ePreop 31: Intraoperative Hypotension (IOH) among Non-Emergent Noncardiac Surgical Cases****

Steward: Provation Anesthesia Quality Registry (AQR QCDR) / Cleveland Clinic | **First Performance Year:** 2020 **2026 Status:** Approved by CMS for the 2026 MIPS performance period. **Available in the Anesthesia MVP.**

MEASURE DESCRIPTION Percentage of general, neuraxial, or regional anesthesia care cases in which the mean arterial pressure (MAP) fell below 65 mmHg for a cumulative total of 15 minutes or more.

MEASURE TYPE: Intermediate Outcome **HIGH PRIORITY STATUS:** Yes | **HIGH PRIORITY TYPE:** Outcome **INVERSE MEASURE: Yes.** A lower score indicates better quality. Note that providers are not expected to receive a score of zero, because some patients will have a MAP below 65 for reasons outside a provider's control. **RISK ADJUSTED: Yes.** The 1st performance rate is risk-adjusted. **PROPORTIONAL MEASURE:** No. This is a **ratio measure** that scores greater than or equal to zero. **NUMBER OF PERFORMANCE RATES:** 1 **CARE SETTING:** Hospital, Ambulatory Surgical Center, Hospital Inpatient, Hospital Outpatient **TELEHEALTH:** No **DATA SOURCE:** Administrative claims data, claims, EHR (AIMS, patient record) **REPORTING OPTIONS:** MVP and Traditional MIPS **CBE NUMBER:** Not applicable | **eCQM:** Not applicable

2026 BENCHMARK

No historical benchmark. CMS may establish a performance-period benchmark using 2026 submissions. This is not a new measure, so new-measure floors do not apply; other CMS rules, including small-practice exceptions, may affect scoring.

Practical implication: ePreop 31 requires appropriate electronic data capture. Consider its clinical usefulness and reporting requirements without assuming that the missing historical benchmark determines the final score.

ELIGIBILITY CONSTRAINT, READ THIS FIRST Denominator-eligible cases **must be sent from an electronic reporting facility** to qualify. **Reporting clinicians who track information manually are not eligible to report this measure.** This is a hard gate. A group without an AIMS or equivalent electronic vitals capture cannot report ePreop 31.

INSTRUCTIONS This measure evaluates the proportion of cases in which the patient's MAP is below 65 mmHg for 15 minutes or more, cumulatively over the course of surgery. The numerator condition is met when MAP is below 65 mmHg for one continuous period lasting 15 minutes or more, **or** when the patient has several discrete periods below 65 mmHg that collectively sum to 15 minutes or more.

This measure is not intended to substitute for clinical judgment about managing intraoperative hypotension for any given patient. For some patients the clinician may manage blood pressure using a higher or lower target MAP, for example a higher target in patients with chronic hypertension.

Data capture rules: - MAP data may be transmitted directly from the monitor to the AIMS or entered manually into an AIMS or other electronic data capture system. If a record includes both monitor-pulled and manually recorded vitals with the same timestamp, **only the monitor values are used**. - The **first blood pressure reading** defines the measure start time (anesthesia start). The measure end time is anesthesia end time. - A given reading is attributed to the period running from the time it was recorded to the time of either the next reading or the measure end time. **If that period exceeds five minutes, the reading is only attributed for five minutes.** - If two MAPs are available at the same point in time from different monitoring methods, the **invasive** value is used. - The measure attributes the full case to **all** reporting clinicians who provide care during any portion of the case. - If MAP values are not available, the clinician may submit paired systolic and diastolic pressures. The registry calculates MAP as **MAP = 1/3 (SBP) + 2/3 (DBP)**.

Artifact rejection. Because longitudinal blood pressure data contains artifactual values (for example, an inaccurate reading caused by the surgeon leaning on the cuff), the measure drops readings meeting any of the following: - Documented as an artifact by the clinician - SBP greater than or equal to 300 mmHg, or less than or equal to 20 mmHg - DBP less than or equal to 5 mmHg, or greater than or equal to 225 mmHg - SBP and DBP within 5 mmHg of each other - MAP less than or equal to 30 mmHg, or greater than or equal to 250 mmHg

Non-emergency surgeries include both elective and urgent surgeries.

DENOMINATOR - *Unadjusted measure score:* All cases in which adults aged 18 and older undergoing noncardiac, non-emergency surgery require general, neuraxial, or regional anesthesia care. - *Risk adjusted measure score:* The expected number of cases in which patients have a MAP below 65 mmHg exceeding a cumulative 15 minutes, with noncardiac non-emergency surgery requiring general, neuraxial, or regional anesthesia care, based on the risk adjustment model.

Denominator Criteria (Eligible Cases): - Patient aged 18 years and older - **AND** Anesthesia Type: General, Neuraxial, or Regional - **AND** Patient encounter during the reporting period matching the measure's CPT list (224 codes; the full list appears at the end of this measure)

DENOMINATOR EXCLUSIONS - **99A16** Patients with a baseline MAP below 65 mmHg. Baseline MAP is the most recent reading from the preoperative holding area. If no such reading is available, the measure uses the most recent MAP taken in the operating room before induction. - **99A19** Patients where electronically recorded MAP or blood pressure readings are unavailable. - **CPT 99135** Surgeries where the add-on code for anesthesia complicated by utilization of controlled hypotension is listed separately in addition to the primary anesthesia procedure code. - ASA Physical Status Classification of **1, 5, or 6** - Emergency cases - Cardiac procedures - Obstetric non-operative procedures - Liver or lung transplant procedures - Cataract procedures

NUMERATOR Patients who have a MAP below 65 mmHg exceeding a cumulative length of 15 minutes.

Performance Met: **99A17** MAP below 65 mmHg exceeding a cumulative length of 15 minutes **OR** ***Performance Not Met:*** **99A18** MAP does not fall below 65 mmHg for a cumulative length of 15 minutes

Note on inverse scoring: as with AQI 18, "Performance Met" here records the undesirable outcome. A lower rate is better.

RATIONALE

MAP below 60 to 70 mmHg among adults having non-cardiac surgery is associated with increased risk of acute kidney injury, myocardial injury, and mortality, and the risk is a function of both hypotension severity and duration (Sessler et al. 2019). Noncardiac surgery patients are at increased risk from intraoperative hypotension, and the anesthesia care team is the party positioned to detect and correct it in real time.

RELEVANT FIELDS (Graphium capture) - Date of procedure, date of birth - ASA CPT code and add-on codes (99135) - ASA physical status - Emergency status - Anesthesia type (general, neuraxial, regional) - Preoperative holding area MAP (baseline) - All intraoperative MAP values with timestamps, or paired SBP/DBP with timestamps - Invasive vs. non-invasive monitoring source per reading - Artifact flags - Anesthesia start and end times - Procedure category exclusion flags (cardiac, obstetric non-operative, liver/lung transplant, cataract)

REPORTING CODES

Code	Definition
99A16	Patient has a baseline MAP below 65 mmHg (exclusion)

Code	Definition
99A19	Electronically recorded MAP or blood pressure readings unavailable (exclusion)
99135	Anesthesia complicated by utilization of controlled hypotension (CPT add-on, exclusion)
99A17	MAP below 65 mmHg exceeding a cumulative length of 15 minutes
99A18	MAP does not fall below 65 mmHg for a cumulative length of 15 minutes

DENOMINATOR CPT CODES

A case must carry one of the codes below to enter this measure's denominator. **The other denominator criteria above still apply** - a matching code makes a case eligible for consideration, not automatically countable.

224 anesthesia CPT codes:

> 00100, 00103, 00160, 00162, 00164, 00170, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00524, 00528, 00529, 00530, 00532, 00534, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00750, 00752, 00756, 00770, 00790, 00792, 00794, 00797, 00800, 00802, 00820, 00830, 00832, 00840, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01140, 01150, 01160, 01170, 01173, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01937, 01938, 01939, 01940, 01941, 01942, 01951, 01952, 01953

Excluded by CPT (1) - a case carrying one of these is taken back out of the denominator:

> 99135

Source: 2026 AQI NACOR QCDR Measure Book. CPT copyright American Medical Association.

QID 404: Anesthesiology Smoking Abstinence*

Steward: CMS | **Collection Type:** MIPS CQM **2026 Status:** Active. Included in the CMS-recommended Anesthesiology Measure Set. **Available in the Anesthesia MVP.**

MEASURE DESCRIPTION The percentage of current smokers who abstain from cigarettes prior to anesthesia on the day of elective surgery or procedure.

MEASURE TYPE: Intermediate Outcome **HIGH PRIORITY STATUS:** Yes **INVERSE MEASURE:** No | **RISK ADJUSTED:** No **NUMBER OF PERFORMANCE RATES:** 1 **REPORTING OPTIONS:** MVP and Traditional MIPS

2026 BENCHMARK

National average performance rate: **79.89%**. Historical benchmark. **Not topped out. Not capped.**

D1	D2	D3	D4	D5	D6	D7	D8	D9	D10
12.60 – 52.93	52.94 – 65.83	65.84 – 75.44	75.45 – 80.36	80.37 – 84.29	84.30 – 87.92	87.93 – 93.12	93.13 – 98.34	98.35 – 99.99	100.00

Reading this benchmark: **this is the widest and most useful benchmark available to anesthesia in 2026.** The scoring range spans 87 percentage points and every decile is meaningfully separated. It is the only anesthesia measure where genuine improvement translates reliably into more points, rather than needing near-perfection to move a decile. It is also an **outcome measure**, which satisfies the Traditional MIPS requirement for at least one outcome or high priority measure on its own. If your group can capture smoking status and abstinence reliably, QID 404 should be a core measure.

INSTRUCTIONS Submit each time an elective surgery, diagnostic, or pain procedure is performed under anesthesia during the performance period. There is no diagnosis associated with this measure.

DENOMINATOR All patients aged 18 years and older who are evaluated in preparation for an elective surgical, diagnostic, or pain procedure requiring anesthesia services, identified as a current smoker prior to the day of the surgery or procedure, with instruction from an anesthesiologist or proxy to abstain from smoking on the day of surgery or procedure.

DENOMINATOR NOTE: Preoperative smoking cessation instruction can be performed by an anesthesiologist or proxy, including but not limited to a surgeon, nursing staff, or other preoperative care team member, as part of the preoperative evaluation.

Denominator Criteria (Eligible Cases): - Patients aged 18 years or older on date of service - **AND** Patient procedure during the performance period matching the measure's CPT list (309 codes spanning the ASA anesthesia range plus pain management and injection codes; the full list appears at the end of this measure) - **AND** Current smoker, including cigarette, cigar, pipe, e-cigarette, or marijuana (**G9642**) - **AND** Elective surgery (**G9643**) - **AND** Received instruction from the anesthesiologist or proxy prior to the day of surgery to abstain from smoking on the day of surgery (**G9497**)

NUMERATOR Patients who abstained from smoking prior to anesthesia on the day of surgery or procedure.

Definition: **Abstinence** is defined by either patient self-report or an exhaled carbon monoxide level below 10 ppm.

Performance Met: **G9644** Patients who abstained from smoking prior to anesthesia on the day of surgery or procedure **OR** ***Performance Not Met:*** **G9645** Patients who did not abstain from smoking prior to anesthesia on the

day of surgery or procedure

RATIONALE

Each year, approximately 10 million cigarette smokers require surgery and anesthesia in the U.S. Smoking is a significant independent risk factor for perioperative heart, lung, and wound-related complications. There is good evidence that perioperative abstinence from smoking reduces the risk of those complications, and that the perioperative period represents a teachable moment for smoking cessation that improves long-term abstinence rates.

While a longer duration of abstinence is associated with greater benefit, even abstinence on the morning of surgery is associated with reduced nicotine and carbon monoxide levels and a reduced risk of myocardial ischemia and surgical site infection. Evidence shows that perioperative tobacco cessation interventions can increase abstinence rates in surgical patients who smoke and decrease the rate of perioperative complications. Recent reviews identified a range of effective interventions, from brief counseling to behavioral therapy and pharmacotherapy, that anesthesiologists and surgeons can incorporate into practice.

Unfortunately, evidence also suggests that few physicians take advantage of the opportunity to intervene, and that many surgical patients still smoke on the morning of surgery. If more surgical patients get help quitting around the time of surgery, this will reduce smoking-related perioperative complications such as wound infection and lead to long-term improvements in health, since the average smoker gains six to eight life years by quitting. This measure therefore not only directly affects acute surgical risk but also serves as a marker for the provision of effective preoperative tobacco use interventions.

RELEVANT FIELDS (Graphium capture) - Date of service, date of birth - ASA CPT code - Smoker status - Elective case flag - Cessation instruction given, and date given (must be prior to day of surgery) - Smoked on day of procedure

REPORTING CODES

Code	Definition
G9642	Current smoker (cigarette, cigar, pipe, e-cigarette, or marijuana)
G9643	Elective surgery
G9497	Received instruction from the anesthesiologist or proxy prior to the day of surgery to abstain from smoking on the day of surgery
G9644	Patients who abstained from smoking prior to anesthesia on the day of surgery or procedure
G9645	Patients who did not abstain from smoking prior to anesthesia on the day of surgery or procedure

DENOMINATOR CPT CODES

A case must carry one of the codes below to enter this measure's denominator. **The other denominator criteria above still apply** - a matching code makes a case eligible for consideration, not automatically countable.

The eligible CPT codes are grouped below for readability. A case needs **one code from either list**, not a code from both lists, to satisfy the CPT criterion. All other denominator criteria still apply.

Procedure codes (49):

> 27095, 27096, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 64400, 64405, 64408, 64415, 64416, 64417, 64418, 64420, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, 64450, 64455, 64461, 64463, 64466, 64467, 64468, 64469, 64473, 64474, 64479, 64483, 64486, 64487, 64488, 64489, 64490, 64493, 64505, 64510, 64517, 64520, 64530

Anesthesia codes (260):

> 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01937, 01938, 01939, 01940, 01941, 01942, 01951, 01952, 01958, 01960, 01961, 01966, 01991, 01992

Source: CMS 2026 MIPS measure specification. CPT copyright American Medical Association.

QID 430: Prevention of Post-Operative Nausea and Vomiting (PONV), Combination Therapy*

Steward: CMS | **Collection Type:** MIPS CQM **2026 Status:** Active. Included in the CMS-recommended Anesthesiology Measure Set. **Available in the Anesthesia MVP.**

MEASURE DESCRIPTION Percentage of patients aged 18 years and older who undergo a procedure under an inhalational general anesthetic AND who have three or more risk factors for post-operative nausea and vomiting, who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.

MEASURE TYPE: Process **HIGH PRIORITY STATUS:** Yes **INVERSE MEASURE:** No | **RISK ADJUSTED:** No **NUMBER OF PERFORMANCE RATES:** 1 **REPORTING OPTIONS:** MVP and Traditional MIPS

2026 BENCHMARK

National average performance rate: **99.34%**. Historical benchmark. **TOPPED OUT.** Not yet subject to the 7-point cap for 2026.

D1	D2	D3	D4	D5	D6	D7	D8	D9	D10
84.00 – 85.99	86.00 – 87.99	88.00 – 89.99	90.00 – 91.99	92.00 – 93.99	94.00 – 95.99	96.00 – 97.99	98.00 – 98.99	99.00 – 99.99	100.00

Reading this benchmark: the national average is 99.34%, which sits in Decile 9. Practically everyone performs at or near ceiling. Full 10 points requires a literal 100%. **Plan for the 7-point cap to arrive in a future performance year** and make sure your six-measure strategy does not depend on this measure carrying full weight indefinitely. ASA formally opposed CMS's removal of topped-out anesthesia measures in its CY 2026 comments, but the direction of travel is clear.

INSTRUCTIONS Submit each time any surgical, therapeutic, or diagnostic procedure under an inhalational general anesthetic is performed during the performance period. There is no diagnosis associated with this measure.

DENOMINATOR All patients aged 18 years and older who undergo any procedure including surgical, therapeutic, or diagnostic under an inhalational general anesthetic, AND who have three or more risk factors for PONV.

Definition, PONV Risk Factors: - Female gender - History of PONV - History of motion sickness - Non-smoker - Intended administration of opioids for post-operative analgesia. This includes opioids given intraoperatively whose effects extend into the PACU or postoperative period, opioids given in the PACU, or opioids given after PACU discharge.

Denominator Criteria (Eligible Cases): - Patients aged 18 years or older on date of service - **AND** Patient procedure during the performance period matching the measure's CPT list (255 codes; the full list appears at the end of this measure) - **AND** Patient received inhalational anesthetic agent (**4554F**) - **AND** Patient exhibits 3 or more risk factors for post-operative nausea and vomiting (**4556F**)

NUMERATOR Patients who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.

Definition, Anti-emetic Therapy: The recommended first- and second-line classes of pharmacologic anti-emetics for PONV prophylaxis in patients at moderate to severe risk include, but are not limited to: - NK-1 receptor antagonists -

5-hydroxytryptamine (5-HT3) receptor antagonists - Glucocorticoids - Phenothiazines - Phenylethylamines - Butyrophenones - Antihistamines - Anticholinergics

NOTE: This list is based on clinical guidelines and evidence, and may not be current. Refer to the FDA's Drug Safety Communications page for up-to-date recall and alert information when prescribing.

Performance Met: **G9775** Patient received at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively **OR** ***Denominator Exception:*** **G9776** Documentation of medical reason for not receiving at least 2 prophylactic pharmacologic anti-emetic agents of different classes (for example, intolerance or other medical reason) **OR** ***Performance Not Met:*** **G9777** Patient did not receive at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively

RATIONALE

Postoperative nausea and vomiting is an important patient-centered outcome of anesthesia care. PONV is highly dissatisfying to patients, though rarely life-threatening. A large body of scientific literature has defined risk factors for PONV, demonstrated effective prophylactic regimens based on those risk factors, and demonstrated high variability in this outcome across individual centers and providers. Several papers have shown that performance can be assessed at the level of individual providers, since the outcome is common enough that sufficient power exists to assess variability and improvement at that level.

RELEVANT FIELDS (Graphium capture) - Date of procedure, date of birth - ASA CPT code - Received inhalational agent - Each of the five PONV risk factors, individually - Count of PONV risk factors (3 or more) - Anti-emetic agents administered, with drug class - Documented medical reason for not administering

REPORTING CODES

Code	Definition
4554F	Patient received inhalational anesthetic agent
4556F	Patient exhibits 3 or more risk factors for post-operative nausea and vomiting
G9775	Patient received at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively
G9776	Documentation of medical reason for not receiving at least 2 prophylactic pharmacologic anti-emetic agents of different classes
G9777	Patient did not receive at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively

DENOMINATOR CPT CODES

A case must carry one of the codes below to enter this measure's denominator. **The other denominator criteria above still apply** - a matching code makes a case eligible for consideration, not automatically countable.

255 anesthesia CPT codes:

00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00566, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01937, 01938, 01939, 01940, 01941, 01942, 01951, 01952, 01961, 01962, 01963, 01965, 01966

Source: CMS 2026 MIPS measure specification. CPT copyright American Medical Association.

QID 463: Prevention of Post-Operative Vomiting (POV), Combination Therapy (Pediatrics)*

Steward: CMS | **Collection Type:** MIPS CQM **2026 Status:** Active. Included in the CMS-recommended Anesthesiology Measure Set. **Available in the Anesthesia MVP.**

MEASURE DESCRIPTION Percentage of patients aged 3 through 17 years who undergo a procedure under general anesthesia in which an inhalational anesthetic is used for maintenance AND who have two or more risk factors for post-operative vomiting, who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.

MEASURE TYPE: Process **HIGH PRIORITY STATUS:** Yes **INVERSE MEASURE:** No | **RISK ADJUSTED:** No **NUMBER OF PERFORMANCE RATES:** 1 **REPORTING OPTIONS:** MVP and Traditional MIPS

2026 BENCHMARK

National average performance rate: **98.99%**. Historical benchmark. **TOPPED OUT.** Not yet subject to the 7-point cap for 2026.

D1	D2	D3	D4	D5	D6	D7	D8	D9	D10
84.00 – 85.99	86.00 – 87.99	88.00 – 89.99	90.00 – 91.99	92.00 – 93.99	94.00 – 95.99	96.00 – 97.99	98.00 – 98.99	99.00 – 99.99	100.00

Reading this benchmark: identical decile structure to QID 430, and the same caution applies. This measure is also only usable by groups with pediatric volume, and a group with a small pediatric denominator can see wild swings in its rate from a handful of cases.

INSTRUCTIONS Submit each time any surgical, therapeutic, or diagnostic procedure under an inhalational general anesthetic is performed during the performance period. There is no diagnosis associated with this measure.

DENOMINATOR All patients aged 3 through 17 years who undergo a procedure under general anesthesia in which an inhalational anesthetic is used for maintenance AND who have two or more risk factors for POV.

Definition, POV Risk Factors: - Surgery 30 minutes or longer - Age 3 years or older - Strabismus surgery - History of POV, or PONV/motion sickness, in the patient - Family history of POV/PONV - Post-pubertal female - Adenotonsillectomy - Otoplasty - Anticholinesterases - Long-acting opioids

Denominator Criteria (Eligible Cases): - Patients aged 3 through 17 years on date of service - **AND** Patient procedure during the performance period matching the measure's CPT list (265 codes; the full list appears at the end of this measure) - **AND** Patient received inhalational anesthetic agent (**4554F**) - **AND** Patient exhibits 2 or more risk factors for post-operative vomiting (**G9954**)

DENOMINATOR EXCLUSION - Cases in which an inhalational anesthetic is used only for induction (**G9955**)

NUMERATOR Patients who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.

Definition, Anti-emetic Therapy: The recommended pharmacologic anti-emetics for POV prophylaxis in pediatric patients at risk include, but may not be limited to: - 5-hydroxytryptamine (5-HT3) receptor antagonists (recommended as first choice for POV prophylaxis in children) - Propofol for induction and maintenance of anesthesia - Dexamethasone - Antihistamines - Butyrophenones

NOTE: This list is based on clinical guidelines and evidence, and may not be current. Refer to the FDA's Drug Safety Communications page.

Numerator Instructions: Denominator exceptions should be determined or confirmed at the date of the denominator-eligible procedure.

Performance Met: **G9956** Patient received combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively **OR** ***Denominator Exception:*** **G9957** Documentation of medical reason for not receiving combination therapy (for example, intolerance or other medical reason) **OR** ***Performance Not Met:*** **G9958** Patient did not receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively

RATIONALE

Postoperative nausea and vomiting is an important patient-centered outcome of anesthesia care. A large body of scientific literature has defined risk factors for PONV, demonstrated effective prophylactic regimens based on those risk factors, and demonstrated high variability across centers and providers.

Between 62% and 73% of children experience POV when prophylactic anti-emetics are not administered. Beyond the discomfort of the condition, POV is a comorbidity that can cause significant postoperative complications including dehydration and postoperative bleeding. In several studies, the incidence of POV decreased significantly in children receiving combination therapy compared to control groups. A separate measure is needed for pediatric patients because the risk factors and recommended prophylaxis differ from adults.

RELEVANT FIELDS (Graphium capture) - Date of procedure, date of birth - ASA CPT code - Received maintenance inhalational agent (not induction only) - Each of the ten POV risk factors, individually - Count of POV risk factors (2 or more) - Anti-emetic agents administered, with drug class - Documented medical reason for not administering

REPORTING CODES

Code	Definition
4554F	Patient received inhalational anesthetic agent
G9954	Patient exhibits 2 or more risk factors for post-operative vomiting
G9955	Cases in which an inhalational anesthetic is used only for induction (denominator exclusion)
G9956	Patient received combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes
G9957	Documentation of medical reason for not receiving combination therapy
G9958	Patient did not receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes

DENOMINATOR CPT CODES

A case must carry one of the codes below to enter this measure's denominator. **The other denominator criteria above still apply** - a matching code makes a case eligible for consideration, not automatically countable.

265 anesthesia CPT codes:

> 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01937, 01938, 01939, 01940, 01941, 01942, 01951, 01952, 01958, 01960, 01961, 01962, 01963, 01965, 01966, 01991, 01992

Source: CMS 2026 MIPS measure specification. CPT copyright American Medical Association.

QID 477: Multimodal Pain Management*

Steward: CMS | **Collection Type:** MIPS CQM **2026 Status:** Active. Included in the CMS-recommended Anesthesiology Measure Set. **Available in the Anesthesia MVP.**

MEASURE DESCRIPTION Percentage of patients aged 18 years and older undergoing selected surgical procedures that were managed with multimodal pain management.

MEASURE TYPE: Process **HIGH PRIORITY STATUS:** Yes **INVERSE MEASURE:** No | **RISK ADJUSTED:** No **NUMBER OF PERFORMANCE RATES:** 1 **REPORTING OPTIONS:** MVP and Traditional MIPS

2026 BENCHMARK

National average performance rate: **97.47%**. Historical benchmark. **TOPPED OUT.** Not yet subject to the 7-point cap for 2026.

D1	D2	D3	D4	D5	D6	D7	D8	D9	D10
84.00 – 85.99	86.00 – 87.99	88.00 – 89.99	90.00 – 91.99	92.00 – 93.99	94.00 – 95.99	96.00 – 97.99	98.00 – 98.99	99.00 – 99.99	100.00

INSTRUCTIONS Report each time a patient undergoes a selected surgical procedure during the reporting period.

DENOMINATOR Patients aged 18 years and older who undergo selected surgical procedures.

DENOMINATOR NOTE: Selected surgical procedures include both elective and urgent open and laparoscopic intra-abdominal, spinal, pelvic, thoracic, breast, joint, head, neck, orthopedic, and fracture repair surgeries.

Denominator Criteria (Eligible Cases): - Patients aged 18 years and older on date of encounter - **AND** Patient procedure during the reporting period matching the measure's CPT list. **This is a much narrower list than the other CMS measures**: 98 codes selected for the procedure categories above. The full list appears at the end of this measure.

DENOMINATOR EXCLUSION - Emergent cases (**M1142**)

NUMERATOR Patients for whom multimodal pain management is administered in the perioperative period, from 6 hours prior to anesthesia start time until discharge from the post-anesthesia care unit.

Definition: **Multimodal pain management** is the use of two or more drugs and/or interventions, **NOT including systemic opioids**, that act by different mechanisms to provide analgesia. These drugs and interventions can be administered via the same route or by different routes. Opioids may be administered for pain relief when indicated but do not count toward this measure.

NUMERATOR NOTE: Documentation of qualifying medications or interventions provided from six hours prior to anesthesia start time through PACU discharge counts toward the numerator.

Performance Met: **G2148** Multimodal pain management was used **OR** ***Denominator Exception:*** **G2149** Documentation of medical reason(s) for not using multimodal pain management (for example, allergy to multiple classes of analgesics, intubated patient, hepatic failure, patient reports no pain during PACU stay, other medical reasons) **OR** ***Performance Not Met:*** **G2150** Multimodal pain management was not used

RATIONALE

Besides providing anesthesia care in the operating room, anesthesiologists are dedicated to providing the best perioperative pain management in order to improve patients' function and facilitate rehabilitation after surgery. In

the past, pain management was limited to opioids. Opioids provide analgesia primarily through a unitary mechanism, and simply adding more opioids does not usually lead to better pain control or improved outcomes. Opioids are responsible for a host of side effects that can be life-threatening, and increasing rates of postoperative complications can be attributed to opioid overuse and abuse.

In 2012 the ASA published guidelines for acute pain management in the perioperative setting, and in 2016 ASA, ASRA, and the American Pain Society collaborated on clinical practice guidelines for the management of postoperative pain. These documents endorse the routine use of multimodal analgesia, employing multiple classes of pain medications or therapies working through different mechanisms of action, rather than relying on opioids alone.

Qualifying classes include, but are not limited to:

- **Non-steroidal anti-inflammatory drugs (NSAIDs):** ibuprofen, diclofenac, ketorolac, celecoxib, nabumetone. NSAIDs act on the prostaglandin system peripherally and decrease inflammation.
- **NMDA antagonists:** in low dose, ketamine, magnesium, and other NMDA antagonists act on N-methyl-D-aspartate receptors in the central nervous system to decrease acute pain and hyperalgesia.
- **Acetaminophen:** acts on central prostaglandin synthesis and provides pain relief through multiple mechanisms.
- **Gabapentinoids:** gabapentin and pregabalin are membrane stabilizers that decrease nerve firing.
- **Regional block:** ASA and ASRA strongly recommend target-specific local anesthetic application in the form of regional analgesic techniques as part of a multimodal protocol whenever indicated.
- **Steroids:** dexamethasone during surgery has been shown to decrease pain and opioid requirements.
- **Local anesthetics:** injection of local anesthetic in or around the surgical site by the surgeon. Systemic lidocaine administered intravenously is an alternative to regional analgesic techniques.

RELEVANT FIELDS (Graphium capture) - Date of procedure, date of birth - ASA CPT code and surgical CPT code - Emergency status - All analgesic medications administered from 6 hours pre-anesthesia through PACU discharge, with drug class - Regional blocks performed - Local anesthetic infiltration - Documented medical reason for not using multimodal management

REPORTING CODES

Code	Definition
M1142	Emergent case (denominator exclusion)
G2148	Multimodal pain management was used
G2149	Documentation of medical reason(s) for not using multimodal pain management
G2150	Multimodal pain management was not used

DENOMINATOR CPT CODES

A case must carry one of the codes below to enter this measure's denominator. **The other denominator criteria above still apply** - a matching code makes a case eligible for consideration, not automatically countable.

98 anesthesia CPT codes:

00102, 00120, 00160, 00162, 00172, 00174, 00190, 00222, 00300, 00320, 00402, 00404, 00406, 00450, 00470, 00472, 00500, 00528, 00529, 00539, 00540, 00541, 00542, 00546, 00548, 00600, 00620, 00625, 00626, 00630, 00670, 00700, 00730, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00797, 00800, 00820, 00830, 00832, 00840, 00844, 00846, 00848, 00860, 00862, 00864, 00865, 00866, 00870, 00872, 00873, 00880, 00902, 00906, 00910, 00912, 00914, 00916, 00918, 00920, 00940, 00942, 00948, 01120, 01160, 01170, 01173, 01210, 01214, 01215, 01220, 01230, 01360, 01392, 01400, 01402, 01480, 01482, 01484, 01486, 01630, 01634, 01636, 01638, 01740, 01742, 01744, 01760, 01830, 01832, 01961

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