

# 2013 EHR Measure Specifications

The specifications listed in this document have been updated to reflect clinical practice guidelines and applicable code sets as of January, 2012. These updates have also been carried over to the 2013 Electronic Health Record (EHR) Downloadable Resource table.

These specifications may be available for potential use in physician quality initiatives, including but not limited to the EHR submission under the 2013 Physician Quality Reporting System (Physician Quality Reporting). A measure's inclusion in this document does not guarantee that measure will be used in any specific Centers for Medicare & Medicaid Services (CMS) program in 2013 or any subsequent year. If a measure is included in the 2013 Physician Quality Reporting System, all measure-related EHR coding/data should be submitted to the EHR Warehouse to ensure the accurate calculation of performance rates. The EHR Warehouse will calculate the rates based on the data that is submitted in the specified format for the program.

In the case of measures that have been used in the 2012 and 2011 PQRS EHR programs, the 2010 PQRI EHR program, and the 2009 and 2008 PQRI EHR testing projects – the specifications detailed in this document supersede any specifications which may have been used in those prior activities.

*Please note that a subset of the 2013 EHR Measure Specifications are available for use in the Physician Quality Reporting System-Medicare Electronic Health Record (EHR) Incentive Pilot. These 44 measures are identified in the table of contents as HITECH Core Clinical Quality Measures (HITECH CORE), HITECH Alternate Core Clinical Quality Measures (HITECH ALT CORE), and HITECH Additional Clinical Quality Measures (HITECH). Please refer to related documents regarding participation in the Physician Quality Reporting System-Medicare Electronic Health Record (EHR) Incentive Pilot posted on the CMS website.*

*To determine which measures are included in any specific CMS program or demonstration, interested parties should refer to the official documentation for that program or demonstration. Please refer to the Medicare Physician Fee Schedule (PFS) 2013 Proposed Rule (to be published in the Federal Register in July, 2012) to identify the measures that may be available for data submission through EHRs under the 2013 Physician Quality Reporting System.*

Measure Owner Designation	
	AMA-PCPI/NCQA (contract) is the measure owner
	AMA-PCPI is the measure owner
	AMA-PCPI/ASCO/NCCN is the measure owner
	NCQA is the measure owner
	CMS/QIP is the measure owner
	AMA-PCPI/ACCF/AHA is the measure owner
	AMA-PCPI/NCQA is the measure owner

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# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #1 (NQF 0059) HITECH: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus

**Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%

**Denominator:** Patients aged 18 through 75 years with a diagnosis of diabetes

#### Denominator Inclusions:

All patients with an active diagnosis of diabetes during the measurement period and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER ED  
OR  
ENCOUNTER NON-ACUTE INPATIENT  
OR  
ENCOUNTER OUTPATIENT

AND

DIABETES

OR

All patients between 18 and 75 years of age at the beginning of the measurement period who were prescribed or are currently taking a medication indicative of diabetes during the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER ED  
OR  
ENCOUNTER NON-ACUTE INPATIENT  
OR  
ENCOUNTER OUTPATIENT

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking medications indicative of diabetes during the measurement period and DRUG\_EXCLUSION = N.

## Numerator: Patients with most recent hemoglobin A1c level > 9.0%

### Numerator Inclusions:

Patients with most recent hemoglobin A1c greater than 9.0% during the measurement period or no test was submitted during the measurement period.

**NOTE:** *For performance, a lower rate indicates better performance/control.*

RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HbA1c TEST  
WITH  
Documentation of HbA1c > 9%

### Denominator Exclusions: (*Exclusions only applied if most recent A1c test value not recorded OR most recent A1c value was less than or equal to 9.0%*)

Patients with an active diagnosis of polycystic ovaries at any time during the patient's history who were prescribed or are currently taking medications indicative of diabetes and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

### AND NOT

Diabetic patients who had a face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

OR

Patients with an active diagnosis of gestational diabetes or steroid induced diabetes during the measurement period who were prescribed or are currently taking medications indicative of diabetes and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

GESTATIONAL DIABETES

OR

STERIOD INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for medications indicative of diabetes.

### AND NOT

Diabetic patients who had a face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

**Rationale:**

Intensive therapy of glycosylated hemoglobin (A1c) reduces the risk of microvascular complications.

**Clinical Recommendation Statements:**

A glycosylated hemoglobin should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals. (AACE/ACE)

The A1c should be universally adopted as the primary method of assessment of glycemic control. On the basis of data from multiple interventional trials, the target for attainment of glycemic control should be A1c values  $\leq 6.5\%$ . (AACE/ACE)

Obtain a glycosylated hemoglobin during an initial assessment and then routinely as part of continuing care. In the absence of well-controlled studies that suggest a definite testing protocol, expert opinion recommends glycosylated hemoglobin be obtained at least twice a year in patients who are meeting treatment goals and who have stable glycemic control and more frequently (quarterly assessment) in patients whose therapy was changed or who are not meeting glycemic goals. (Level of Evidence: E) (ADA)

Because different assays can give varying glycated hemoglobin values, the ADA recommends that laboratories only use assay methods that are certified as traceable to the Diabetes Control and Complications Trial A1c reference method. The ADA's goal for glycemic control is A1c  $< 7\%$ . (Level of Evidence: B) (ADA)

Monitor and treat hyperglycemia, with a target A1c of 7%, but less stringent goals for therapy may be appropriate once patient preferences, diabetes severity, life expectancy and functional status have been considered. (AGS)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #2 (NQF 0064) HITECH: Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus

**Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL)

**Denominator:** Patients aged 18 through 75 years with a diagnosis of diabetes

#### Denominator Inclusions:

All patients with an active diagnosis of diabetes during the measurement period and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER ED  
OR  
ENCOUNTER NON-ACUTE INPATIENT  
OR  
ENCOUNTER OUTPATIENT

AND

DIABETES

OR

All patients between 18 and 75 years of age at the beginning of the measurement period who were prescribed or are currently taking a medication indicative of diabetes during the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER ED  
OR  
ENCOUNTER NON-ACUTE INPATIENT  
OR  
ENCOUNTER OUTPATIENT

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking medications indicative of diabetes during the measurement period and DRUG\_EXCLUSION = N.

## Numerator 1: Patients with LDL-C test result during the measurement period

### Numerator Inclusions:

Patients with most recent LDL test the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

LDL TEST

AND

## Numerator 2: Patients with most recent LDL-C < 100 mg/dL

### Numerator Inclusions:

Patients with most recent LDL-C less than 100 mg/dL during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

LDL TEST

WITH

Documentation of LDL Test < 100 mg/dL

**Denominator Exclusions:** (*Exclusions only applied if most recent LDL cholesterol test value not recorded OR most recent LDL value was greater than or equal to 100 mg/dL*)

Patients with an active diagnosis of polycystic ovaries at any time during the patient's history who were prescribed or are currently taking medications indicative of diabetes and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

AND NOT

Diabetic patients who had a face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

OR

Patients with an active diagnosis of gestational diabetes or steroid induced diabetes during the measurement period who were prescribed or are currently taking medications indicative of diabetes and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

GESTATIONAL DIABETES

OR

STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for medications indicative of diabetes.

AND NOT

Diabetic patients who have a face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

**Rationale:**

Persons with diabetes are at increased risk for coronary heart disease (CHD). Lowering serum cholesterol levels can reduce the risk for CHD events.

**Clinical Recommendation Statements:**

A fasting lipid profile should be obtained during an initial assessment, each follow-up assessment, and annually as part of the cardiac-cerebrovascular-peripheral vascular module. (AAACE/ACE)

A fasting lipid profile should be obtained as part of an initial assessment. Adult patients with diabetes should be tested annually for lipid disorders with fasting serum cholesterol, triglycerides, HDL cholesterol, and calculated LDL cholesterol measurements. If values fall in lower-risk levels, assessments may be repeated every two years. (Level of Evidence: E) (ADA)

Patients who do not achieve lipid goals with lifestyle modifications require pharmacological therapy. Lowering LDL cholesterol with a statin is associated with a reduction in cardiovascular events. (Level of Evidence: A)

Lipid-lowering therapy should be used for secondary prevention of cardiovascular mortality and morbidity for all patients with known coronary artery disease and type 2 diabetes. (ACP)

Statins should be used for primary prevention against macrovascular complications in patients with type 2 diabetes and other cardiovascular risk factors.

Once lipid-lowering therapy is initiated, patients with type 2 diabetes mellitus should be taking at least moderate doses of a statin.

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction, therefore monitor and treat hypertension and dyslipidemias. (AGS)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #3 (NQF 0061) HITECH: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus

**Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg)

**Denominator:** Patients aged 18 through 75 years with a diagnosis of diabetes

#### Denominator Inclusions:

All patients with an active diagnosis of diabetes during the measurement period and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

AND

DIABETES

OR

All patients between 18 and 75 years of age at the beginning of the measurement period who were prescribed or are currently taking a medication indicative of diabetes during the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking medications indicative of diabetes during the measurement period and DRUG\_EXCLUSION = N.

## Numerator: Patients whose most recent blood pressure < 140/90 mmHg

### Numerator Inclusions:

Patients with most recent blood pressure measurement less than 140/90 mmHg during the most recent qualifying visit during the measurement period.

**NOTE:** *Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.*

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**SYSTOLIC BLOOD PRESSURE**

WITH

*Documentation of Systolic Blood Pressure < 140 mm[Hg]*

AND

**DIASTOLIC BLOOD PRESSURE**

WITH

*Documentation of Diastolic Blood Pressure < 90 mm[Hg]*

**Denominator Exclusions:** *(Exclusions only applied if most recent BP value not recorded OR most recent systolic value was greater than or equal to 140 mmHg OR most recent diastolic value was greater than or equal to 90 mmHg)*

Patients with an active diagnosis of polycystic ovaries at any time during the patient's history who were prescribed or are currently taking medications indicative of diabetes and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**POLYCYSTIC OVARIES**

### AND NOT

Diabetic patients who had a face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**DIABETES**

AND

**ENCOUNTER ACUTE INPT**

OR

**ENCOUNTER ED**

OR

**ENCOUNTER NON-ACUTE INPATIENT**

OR

**ENCOUNTER OUTPATIENT**

OR

Patients with an active diagnosis of gestational diabetes or steroid induced diabetes during the measurement period who were prescribed or are currently taking medications indicative of diabetes and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

GESTATIONAL DIABETES

OR

STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for medications indicative of diabetes.

### AND NOT

Diabetic patients who had a face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

**Rationale:**

Intensive control of blood pressure in patients with diabetes reduces diabetes complications, diabetes-related deaths, strokes, heart failure, and microvascular complications.

**Clinical Recommendation Statements:**

Recommends that a blood pressure determination during the initial evaluation, including orthostatic evaluation, be included in the initial and every interim physical examination. (AAACE/ACE)

Blood pressure control must be a priority in the management of persons with hypertension and type 2 diabetes. (ACP)

Blood pressure should be measured at every routine diabetes visit. Patients found to have systolic blood pressure >130 mmHg or diastolic >80 mmHg should have blood pressure confirmed on a separate day. Orthostatic measurement of blood pressure should be performed to assess for the presence of autonomic neuropathy. (Level of Evidence: E) (ADA)

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction; therefore, monitor and treat hypertension and dyslipidemias. (AGS)

Measurement of blood pressure in the standing position is indicated periodically, especially in those at risk for postural hypotension. At least two measurements should be made and the average recorded. After BP is at goal and stable, follow-up visits can usually be at 3- to 6-month intervals. Comorbidities such as heart failure, associated diseases such as diabetes, and the need for laboratory tests influence the frequency of visits. (JNC)

All individuals should be evaluated during health encounters to determine whether they are at increased risk of having or of developing chronic kidney disease. This evaluation of risk factors should include blood pressure measurement. (NKF)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ► Measure #5 (NQF 0081) HITECH: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

**Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy

**Denominator:** Heart failure patients aged 18 years and older with LVEF < 40% or with moderately or severely depressed left ventricular systolic function

#### Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with an active diagnosis of heart failure during the measurement period, and who also have LVSD (defined as ejection fraction less than 40%) or a diagnosis of moderately or severely depressed left ventricular systolic function before their last qualifying visit. A prior ejection fraction study documenting LVSD can be used to identify patients. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional (ENCOUNTER NURSING FACILITY or ENCOUNTER OUTPATIENT) or at least one face-to-face visit (ENCOUNTER INPATIENT DISCHARGE) with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY  
OR  
ENCOUNTER OUTPATIENT  
OR  
ENCOUNTER INPATIENT DISCHARGE

AND

HEART FAILURE

AND

RESULTS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EJECTION FRACTION  
WITH  
*Documentation of Ejection Fraction < 40%*

OR

LVEF ASSMT  
WITH  
*Documentation of LVEF ASSMT < 40%*

OR

LEFT VENTRICULAR SYSTOLIC DYSFUNCTION  
AND  
*Severity: 'Moderate or Severe' Qualifier*

## Numerator: Patients who were prescribed ACE inhibitor or ARB therapy

### Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking ACE inhibitor or ARB during the measurement period and DRUG\_EXCLUSION = N.

### Denominator Exclusions: (*Exclusions only applied if the patient did not receive ACE inhibitor or ARB therapy*)

When drug therapy is not prescribed during the measurement period for a valid medical, patient or system reason the appropriate medication that would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for ACE inhibitor or ARB.

AND

MEDICAL REASON

OR

PATIENT REASON

OR

SYSTEM REASON

OR

PATIENT REASON FOR ACE INHIBITOR OR ARB DECLINE

OR

Patients who had one of the following conditions diagnosed before or during their last qualifying visit during the measurement period and the condition is active during their last qualifying visit.

PROBLEMS and ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY

OR

DEFICIENCIES OF CIRCULATING ENZYMES

OR

DISEASE OF AORTIC AND MITRAL VALVES

OR

NONRHEUMATIC MITRAL (VALVE) DISEASE

OR

CHRONIC KIDNEY DISEASE WITH AND WITHOUT HYPERTENSION

OR

HYPERTENSIVE RENAL DISEASE WITH RENAL FAILURE

OR

ARTHEROSCLEROSIS OF RENAL ARTERY

OR

RENAL FAILURE AND ESRD

OR

ACUTE RENAL FAILURE

OR

ATRESIA AND STENOSIS OF AORTA

OR

PATIENT REASON FOR ACE INHIBITOR OR ARB DECLINE

OR

Patients who had one of the following conditions at any time before or during their last qualifying visit during the measurement period.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ACE ALLERGY CODE

OR

ARB ALLERGY CODE

**OR**

When drug therapy was not prescribed during the measurement period due to patient allergy, adverse effects or intolerance identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received during the measurement period.

*NOTE: When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for ACE inhibitor or ARB.

**AND**

MEDICATION ALLERGY

OR

MEDICATION ADVERSE EFFECTS

OR

MEDICATION INTOLERANCE

**Rationale:**

In the absence of contraindications, ACE Inhibitors or ARBs are recommended for all patients with symptoms of heart failure and reduced left ventricular systolic function, as measured by left ventricular ejection fraction (LVEF). Both drugs have been shown to decrease mortality and hospitalizations.

**Clinical Recommendation Statements:**

Angiotensin converting enzyme inhibitors are recommended for all patients with current or prior symptoms of HF and reduced LVEF, unless contraindicated. (Class I Recommendation, Level of Evidence: A)(ACC/AHA)

Angiotensin II receptor blockers approved for the treatment of HF are recommended in patients with current or prior symptoms of HF and reduced LVEF who are ACEI-intolerant. (Class I Recommendation, Level of Evidence: A) (ACC/AHA)

Angiotensin II receptor blockers are reasonable to use as alternatives to ACEIs as first-line therapy for patients with mild to moderate HF and reduced LVEF, especially for patients already taking ARBs for other indications. (Class IIa Recommendation, Level of Evidence: A) (ACC/AHA)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ► Measure #6 (NQF 0067) HITECH: Coronary Artery Disease (CAD): Antiplatelet Therapy

**Description:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who were prescribed aspirin or clopidogrel

**Denominator:** All patients aged 18 years and older with a diagnosis of coronary artery disease

#### Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with an active diagnosis of CAD during the measurement period or had a cardiac surgery at any time before or during their last qualifying visit. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional (ENCOUNTER NURSING FACILITY or ENCOUNTER OUTPATIENT) or at least one face-to-face visit (ENCOUNTER INPATIENT DISCHARGE) with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for inclusion in this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY

OR

ENCOUNTER OUTPATIENT

OR

ENCOUNTER INPATIENT DISCHARGE

AND

CORONARY ARTERY DISEASE INCLUDES MI

OR

CARDIAC SURGERY

## Numerator: Patients who were prescribed aspirin or clopidogrel

### Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking antiplatelet therapy during the measurement period and DRUG\_EXCLUSION = N.

### Denominator Exclusions: (*Exclusions only applied if the patient did not receive antiplatelet therapy*)

When drug therapy is not prescribed during the measurement period for a valid medical, patient or system reason, the appropriate medication that would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for antiplatelet therapy.

AND

MEDICAL REASON

OR

PATIENT REASON

OR

SYSTEM REASON

OR

When drug therapy was not prescribed during the measurement period due to patient allergy, adverse effects or intolerance identified at any time before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for antiplatelet therapy.

AND

MEDICATION ALLERGY

OR

MEDICATION ADVERSE EFFECTS

OR

MEDICATION INTOLERANCE

OR

Patients who had one of the following conditions diagnosed before or during their last qualifying visit during the measurement period and the condition is active during their last qualifying visit.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

BLEEDING COAGULATION DISORDERS

**Rationale:**

Oral antiplatelet therapy, preferably aspirin unless contraindicated, is recommended for all patients with coronary artery disease. By limiting the ability of clots to form in the arteries, antiplatelet agents have proven benefits in reducing the risk of non-fatal myocardial infarction, non-fatal stroke and death.

**Clinical Recommendation Statements:**

Chronic Stable Angina: Class I – Aspirin 75-325 mg daily should be used routinely in all patients with acute and chronic ischemic heart disease with or without manifest symptoms in the absence of contraindications. Class IIa – Clopidogrel is recommended when aspirin is absolutely contraindicated. Class III – Dipyridamole. Because even the usual oral doses of dipyridamole can enhance exercise-induced myocardial ischemia in patients with stable angina, it should not be used as an antiplatelet agent. (ACC/AHA/ACP-ASIM)

Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Class I – Aspirin 75 to 325 mg/dl in the absence of contraindications. Class I – Clopidogrel 75 qd for patients with a contraindication to ASA. (ACC/AHA)

Acute Myocardial Infarction (AMI): Class I – A dose of aspirin, 160 to 325 mg, should be given on day one of AMI and continued indefinitely on a daily basis thereafter. Trials suggest long-term use of aspirin in the post infarction patient in a dose as low as 75 mg per day can be effective, with the likelihood that side effects can be reduced. Class IIb – Other antiplatelet agents such as dipyridamole, ticlopidine or clopidogrel may be substituted if true aspirin allergy is present or if the patient is unresponsive to aspirin. (ACC/AHA)

Coronary Artery Bypass Graft Surgery: Aspirin is the drug of choice for prophylaxis against early saphenous graft thrombotic closure and should be considered a standard of care for the first postoperative year. In general, patients are continued on aspirin indefinitely, given its benefit in the secondary prevention of AMI. Ticlopidine is efficacious but offers no advantage over aspirin except as an alternative in the truly aspirin-allergic patient. Clopidogrel offers the potential of fewer side effects compared with ticlopidine as an alternative to aspirin for platelet inhibition. Indobufen appears to be as effective as aspirin for saphenous graft patency over the first postoperative year but with fewer gastrointestinal side effects. Current evidence suggests that dipyridamole adds nothing to the aspirin effect for saphenous graft patency. (ACC/AHA)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ► Measure #7 (NQF 0070) HITECH: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)

**Description:** Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy

**Denominator:** All patients aged 18 years and older with a diagnosis of coronary artery disease who also have prior myocardial infarction (MI) at any time

#### Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with an active diagnosis of CAD during the measurement period or had a cardiac surgery at any time before or during their last qualifying visit who also had prior MI at any time before or during their last qualifying visit. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional (ENCOUNTER NURSING FACILITY or ENCOUNTER OUTPATIENT) or at least one face-to-face visit (ENCOUNTER INPATIENT DISCHARGE) with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY

OR

ENCOUNTER OUTPATIENT

OR

ENCOUNTER INPATIENT DISCHARGE

AND

CORONARY ARTERY DISEASE NO MI

OR

CARDIAC SURGERY

AND

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data elements:

MYOCARDIAL INFARCTION

**Numerator:** Patients who were prescribed beta-blocker therapy

#### Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking beta-blocker therapy during the measurement period and DRUG\_EXCLUSION = N.

**Denominator Exclusions:** (*Exclusions only applied if the patient did not receive beta-blocker therapy*)

When drug therapy is not prescribed during the measurement period for a valid medical, patient or system reason, the appropriate medication that would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for beta-blocker therapy.

AND

MEDICAL REASON

OR

PATIENT REASON

OR

SYSTEM REASON

OR

Patients who had one of the following conditions diagnosed before or during their last qualifying visit during the measurement period and the condition is active during their last qualifying visit.

PROBLEMS, PROCEDURES, RESULTS, VITAL SIGNS, ALERTS and MEDICAL EQUIPMENT tab(s) list applicable codes for this measure and are associated with the following data element(s):

ATRIOVENTRICULAR BLOCK

WITHOUT

CARDIAC PACER IN SITU

OR

CARDIAC PACER

OR

ARRHYTHMIA

OR

HYPOTENSION

OR

ASTHMA

OR

BRADYCARDIA

OR

ATRESIA AND STENOSIS OF AORTA

OR

CARDIAC MONITORING

OR

ALLERGY CODE

OR

When drug therapy was not prescribed during the measurement period due to patient allergy, adverse effects or intolerance identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for beta-blocker therapy.

AND

MEDICATION ALLERGY

OR

MEDICATION ADVERSE EFFECTS

OR

MEDICATION INTOLERANCE

OR

Patients who had two consecutive heart rate readings less than 50 beats per minute at any time before or during their last qualifying visit during the measurement period.

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HEART RATE

WITH

Documentation of Heart Rate < 50 /min

**Rationale:**

In the absence of contraindications, beta-blocker therapy has been shown to reduce the risk of a recurrent MI and decrease mortality for those patients with a prior MI.

**Clinical Recommendation Statements:**

Chronic Stable Angina: Class I – Beta-blockers as initial therapy in the absence of contraindications in patients with prior MI. Class I – Beta-blockers as initial therapy in the absence of contraindications in patients without prior MI. (ACC/AHA/ACP-ASIM)

Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Class I – Drugs required in the hospital to control ischemia should be continued after hospital discharge in patients who do not undergo coronary revascularization, patients with unsuccessful revascularization, or patients with recurrent symptoms after revascularization. Upward or downward titration of the doses may be required. Class I – Beta-blockers in the absence of contraindications. (ACC/AHA)

Acute Myocardial Infarction: Class I – All but low-risk patients without a clear contraindication to  $\beta$ -adrenoceptor blocker therapy. Treatment should begin within a few days of the event (if not initiated acutely) and continue indefinitely. Class IIa – Low-risk patients without a clear contraindication to  $\beta$ -adrenoceptor blocker therapy. Survivors of non-ST-elevation MI. Class IIb – Patients with moderate or severe LV failure or other relative contraindications to  $\beta$ -adrenoceptor blocker therapy, provided they can be monitored closely. (ACC/AHA)

Although no study has determined if long-term  $\beta$ -adrenoceptor blocker therapy should be administered to survivors of MI who subsequently have successfully undergone revascularization, there is no reason to believe that these agents act differently in coronary patients who have undergone revascularization. (ACC/AHA)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ► Measure #8 (NQF 0083) HITECH: Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

**Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy

**Denominator:** Patients aged 18 years and older with a diagnosis of heart failure with left ventricular ejection fraction (LVEF) < 40% or with moderately or severely depressed left ventricular systolic function

#### Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with an active diagnosis of heart failure during the measurement period, and who also have LVSD (defined as ejection fraction less than 40%) or a diagnosis of moderately or severely depressed left ventricular systolic function before their last qualifying visit. Any prior ejection fraction study documenting LVSD can be used to identify patients. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY

OR

ENCOUNTER OUTPATIENT

AND

HEART FAILURE

AND

RESULTS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EJECTION FRACTION

WITH

*Documentation of Ejection Fraction < 40%*

OR

LVE ASSMT

WITH

*Documentation of LVE ASSMT < 40%*

OR

LEFT VENTRICULAR SYSTOLIC DYSFUNCTION

AND

*Severity: 'Moderate or Severe' Qualifier*

*Severity: 'Moderate or Severe' Qualifier*

## Numerator: Patients who were prescribed beta-blocker therapy

### Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking beta-blocker therapy during the measurement period and DRUG\_EXCLUSION = N.

### Denominator Exclusions: (*Exclusions only applied if the patient did not receive beta-blocker therapy*)

When drug therapy is not prescribed during the measurement period for a valid medical, patient or system reason, the appropriate medication that would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table lists applicable codes for beta-blocker therapy.

AND

MEDICAL REASON

OR

PATIENT REASON

OR

SYSTEM REASON

OR

Patients who had one of the following conditions diagnosed before or during their last qualifying visit during the measurement period and the condition is active during their last qualifying visit.

PROCEDURES, PROBLEMS, RESULTS, VITAL SIGNS, and MEDICAL EQUIPMENT tab(s) list applicable codes for this measure and are associated with the following data element(s):

ATRIOVENTRICULAR BLOCK

WITHOUT

CARDIAC PACER IN SITU

OR

CARDIAC PACER

OR

ARRHYTHMIA

OR

HYPOTENSION

OR

ASTHMA

OR

BRADYCARDIA

OR

ATRESIA AND STENOSIS OF AORTA

OR

CARDIAC MONITORING

OR

When drug therapy was not prescribed during the measurement period due to patient allergy, adverse effects or intolerance identified before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table lists applicable codes for beta-blocker therapy.

AND

MEDICATION ALLERGY

OR

MEDICATION ADVERSE EFFECTS

OR

MEDICATION INTOLERANCE

OR

Patients who had two consecutive heart rate readings less than 50 beats per minute at any time before or during their last qualifying visit during the measurement period.

VITAL SIGNS tab(s) in the Downloadable Resource table lists applicable codes for this measure and are associated with the following data element(s):

HEART RATE

WITH

*Documentation of Heart Rate < 50 /min*

**Rationale:**

Beta-blockers are recommended for all patients with symptoms of heart failure and left ventricular systolic dysfunction, unless contraindicated. Treatment with beta-blockers has been shown to provide multiple benefits to the patient, including reducing the symptoms of heart failure, improving the clinical status of patients, and decreasing the risk of mortality and hospitalizations.

**Clinical Recommendation Statements:**

Beta-blockers (using 1 of the 3 proven to reduce mortality, i.e., bisoprolol, carvedilol, and sustained release metoprolol succinate) are recommended for all stable patients with current or prior symptoms of HF and reduced LVEF, unless contraindicated. (Class I Recommendation, Level of Evidence: A) (ACC/AHA)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

◆ **Measure #9 (NQF 0105) HITECH: Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment**

**Description:** The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment

**Denominator:** Patients 18 years and older diagnosed with a new episode of major depression and treated with antidepressant medication

### Denominator Inclusions:

All patients greater than or equal to 18 years of age as of May 1<sup>st</sup> of the year prior to the measurement period with a documented diagnosis of a new episode of major depression between May 1<sup>st</sup> of the previous year and April 30<sup>th</sup> of the measurement period during a face-to-face visit (ENCOUNTER ED or ENCOUNTER OUTPATIENT BH) or (ENCOUNTER POINT OF SERVICE MODIFIER with ENCOUNTER OUTPT BH REQ POS) with the eligible professional AND who had an antidepressant prescribed within the thirty days prior and fourteen days after the new episode of major depression. To be eligible for performance calculations, patients must have at least two face-to-face visits (ENCOUNTER ED or ENCOUNTER OUTPATIENT BH) or (ENCOUNTER POINT OF SERVICE MODIFIER with ENCOUNTER OUTPT BH REQ POS) with the same eligible professional between May 1<sup>st</sup> of the previous year and April 30<sup>th</sup> of the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MAJOR DEPRESSION

AND

ENCOUNTER ED

OR

ENCOUNTER OUTPATIENT BH

OR

ENCOUNTER OUTPT BH REQ POS

WITH

*Encounter Point of Service Modifier*

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antidepressant medications within the thirty days prior and fourteen days after the new episode of major depression and DRUG\_EXCLUSION = N.

OR

All patients greater than or equal to 18 years of age as of May 1<sup>st</sup> of the year prior to the measurement period with a documented diagnosis of a new episode of major depression between May 1<sup>st</sup> of the previous year and April 30<sup>th</sup> of the measurement period during a face-to-face visit (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER ACUTE INPT) with the eligible professional AND who had an antidepressant prescribed within the thirty days prior and fourteen days after the new episode of major depression. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER ACUTE INPT) with the eligible professional between May 1<sup>st</sup> of the previous year and April 30<sup>th</sup> of the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**MAJOR DEPRESSION**

AND

**ENCOUNTER NON-ACUTE INPATIENT**

OR

**ENCOUNTER ACUTE INPT**

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antidepressant medications within the thirty days prior and fourteen days after the new episode of major depression and DRUG\_EXCLUSION = N.

## AND NOT

All patients greater than or equal to 18 years of age as of May 1<sup>st</sup> of the year prior to the measurement period with a diagnosis of major depression or depression any time prior to May 1<sup>st</sup> of the previous year OR who had an antidepressant prescribed during the ninety days prior to a first antidepressant prescription for a new episode of major depression.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**MAJOR DEPRESSION**

**DEPRESSION**

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antidepressant medications during the ninety days prior to a first antidepressant prescription for a new episode of major depression and DRUG\_EXCLUSION = N.

## Numerator 1: Patients with an 84-day (12-week) acute treatment of antidepressant medication

### Numerator Inclusions:

Patients who were prescribed or who were at the completion of an 84-day (12-week) acute treatment of antidepressant medication within the four months following a new episode of major depression.

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antidepressant medications for an 84-day acute treatment and DRUG\_EXCLUSION = N.

**AND**

## Numerator 2: Patients with a 180-day (6-month) continuation phase treatment of antidepressant medication

### Numerator Inclusions:

Patients who were prescribed or who were at the completion of a 180-day (6-month) continuation phase treatment of antidepressant medication within the eight months following a new episode of major depression.

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed antidepressant medications for a 180-day continuation phase treatment and DRUG\_EXCLUSION = N.

### Denominator Exclusions:

None

## **Rationale:**

This multi-component measure assesses different facets of the successful pharmacological management of depression. Depression has a significant impact on patients' quality of life which includes: interference with completing work responsibilities, lack of motivation, and difficulty in concentrating, discomfort, and dealing with coworkers. Depression contributes significantly to poor disease outcomes and premature death. Studies have shown that increasing the intensity of depression treatment may be an important key to improvements in outcomes and cost-effectiveness and that appropriate therapy improves the daily functioning and overall health of patients with depression.

Clinical guidelines for depression stress the importance of effective clinical management in: increasing patients' medication compliance; monitoring treatment effectiveness by providers, and identifying and managing side effects. If pharmacological treatment is initiated, appropriate dosing and continuation of therapy through the acute and continuation phases decreases recurrence of depression. Thus, evaluation of length of treatment serves as an important indicator of success in promoting patient compliance with the establishment and maintenance of an effective medication regimen.

## **Clinical Recommendation Statements:**

American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Major Depressive Disorder, 2000 revised, 2005 reviewed

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient and close adherence to treatment plans. Treatment consists of an acute phase, during which remission is induced; a continuation phase, during which remission is preserved; and a maintenance phase, during which the susceptible patient is protected against the recurrence of a subsequent major depressive episode.

When pharmacotherapy is part of the treatment plan, it must be integrated with psychiatric management and any other treatments that are being provided. Patients who have started taking an antidepressant medication should be carefully monitored to assess their response to pharmacotherapy as well as the emergence of side effects, clinical condition and safety. (APA "I" Recommendation: Recommended with substantial clinical confidence)

Factors to consider when determining the frequency of patient monitoring include the severity of illness, the patient's cooperation with treatment, the availability of social supports, and the presence of co-morbid general medical problems. Visits should be frequent enough to monitor and address suicidality and to promote treatment adherence. In practice, the frequency of monitoring during the acute phase of pharmacotherapy can vary from once a week in routine cases to multiple times per week in more complex cases. Patients who have been treated with antidepressant medications in the acute phase should be maintained on these agents to prevent relapse. (APA "I" Recommendation: Recommended with substantial clinical confidence)

Reference: American Psychiatric Association practice guideline for the treatment of patients with major depressive disorder. *Am J Psychiatry* 2000 Apr;157(4 Suppl):1-45.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### \* Measure #12 (NQF 0086) HITECH: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

**Description:** Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months

**Denominator:** All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

#### Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with an active diagnosis of primary open-angle glaucoma during the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OPHTHALMOLOGICAL SERVICES

OR

ENCOUNTER OFFICE & OUTPATIENT CONSULT

OR

ENCOUNTER NURSING FACILITY

OR

ENCOUNTER DOMICILIARY

AND

PRIMARY OPEN ANGLE GLAUCOMA (POAG)

**Numerator:** Patients who have an optic nerve head evaluation during one or more office visits within 12 months

#### Numerator Inclusions:

Patients who had an optic nerve head evaluation at least once during a qualifying visit during the measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

OPTIC NERVE HEAD EVALUATION

**Denominator Exclusions:** *(Exclusions only applied if the patient has not received an optic nerve head evaluation at least once during the measurement period)*

When an optic nerve head evaluation was not performed during the measurement period for a valid medical reason, the procedure that would have been performed should be submitted along with a negation code to indicate the reason the appropriate procedure was not performed at least once during a qualifying visit during the measurement period.

PROCEDURES and PROCEDURES(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

OPTIC NERVE HEAD EVALUATION  
AND  
MEDICAL REASON

**Rationale:**

Changes in the optic nerve are one of two characteristics which currently define progression and thus worsening of glaucoma disease status (the other characteristic is visual field). There is a significant gap in documentation patterns of the optic nerve for both initial and follow-up care (Fremont, 2003), even among specialists (Lee, 2006). Examination of the optic nerve head and retinal nerve fiber layer provides valuable structural information about glaucomatous optic nerve damage. Visible structural alterations of the optic nerve head or retinal nerve fiber layer and development of peripapillary choroidal atrophy frequently occur before visual field defects can be detected. Careful study of the optic disc neural rim for small hemorrhages is important, since these hemorrhages can precede visual field loss and further optic nerve damage.

**Clinical Recommendation Statements:**

The physical exam focuses on nine elements: visual acuity, pupils, slit-lamp biomicroscopy of the anterior segment, measurement of intraocular pressure (IOP), determination of central corneal thickness, gonioscopy, evaluation of optic nerve head and retinal nerve fiber layer, documentation of optic nerve head appearance, evaluation of fundus (through dilated pupil), and evaluation of the visual field. (Level A: II Recommendation for optic nerve head evaluation) (AAO, 2005)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### \* Measure #18 (NQF 0088) HITECH: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

**Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months

**Denominator:** All patients aged 18 years and older with a diagnosis of diabetic retinopathy

#### Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with an active diagnosis of diabetic retinopathy during the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER DOMICILIARY  
OR  
ENCOUNTER NURSING FACILITY  
OR  
ENCOUNTER OFFICE & OUTPATIENT CONSULT  
OR  
ENCOUNTER OPHTHALMOLOGICAL SERVICES

AND

DIABETIC RETINOPATHY

**Numerator:** Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months

#### Numerator Inclusions:

Patients who had a dilated macular or fundus exam performed during one or more visits during the measurement period. Documentation of the level of severity of retinopathy AND the presence or absence of macular edema must be done during a qualifying visit during the measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MACULAR OR FUNDUS EXAM

AND

PROBLEMS and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**SEVERITY OF RETINOPATHY AND MACULAR EDEMA FINDINGS**

OR

**MACULAR EDEMA FINDINGS**

AND

**Level of Severity of Retinopathy Findings**

**Denominator Exclusions:** *(Exclusions only applied if the patient has not had a dilated macular or fundus exam performed during one or more office visits during the measurement period)*

When a dilated macular or fundus exam was not performed during the measurement period for a valid medical or patient reason, the procedure that would have been performed should be submitted along with a negation code to indicate the reason the appropriate procedure was not performed at least once during a qualifying visit during the measurement period.

PROCEDURES and PROCEDURES(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**MACULAR OR FUNDUS EXAM**

AND

**MEDICAL REASON**

OR

**PATIENT REASON**

**Rationale:**

Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study – DRS, Early Treatment Diabetic Retinopathy Study – ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. (McGlynn, 2003). Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.

**Clinical Recommendation Statements:**

Since treatment is effective in reducing the risk of visual loss, detailed examination is indicated to assess for the following features that often lead to visual impairment: presence of macular edema, optic nerve neovascularization and/or neovascularization elsewhere, signs of severe NPDR and vitreous or preretinal hemorrhage. (Level A:III Recommendation) (AAO, 2003)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

\* Measure #19 (NQF 0089) HITECH: Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care

**Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with a documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

**Denominator:** All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

### Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period with an active diagnosis of diabetic retinopathy during the measurement period who had a dilated macular or fundus exam during a qualifying visit during the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER DOMICILIARY

OR

ENCOUNTER NURSING FACILITY

OR

ENCOUNTER OFFICE & OUTPATIENT CONSULT

OR

ENCOUNTER OPHTHALMOLOGICAL SERVICES

AND

DIABETIC RETINOPATHY

AND

MACULAR OR FUNDUS EXAM

**Numerator:** Patients with documentation, at least once within 12 months, of findings of dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

**Numerator Inclusions:**

Patients with documentation of findings of dilated macular or fundus exam that have been documented as 'communicated' after the qualifying visit to the physician who manages the patient's diabetic care at least once during the measurement period.

PROBLEMS Tab(s) lists applicable codes for this measure and are associated with the following data elements:

MACULAR EDEMA FINDINGS  
AND  
Level of Severity of Retinopathy Findings

OR

SEVERITY OF RETINOPATHY AND MACULAR EDEMA FINDINGS

**Denominator Exclusions:** *(Exclusions only applied if the patient did not have documentation, at least once during the measurement period, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care)*

When documentation of the communication of the findings of the dilated macular or fundus exam to the physician who manages the patient's diabetic care was not done after a qualifying visit for a valid patient or medical reason during the measurement period, the results and plan of care that would have been performed should be submitted along with a negation code to indicate the reason the appropriate results and plan of care was not performed at least once within the measurement period.

PROBLEMS and PROBLEMS(negation) Tab(s) lists applicable codes for this measure and are associated with the following data elements:

SEVERITY OF RETINOPATHY AND MACULAR EDEMA FINDINGS

AND

PATIENT REASON  
OR  
MEDICAL REASON

OR

MACULAR EDEMA FINDINGS

AND

PATIENT REASON  
OR  
MEDICAL REASON

OR

LEVEL OF SEVERITY OF RETINOPATHY FINDINGS

AND

PATIENT REASON  
OR  
MEDICAL REASON

**Rationale:**

The physician that manages the on-going care of the patient with diabetes should be aware of the patient's dilated eye examination and severity of retinopathy to manage the on-going diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease. (Diabetes Control and Complications Trial – DCCT, UK Prospective Diabetes Study – UKPDS)

**Clinical Recommendation Statements:**

While it is clearly the responsibility of the ophthalmologist to manage eye disease, it is also the ophthalmologist's responsibility to ensure that patients with diabetes are referred for appropriate management of their systemic condition. It is the realm of the patient's family physician, internist or endocrinologist to manage the systemic diabetes. The ophthalmologist should communicate with the attending physician. (Level A: III Recommendation) (AAO, 2003)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

\* Measure #39 (NQF 0046): Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older

**Description:** Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

**Denominator:** All female patients aged 65 years and older

**Denominator Inclusions:**

All female patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**ENCOUNTER ALL INPATIENT AND AMBULATORY**

**Numerator:** Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

**Numerator Inclusions:**

Female patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**DXA (DUAL-ENERGY X-RAY ABSORPTIOMETRY) SCAN**

**OR**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking pharmacologic therapy for osteoporosis during the measurement period and DRUG\_EXCLUSION = N.

**Denominator Exclusions:** (*Exclusions only applied if the patient has not received a DXA measurement at least once since age 60 or pharmacologic therapy prescribed during the measurement period*)

When a central DXA scan was not performed for a valid medical, patient or system reason, the procedure that would have been performed should be submitted along with a negation code to indicate the reason the appropriate procedure was not performed at least once since age 60.

PROCEDURES, PROCEDURES(negation), RESULTS, and RESULTS(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**DXA (DUAL-ENERGY X-RAY ABSORPTIOMETRY) SCAN**

**AND**

**MEDICAL REASON**

**OR**

**PATIENT REASON**

**OR**

**SYSTEM REASON**

**OR**

When pharmacologic therapy is not prescribed for a valid medical, patient or system reason during the measurement period, the medication that patient would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate pharmacologic therapy was not ordered or received during the measurement period.

*NOTE: When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS (negation) tab(s) in the Downloadable Resource table list applicable codes for pharmacologic therapy for osteoporosis.

**AND**

**MEDICAL REASON**

**OR**

**PATIENT REASON**

**OR**

**SYSTEM REASON**

**Rationale:**

Patients with elevated risk for osteoporosis should have the diagnosis of osteoporosis excluded or be on treatment of osteoporosis.

**Clinical Recommendation Statements:**

The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. (B Recommendation) (USPSTF)

The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures. Use of risk factors, particularly increasing age, low weight, and non-use of estrogen replacement, to screen younger women may identify high-risk women. (B Recommendation) (USPSTF)

BMD measurement should be performed in all women beyond 65 years of age. Dual x-ray absorptiometry of the lumbar spine and proximal femur provides reproducible values at important sites of osteoporosis-associated fracture. These sites are preferred for baseline and serial measurements. (AACE)

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

BMD testing should be performed on:

- All women aged 65 and older regardless of risk factors
- Younger postmenopausal women with one or more risk factors (other than being white, postmenopausal, and female)
- Postmenopausal women who present with fractures (NQF)

The decision to test for BMD should be based on an individual's risk profile. Testing is never indicated unless the results could influence a treatment decision. (NQF)

Markers of greater osteoporosis and fracture risk include older age, hypogonadism, corticosteroid therapy, and established cirrhosis. (Level B Evidence) (NQF)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (NQF)

Pharmacologic therapy should be initiated to reduce fracture risk in women with:

- BMD T-scores below -2.0 by central dual x-ray absorptiometry (DXA) with no risk factors
- BMD T-scores below -1.5 by central dual x-ray absorptiometry (DXA) with one or more risk factors
- A prior vertebral or hip fracture (NQF)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### \* Measure #47 (NQF 0326): Advance Care Plan

**Description:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

**Denominator:** All patients aged 65 years and older

#### Denominator Inclusions:

All patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

**Numerator:** Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

#### Numerator Inclusions:

Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan during the measurement period.

AdvanceDirectiveStatusCodes on the VOCABS AND VALUESETS tab in the Downloadable Resource table lists applicable codes for this measure:

AdvanceDirectiveStatusCode

#### Denominator Exclusions:

None

## **Rationale:**

It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno 1997) than the risk that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.

## **Clinical Recommendation Statements:**

Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.

### Oral statements

- Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.
- Properly verified oral statements carry same ethical and legal weight as those recorded in writing.

### Instructional advance directives (DNR orders, living wills)

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

### Durable power of attorney for health care or health care proxy

- A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)

The National Hospice and Palliative Care Organization provides the Caring Connection web site, which provides resources and information on end-of-life care, including a national repository of state-by-state advance directives.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### \* Measure #48 (NQF 0098): Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

**Description:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months

**Denominator:** All female patients aged 65 years and older

#### Denominator Inclusions:

All female patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

**Numerator:** Patients who were assessed for the presence or absence of urinary incontinence within 12 months

#### Numerator Inclusions:

Female patients who were assessed for the presence or absence of urinary incontinence during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

UI CODE

OR

UI ASSESS CODE

**Denominator Exclusions:** *(Exclusions only applied if patients were not assessed for presence or absence of urinary incontinence during the measurement period)*

Patients who had one of the following active conditions during the measurement period.

PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MEDICAL REASON

OR

EXCLUSION CODE

**Rationale:**

Female patients may not volunteer information regarding incontinence so they should be asked by their physician.

**Clinical Recommendation Statements:**

Strategies to increase recognition and reporting of UI are required and especially the perception that it is an inevitable consequence of aging for which little or nothing can be done. (ICI)

Patients with urinary incontinence should undergo a basic evaluation that includes a history, physical examination, measurement of post-void residual volume, and urinalysis. (ACOG) (Level C)

Health care providers should be able to initiate evaluation and treatment of UI basing their judgment on the results of history, physical examination, post-voiding residual and urinalysis. (ICI) (Grade B for women)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ☐ Measure #53 (NQF 0047) HITECH: Asthma: Pharmacologic Therapy for Persistent Asthma

**Description:** Percentage of patients aged 5 through 50 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment

**Denominator:** All patients aged 5 through 50 years with a diagnosis of mild, moderate, or severe persistent asthma

#### Denominator Inclusions:

All patients aged 5 through 50 years at the beginning of the measurement period with an active diagnosis of mild, moderate, or severe persistent asthma during the measurement period. To be eligible for performance calculations, patient must have at least two face-to-face visits with the same eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OFFICE & OUTPATIENT CONSULT

AND

ASTHMA

AND

*Severity: 'Persistent'*

OR

ASTHMA PERSISTENT

**Numerator:** Patients who were prescribed *either* the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta<sub>2</sub>-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines)

#### Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed inhaled corticosteroid, inhaled corticosteroid with long-acting beta<sub>2</sub>-agonist or alternative asthma medication (with an active status) during the measurement period and DRUG\_EXCLUSION = N.

**Denominator Exclusions:** (*Exclusions only applied if the patient did not receive either the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta<sub>2</sub>-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines during the measurement period)*)

When drug therapy is not prescribed during the measurement period for a valid patient reason, the appropriate medication that would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table lists applicable codes for inhaled corticosteroid, inhaled corticosteroid with long-acting beta<sub>2</sub>-agonist or alternative asthma medication.

**AND**

PATIENT REASON

**OR**

When drug therapy was not prescribed during the measurement period due to patient allergy, adverse effects or intolerance identified at any time before or during their last qualifying visit, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table lists applicable codes for inhaled corticosteroid, inhaled corticosteroid with long-acting beta<sub>2</sub>-agonist or alternative asthma medication.

**AND**

MEDICATION ALLERGY

OR

MEDICATION ADVERSE EFFECTS

OR

MEDICATION INTOLERANCE

## Rationale:

Although current guidelines recommend inhaled corticosteroids as the preferred pharmacological treatment for persistent asthma, other long-term control medications are acceptable alternatives. Long Acting-inhaled Beta2 Agonists (LABA) are recommended in combination with Inhaled Corticosteroids.

## Clinical Recommendation Statements:

A stepwise approach to therapy is recommended to maintain long-term control:

Step 1: Mild Intermittent Asthma

- No daily medication needed

Step 2: Mild Persistent Asthma

- *Preferred treatment:* Low-dose inhaled corticosteroids (ICS)
- *Alternative treatment:* Cromolyn, leukotriene modifier, nedocromil, OR sustained-release theophylline

Step 3: Moderate Persistent Asthma

- *Preferred treatment:* Low-medium dose ICS + long-acting inhaled beta<sub>2</sub>-agonists (LABA)
- *Alternative treatment:* Increase medium-dose ICS OR low-medium dose ICS and either leukotriene modifier or theophylline (If needed, may increase ICS within medium-dose range in either treatment)

Step 4: Severe Persistent Asthma

- *Preferred treatment:* High-dose ICS + LABA AND, if needed, corticosteroid tablets or syrup long-term

Studies comparing ICS to cromolyn, nedocromil, theophylline, or leukotriene receptor antagonists are limited, but available evidence shows that none of these long-term control medications appear to be as effective as ICS in improving asthma outcomes.

For quick relief for all patients, a short-acting bronchodilator is recommended as needed for symptoms. (NAEPP/NHLBI)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### Measure #64 (NQF 0001) HITECH: Asthma: Assessment of Asthma Control

**Description:** Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

**Denominator:** All patients aged 5 through 50 years with a diagnosis of asthma

#### Denominator Inclusions:

All patients aged 5 through 50 years at the beginning of the measurement period with an active diagnosis of asthma during the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OFFICE & OUTPATIENT CONSULT  
AND  
ASTHMA

**Numerator:** Patients who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

#### Numerator Inclusions:

Patients who were evaluated for the frequency of daytime and nocturnal asthma symptoms during a qualifying visit during the measurement period.

PROBLEMS and RESULTS Tab(s) lists applicable codes for inclusion in this measure and are associated with the following data element(s):

ASTHMA DAYTIME SYMPTOMS QUANTIFIED  
AND  
ASTHMA NIGHTTIME SYMPTOMS QUANTIFIED

OR

ASTHMA DAYTIME SYMPTOMS  
AND  
ASTHMA NIGHTTIME SYMPTOMS

OR

ASTHMA SYMPTOM ASSESSMENT TOOL

#### Denominator Exclusions:

None

**Rationale:**

Appropriate treatment of asthma patients requires accurate classification of asthma severity. Physician assessment of the frequency of asthma symptoms is the first step in classifying asthma severity.

**Clinical Recommendation Statements:**

To determine whether the goals of therapy are being met, monitoring is recommended in the 6 areas listed below:

- Signs and symptoms (daytime; nocturnal awakening) of asthma
- Pulmonary function (spirometry; peak flow monitoring)
- Quality of life/functional status
- History of asthma exacerbations
- Pharmacotherapy (as-needed use of inhaled short-acting beta2-agonist, adherence to regimen of long-term-control medications)
- Patient-provider communication and patient satisfaction (NAEPP/NHLBI)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #66 (NQF 0002) HITECH: Appropriate Testing for Children with Pharyngitis

**Description:** Percentage of children aged 2 through 18 years with a diagnosis of pharyngitis, who were prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode

**Denominator:** All patients aged 2 through 18 years with a diagnosis of pharyngitis

#### Denominator Inclusions:

All patients aged 2 through 18 years at the beginning of the measurement period with an active diagnosis of pharyngitis during a qualifying visit during the measurement period, and who were dispensed an antibiotic within three days after the qualifying visit who have not had pharyngitis antibiotics within the thirty days prior to the qualifying visit. To be eligible for performance calculations, patient must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED

OR

ENCOUNTER OUTPATIENT

AND

PHARYNGITIS

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed pharyngitis antibiotics within three days after the qualifying visit who have not had pharyngitis antibiotics at any time during the thirty days prior to the qualifying visit and DRUG\_EXCLUSION = N.

**Numerator:** Patients who were dispensed an antibiotic and who received a group A streptococcus (strep) test for the episode

#### Numerator Inclusions:

Patients who received a group A streptococcus (strep) test for the episode within three days prior and three days after the qualifying visit during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

GROUP A STREPTOCOCCUS TEST

#### Denominator Exclusions:

None

**Rationale:**

Clinical practice guidelines recommend group A streptococcus pharyngitis be treated with antibiotics (Schwartz et al, 1998).

**Clinical Recommendation Statements:**

The group A strep test (rapid assay or throat culture) is the definitive test of group A strep pharyngitis. Pharyngitis is the only respiratory tract infection with an objective diagnostic test that can be validated with administrative data, and not medical records. A process measure that requires the performance of a group A strep test for children given antibiotics for pharyngitis is supported by the guidelines. (Ibid)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

Measure #71 (NQF 0387) HITECH: Breast Cancer: Hormonal Therapy for Stage IC–IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer

**Description:** Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period

**Denominator:** All female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

### Denominator Inclusions:

All female patients greater than or equal to 18 years of age at the beginning of the measurement period with an active diagnosis of breast cancer stage IC-IIIC and EP or PR positive before or during their last qualifying visit during the measurement period. History of breast cancer includes patients with an initial diagnosis date for breast cancer within the five years prior to the last qualifying visit during the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OFFICE VISIT

AND

BREAST CANCER

OR

BREAST CANCER HISTORY

AND

BREAST CANCER STAGE IC-IIIC

AND

BREAST CANCER ER OR PR POSITIVE

**Numerator:** Patients who were prescribed tamoxifen or aromatase inhibitor (AI) within the 12 month reporting period

### Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking Tamoxifen or Aromatase Inhibitor therapy during the measurement period before or during the last qualifying visit during the measurement period and DRUG\_EXCLUSION = N.

**Denominator Exclusions:** (*Exclusions only applied if the patient did not receive Tamoxifen or Aromatase Inhibitor Therapy during the measurement period*)

When drug therapy is not prescribed during the measurement period for a valid medical, patient or system reason, the medication that patient would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication treatment was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Tamoxifen or Aromatase Inhibitor therapy.

**AND**

MEDICAL REASON

OR

PATIENT REASON

OR

SYSTEM REASON

**OR**

When drug therapy is not prescribed due to patient allergy, adverse effects or intolerance identified at any time before or during their last qualifying visit during the measurement period, the medication that patient would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication treatment was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table lists applicable codes for Tamoxifen or Aromatase Inhibitor therapy.

**AND**

MEDICATION ALLERGY

OR

MEDICATION ADVERSE EFFECTS

OR

MEDICATION INTOLERANCE

**OR**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking Gonadotropin-Releasing Hormone Analogue Medication (with an active status) at any time before or during the last qualifying visit and DRUG\_EXCLUSION = Y.

**OR**

Patients who had one of the following conditions diagnosed before or during their last qualifying visit during the measurement period and the condition is active during their last qualifying visit.

PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

BILATERAL OOPHORECTOMY

OR

METASTATIC SITES COMMON TO BREAST CANCER

**OR**

Patients who received radiation therapy or chemotherapy after their initial diagnosis of breast cancer and up to their last qualifying visit during the measurement period.

PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

RADIATION THERAPY

OR

CHEMOTHERAPY

**Rationale:**

Despite evidence suggesting the role of adjuvant endocrine therapy in lowering the risk of tumor recurrence, many female patients who should be receiving this therapy are not. This measure assesses whether patients with a certain stage of breast cancer (IC through IIIC) and ER/PR+ are currently receiving the therapy. There are allowable medical, patient, and system reasons to document instances in which a woman with stage IC through IIIC, ER/PR+ may not be a candidate for the therapy.

**Note:** The reporting/managing physician does not need to have actually written the prescription; however, the reporting/managing physician must verify that the patient already has been prescribed the hormonal therapy by another physician.

**Clinical Recommendation Statements:**

Adjuvant therapy for postmenopausal women with hormone receptor–positive breast cancer should include an aromatase inhibitor in order to lower the risk of tumor recurrence. Aromatase inhibitors are appropriate as initial treatment for women with contraindications to tamoxifen. For all other postmenopausal women, treatment options include 5 years of aromatase inhibitors treatment or sequential therapy consisting of tamoxifen (for either 2 to 3 years or 5 years) followed by aromatase inhibitors for 2 to 3, or 5 years (ASCO guidelines include narrative rankings). (ASCO)

Patients intolerant of aromatase inhibitors should receive tamoxifen. Women with hormone receptor–negative tumors should not receive adjuvant endocrine therapy (ASCO guidelines include narrative rankings). (ASCO)

Patients with invasive breast cancers that are estrogen or progesterone receptor positive should be considered for adjuvant endocrine therapy regardless of patient age, lymph node status, or whether or not adjuvant chemotherapy is to be administered (Category 2A). (NCCN)

The most firmly established adjuvant endocrine therapy is tamoxifen for both premenopausal and postmenopausal women. Prospective, randomized trials demonstrate that the optimal duration of tamoxifen appears to be five years. In patients receiving both tamoxifen and chemotherapy, chemotherapy should be given first, followed by sequential tamoxifen. Several studies have evaluated aromatase inhibitors in the treatment of postmenopausal women with early-stage breast cancer (Category 2A). (NCCN)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### Measure #72 (NQF 0385) HITECH: Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

**Description:** Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period

**Denominator:** All patients aged 18 years and older with Stage IIIA through IIIC colon cancer

#### Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period who currently have or had a diagnosis of colon cancer stage III before or during their last qualifying visit during the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OFFICE VISIT

AND

COLON CANCER

OR

COLON CANCER HISTORY

AND

COLON CANCER STAGE III

**Numerator:** Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or who have previously received adjuvant chemotherapy within the 12-month reporting period

#### Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or currently receiving Chemotherapy for Colon Cancer before or during the last qualifying visit during the measurement period and DRUG\_EXCLUSION = N.

**Denominator Exclusions:** (*Exclusions only applied if the patient did not receive Chemotherapy for Colon Cancer*)

When drug therapy is not prescribed during the measurement period for a valid medical, patient or system reason, the medication that patient would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication treatment was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS (negation) tab(s) in the Downloadable Resource table lists applicable codes for Chemotherapy for Colon Cancer.

**AND**

MEDICAL REASON

OR

PATIENT REASON

OR

SYSTEM REASON

**OR**

When drug therapy is not prescribed due to patient allergy, adverse effects or intolerance identified at any time before or during their last qualifying visit, the medication that patient would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate medication treatment was not ordered or received during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS (negation) tab(s) in the Downloadable Resource table lists applicable codes for Chemotherapy for Colon Cancer.

**AND**

MEDICATION ALLERGY

OR

MEDICATION ADVERSE EFFECTS

OR

MEDICATION INTOLERANCE

**OR**

Patients who had one of the following conditions diagnosed before or during their last qualifying visit during the measurement period and the condition is active during their last qualifying visit.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

METASTATIC SITES COMMON TO COLON CANCER

OR

ACUTE RENAL INSUFFICIENCY

OR

NEUTROPENIA

OR

LEUKOPENIA

OR

ECOG PERFORMANCE STATUS-POOR

**Rationale:**

Patients with Stage IIIA through Stage IIIC colon cancer do not always receive the recommended treatment of adjuvant chemotherapy. This measure is intended to determine whether and how often chemotherapy is administered. The specific chemotherapy drugs specified in this measure reflect the most current guidelines of the National Comprehensive Cancer Network.

**Clinical Recommendation Statements:**

For stage III patients (T1-4, N1-2, M0), the panel recommends 6 months of adjuvant chemotherapy following primary surgical treatment. The treatment options are: 5-FU/LV/oxaliplatin (mFOLFOX6) as the standard of care (category 1); 5-FU/oxaliplatin (FLOX, category 1); capecitabine/oxaliplatin (CapeOx); or single agent capecitabine or 5-FU/LV in patients felt to be inappropriate for oxaliplatin therapy. (NCCN)

There is currently a shortage of leucovorin in the United States. There are no specific data to guide management under these circumstances, and all proposed strategies are empiric. The panel recommends several possible options to help alleviate the problems associated with this shortage. One is the use of levo-leucovorin, which is commonly used in Europe. A dose of 200 mg/m<sup>2</sup> of levo-leucovorin is equivalent to 400 mg/m<sup>2</sup> of standard leucovorin. Another option is for practices or institutions to use lower doses of leucovorin for all doses in all patients, since the panel feels that lower doses are likely to be as efficacious as higher doses, based on several studies...Finally, if none of the above options are available, treatment without leucovorin would be reasonable. (NCCN)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ▲Measure #102 (NQF 0389) HITECH: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients

**Description:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer

**Denominator:** All patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

#### Denominator Inclusions:

All male patients, regardless of age, with an active diagnosis of prostate cancer before or during the measurement period with a low risk for prostate cancer recurrence and a PSA test of less than or equal to 10 ng/mL and a Gleason Score of less than or equal to 6 before or during the prostate cancer treatment. To be eligible for performance calculations, patients must have at least one prostate cancer treatment with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and RESULTS tab(s) in the Downloadable Resource table lists applicable codes in this measure and are associated with the following data element(s):

PROSTATE CANCER TREATMENT

AND

PROSTATE CANCER

AND

AJCC CANCER STAGE LOW RISK RECURRENCE PROSTATE CANCER

AND

PROSTATE SPECIFIC ANTIGEN TEST

WITH

Documentation of PSA ≤10 ng/mL

AND

GLEASON SCORE <=6

OR

GLEASON SCORE

WITH

Documentation of GLEASON SCORE ≤6

**Numerator:** Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer

**Numerator Inclusions:**

Male patients who did *not* have a bone scan performed at any time since the diagnosis of prostate cancer.

**NOTE:** *This measure is intended to identify an overuse of bone scans for patients with a diagnosis of prostate cancer. The lack of BONE SCAN codes will indicate that the bone scan was not performed and will meet the quality action for this measure.*

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**BONE SCAN**

**Denominator Exclusions:** *(Exclusions only applied if the patient has received a bone scan since diagnosis of prostate cancer)*

Patients who had one of the following active conditions at any time since the diagnosis of prostate cancer.

PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**PAIN RELATED TO PROSTATE CANCER**  
**OR**  
**SALVAGE THERAPY**

**Rationale:**

A bone scan is generally not required for staging prostate cancer in men with a low risk of recurrence and receiving primary therapy. This measure is written as a negative measure so that the performance goal is 100%, consistent with the other measures for this condition.

**Clinical Recommendation Statements:**

Routine use of a bone scan is not required for staging asymptomatic men with clinically localized prostate cancer when their PSA is equal to or less than 20.0 ng/mL. (AUA)

Patients with a life expectancy > 5 years or symptomatic:

- A bone scan is appropriate for T1 to T2 disease in the presence of a PSA greater than 20 ng/mL, Gleason score of 8 or higher, clinical stage of T3 to T4, or symptomatic disease.
- Patients at higher risk of metastatic disease may undergo pelvic computed tomography (CT) or magnetic resonance imaging (MRI) scanning with possible fine-needle aspiration of enlarged lymph nodes or staging lymph node dissection. Nomograms or risk tables may be used to identify patients with a higher likelihood of having metastatic disease. If the nomogram indicates a probability of lymph node involvement greater than 20% or if the patient is stage T3 or T4, this is recommended as a threshold for doing a staging CT scan or MRI evaluation.

For all other patients, no additional imaging is required for staging. (NCCN) (Category 2A)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ▲Measure #110 (NQF 0041) HITECH ALT CORE: Preventive Care and Screening: Influenza Immunization

**Description:** Percentage of patients aged 6 months and older who received an influenza immunization during the flu season (October 1 through March 31)

**Denominator:** All patients aged 6 months and older seen for a visit between October 1 and March 31

#### Denominator Inclusions:

All patients greater than or equal to 6 months of age at the beginning of the measurement period with an encounter during the flu season (October through December of the year prior to the measurement period or January through March during the measurement period). To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional (ENCOUNTER OUTPATIENT) or at least one face-to-face visit (ENCOUNTER PREV MED 40 AND OLDER, ENCOUNTER PREV MED GROUP COUNSELING, ENCOUNTER PREV MED – INDIVIDUAL COUNSELING, ENCOUNTER PREV MED OTHER SERVICES, ENCOUNTER NURSING FACILITY, or ENCOUNTER NURSING DISCHARGE) with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

OR

ENCOUNTER PREV MED 40 AND OLDER

OR

ENCOUNTER PREV MED GROUP COUNSELING

OR

ENCOUNTER PREV MED – INDIVIDUAL COUNSELING

OR

ENCOUNTER PREV MED OTHER SERVICES

OR

ENCOUNTER NURSING FACILITY

OR

ENCOUNTER NURSING DISCHARGE

**Numerator:** Patients who received an influenza immunization during the flu season (October 1 through March 31)

#### Numerator Inclusions:

Patients who received an influenza vaccination in October through December of the year prior to the measurement period or January through March during the measurement period.

**NOTE:** *Includes patients who have previous receipt of an influenza immunization at home, hospital, surgery or work*

IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

INFLUENZA VACCINATION

OR

MEDICATIONS tab(s) in the Downloadable Resource table lists applicable codes for patients who received the influenza vaccine during the flu season and DRUG\_EXCLUSION = N.

**Denominator Exclusions:** (*Exclusions only applied if influenza vaccination not received*)

When an influenza vaccination is not received for a valid medical, patient or system reason identified before or during their last qualifying visit in the appropriate flu season, the influenza vaccination that would have been received should be submitted along with a negation code to indicate the reason the influenza vaccination was not given.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

IMMUNIZATIONS, and IMMUNIZATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**INFLUENZA VACCINATION**

**AND**

**INFLUENZA VACCINE DECLINED**

**OR**

**MEDICAL REASON**

**OR**

**PATIENT REASON**

**OR**

**SYSTEM REASON**

**OR**

When the influenza vaccine is not received for a valid medical, patient or system reason identified before or during their last qualifying visit in the appropriate flu season, the influenza vaccine that would have been received should be submitted along with a negation code to indicate the reason the influenza vaccine was not received.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for influenza vaccine.

**AND**

**INFLUENZA VACCINE DECLINED**

**OR**

**MEDICAL REASON**

**OR**

**PATIENT REASON**

**OR**

**SYSTEM REASON**

**OR**

When the influenza vaccine is not received due to patient allergy, adverse effects or intolerance identified before or during their last qualifying visit in the appropriate flu season, the influenza vaccine that the patient is allergic to should be submitted along with a negation code to indicate the reason the influenza vaccine was not received.

*NOTE: When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

IMMUNIZATIONS, and IMMUNIZATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

INFLUENZA VACCINATION

AND

PROCEDURE INTOLERANCE

OR

PROCEDURE ADVERSE EVENT

OR

When the influenza vaccine is not received due to patient allergy, adverse effects or intolerance identified before or during their last qualifying visit in the appropriate flu season, the influenza vaccine that the patient is allergic to should be submitted along with a negation code to indicate the reason the influenza vaccine was not received.

*NOTE: When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for influenza vaccine.

AND

MEDICATION INTOLERANCE

OR

MEDICATION ADVERSE EFFECTS

OR

MEDICATION ALLERGY

OR

Patient who has one of the following conditions at any time before or during their last qualifying visit during the flu season.

ALERTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ALLERGY TO EGGS

OR

INFLUENZA VACCINE CONTRAINDICATED

OR

INFLUENZA VACCINE DECLINED

**Rationale:**

Influenza vaccination has shown to decrease hospitalizations for influenza, especially for those with risk factors, however annual influenza vaccination rates remain low.

**Clinical Recommendation Statements:**

Annual influenza immunization is recommended for all groups who are at increased risk for complications from influenza including persons aged  $\geq 50$  years. (CDC, USPSTF)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #111 (NQF 0043) HITECH: Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older

**Description:** Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine

**Denominator:** All patients 65 years and older

#### Denominator Inclusions:

All patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**ENCOUNTER OUTPATIENT**

**Numerator:** Patients who have ever received a pneumococcal vaccination

#### Numerator Inclusions:

Patients who received a pneumococcal vaccination at any time in the patient's history before or during the measurement period.

IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**PNEUMOCOCCAL VACCINATION**

**OR**

**PNEUMOCOCCAL VACCINATION AGES 2 AND OLDER**

**OR**

MEDICATIONS tab(s) in the Downloadable Resource table lists applicable codes for patients who received the pneumococcal vaccination at any time in the patient's history and DRUG\_EXCLUSION = N.

#### Denominator Exclusions:

None

**Rationale:**

The elderly have a much higher mortality from community-acquired pneumonia due to increased risk factors such as comorbidities, an increase in the number of medications taken and weaknesses or disease of lung tissue. Pneumonia accounts for an estimated 20 percent of nosocomial infections among the elderly, second only to urinary tract infections. The disease burden is large for older adults and the potential for prevention is high. (Ely, E., 1997)

Drugs such as penicillin were once effective in treating these infections; but the disease has become more resistant, making treatment of pneumococcal infections more difficult. This makes prevention of the disease through vaccination even more important. (CDC. National Immunization Program—*Pneumococcal Disease*, 2005)

**Clinical Recommendation Statements:**

The U.S. Preventive Services Task Force's *Guide to Clinical Preventive Services* recommends pneumococcal vaccine for all immunocompetent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease. Routine revaccination is not recommended, but may be appropriate in immunocompetent individuals at high risk for morbidity and mortality from pneumococcal disease (e.g., persons  $\geq$  75 years of age or with severe chronic disease) who were vaccinated more than five years previously. Medicare Part B fully covers the cost of the vaccine and its administration every five years. (United States Preventive Services Task Force, 1998)

Pneumococcal infection is a common cause of illness and death in the elderly and persons with certain underlying conditions. In 1998, an estimated 3,400 adults aged  $\geq$  65 years died as a result of invasive pneumococcal disease. Pneumococcal infection accounts for more deaths than any other vaccine-preventable bacterial disease. (CDC, 2002; Pneumococcal Pneumonia, NIAID Fact Sheet, December 2004.)

One of the *Healthy People 2010* objectives is to increase pneumococcal immunization levels for the non-institutionalized, high-risk populations to at least 90 percent (objective no. 14.29). While the percent of persons 65 years and older receiving the pneumococcal vaccine has increased, it still remains considerably below the *Healthy People 2010* objective. According to the National Health Interview Survey (NHIS), which is used to track performance on year 2010 objectives, in 1998 only 46 percent of adults age 65 years and older report receiving the vaccine. The figure was 45 percent based on the 1997 Behavioral Risk Factor Surveillance System (BRFSS) survey. (National Center for Health Statistics., 2005; CDC, 1997)

A particular strength of this measure is that it provides an opportunity to compare performance against national, state and/or regional benchmarks, which are collected through nationally organized and administered surveys.

At the physician practice level where a patient survey may not be feasible, data collection on pneumonia vaccination status through chart abstraction is a viable option.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #112 (NQF 0031) HITECH: Preventive Care and Screening: Screening Mammography

**Description:** Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer

**Denominator:** All female patients aged 40 through 69 years

#### Denominator Inclusions:

All female patients between 40 and 69 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**ENCOUNTER OUTPATIENT**

#### AND NOT

Female patients who had a bilateral mastectomy at any time before or during the measurement period.

PROCEDURES and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**BILATERAL MASTECTOMY**

OR

**UNILATERAL MASTECTOMY CPT**

AND

**-50 modifier associated with CPT code** (indicates the procedure was performed bilaterally)

#### OR

Female patients who had *two* unilateral mastectomies on two different dates of service at any time before or during the measurement period.

PROCEDURES and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**UNILATERAL MASTECTOMY**

## Numerator: Patients who had a mammogram at least once within 24 months

### Numerator Inclusions:

Female patients who had a mammogram during the measurement period or year prior to the measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**BREAST CANCER SCREENING**

### Denominator Exclusions:

None

## **Rationale:**

Breast cancer ranks as the second leading cause of death in women. For women 40 to 49 years of age mammography can reduce mortality by 17 percent. (AMA, 2003)

## **Clinical Recommendation Statement:**

The U.S. Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older. (USPSTF, 2002)

- The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women aged 50-69, the age group generally included in screening trials. (USPSTF, 2002)
- For women aged 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50. (USPSTF, 2002)
- The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. (USPSTF, 2002)

The USPSTF concluded that the evidence is also generalizable to women aged 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increases along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminishes from ages 40-70. The balance of benefits and potential harms; therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. (USPSTF, 2002)

American Cancer Society: Yearly Mammograms starting at age 40 and continuing for as long as a woman is in good health. (Smith, 2003)

American College of Preventive Medicine (ACPM):

- Low-risk women (no family history, familial cancer syndrome, or prior cancer). There is inadequate evidence for or against mammography screening of women under the age of 50. Women between the ages of 50-69 should have annual or biennial, high-quality, two-view mammography. Women aged 70 and older should continue undergoing mammography screening provided their health status permits breast cancer treatment. (Ferrini, 1996)
- Higher-risk women: Women with a family history of pre-menopausal breast cancer in a first-degree relative or those with a history of breast and/or gynecologic cancer may warrant more aggressive screening. Women with these histories often begin screening at an earlier age, although there is no direct evidence of effectiveness to support this practice. The future availability of genetic screening may define new recommendations for screening high-risk women. (Ferrini, 1996)

The American Medical Association (AMA), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Radiology (ACR), all support screening with mammography and CBE beginning at age 40. (AMA, 1999; ACOG, 2000; Feig, 1998)

The Canadian Task Force on Preventive Health Care (CTFPHC), and the American Academy of Family Physicians (AAFP), recommends beginning mammography for average-risk women at age 50. (Canadian Task Force on the Periodic Health Examination, 1999; AAFP, 2005)

AAFP recommends that mammography in high-risk women begin at age 40, and recommends that all women aged 40-49 be counseled about the risks and benefits of mammography before making decisions about screening. (AAFP, 2005)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #113 (NQF 0034) HITECH: Preventive Care and Screening: Colorectal Cancer Screening

**Description:** Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening

**Denominator:** All patients aged 50 through 75 years

#### Denominator Inclusions:

All patients between 50 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

#### AND NOT

Patients who had a total colectomy any time before or during the measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

TOTAL COLECTOMY

**Numerator:** Patients who had at least one or more screenings for colorectal cancer during or prior to the reporting period

#### Numerator Inclusions:

Patients with any of the recommended colorectal cancer screening test(s) performed.

*Current colorectal cancer screening is defined as performing any of the following:*

- Fecal occult blood test during the measurement period*
- Flexible sigmoidoscopy during the measurement period or four years prior*
- Colonoscopy during the measurement period or nine years prior*

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

FECAL OCCULT BLOOD TEST (FOBT)

OR

FLEXIBLE SIGMOIDOSCOPY

OR

COLONOSCOPY

**Denominator Exclusions:** *(Exclusions only applied if screening for colorectal cancer not performed)*

Patients who have had a diagnosis of colorectal cancer at any time in the patient's history before or during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**COLORECTAL CANCER**

**Rationale:**

Colorectal cancer is the second leading cause of cancer-related death in the United States. There were an estimated 135,400 new cases and 56,700 deaths from the disease during 2001. Colorectal cancer (CRC) places significant economic burden on the society as well with treatment costs over \$6.5 billion per year and, among malignancies, is second only to breast cancer at \$6.6 billion per year. (Schrag, 1999)

Colorectal cancer screening can detect pre-malignant polyps and early stage cancers. Unlike other screening tests that only detect disease, colorectal cancer screening can guide removal of pre-malignant polyps, which in theory can prevent development of colon cancer. Three tests are currently available for screening: fecal occult blood testing (FOBT), flexible sigmoidoscopy, and colonoscopy.

**Clinical Recommendation Statements:**

During the past decade, compelling evidence has accumulated that systematic screening of the population can reduce mortality from colorectal cancer. Three randomized, controlled trials demonstrated that fecal occult blood testing (FOBT), followed by complete diagnostic evaluation of the colon for a positive test, reduced colorectal cancer mortality. (Hardcastle et al., 1996; Mandel & Oken, 1998; Kronborg; 1996) One of these randomized trials (Mandel et al., 1993) compared annual FOBT screening to biennial FOBT screening, and found that annual screening resulted in greater reduction in colorectal cancer mortality. Two case control studies have provided evidence that sigmoidoscopy reduces colorectal cancer mortality. (Selby et al., 1992; Newcomb et al., 1992) Approximately 75% of all colorectal cancers arise sporadically. (Stephenson et al., 1991) Part of the effectiveness of colorectal cancer screening is mediated by the removal of the precursor lesion—an adenomatous polyp. (Vogtelstein et al., 1988) It has been shown that removal of polyps in a population can reduce the incidence of colorectal cancer. (Winawer, 1993) Colorectal screening may also lower mortality by allowing detection of cancer at earlier stages, when treatment is more effective. (Kavanaugh, 1998)

The U.S. Preventive Services Task Force (USPSTF) published an updated recommendation colorectal cancer screening in 2008. The guideline strongly recommends that clinicians screen men and women ages 50 to 75 years of age for colorectal cancer. (A recommendation) The USPSTF recommends not screening adults age 85 and older due to possible harms. (D recommendation) The appropriateness of colorectal cancer screening for men and women aged 76 to 85 years old should be considered on an individual basis. (C recommendation) While the approved modalities vary for patients 50 to 75 years old, the USPSTF found there is insufficient evidence to assess the benefits and harms of computed tomographic colonography (CTC) and fecal DNA (fDNA) testing as screening modalities for colorectal cancer for all patients. (I statement)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #117 (NQF 0055) HITECH: Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient

**Description:** Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam

**Denominator:** All patients aged 18 through 75 years with a diagnosis of diabetes

#### Denominator Inclusions:

All patients with an active diagnosis of diabetes during the measurement period and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER ED  
OR  
ENCOUNTER NON-ACUTE INPATIENT  
OR  
ENCOUNTER OUTPATIENT

AND

DIABETES

OR

All patients between 18 and 75 years of age at the beginning of the measurement period who were prescribed or are currently taking a medication indicative of diabetes during the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER ED  
OR  
ENCOUNTER NON-ACUTE INPATIENT  
OR  
ENCOUNTER OUTPATIENT

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients **who** were prescribed or are currently taking medications indicative of diabetes during the measurement period and DRUG\_EXCLUSION = N.

## Numerator: Patients who had a dilated eye exam for diabetic retinal disease at least once within 12 months

### Numerator Inclusions:

Patients who had a dilated eye exam at least once during the measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

EYE EXAM

### OR

Patients who had a dilated eye exam in the year prior to the measurement period without an active diagnosis of diabetic retinopathy in the year prior to the measurement period.

PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

EYE EXAM  
AND NOT  
DIABETIC RETINOPATHY

### Denominator Exclusions: *(Exclusions only applied if the patient has not received a dilated eye exam at least once during the measurement period or a dilated eye exam without diabetic retinopathy in the year prior to the measurement period)*

Patients with an active diagnosis of polycystic ovaries at any time during the patient's history who were prescribed or are currently taking medications indicative of diabetes during the measurement period and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

### AND NOT

Diabetic patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

OR

Patients with an active diagnosis of gestational diabetes or steroid induced diabetes who were prescribed or are currently taking medications indicative of diabetes during the measurement period and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

GESTATIONAL DIABETES

OR

STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes indicative of diabetes.

AND NOT

Diabetic patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

## **Rationale:**

Examination of the eyes is the first step in the treatment of any existing or developing conditions related to retinopathy and the first step in the prevention of blindness.

## **Clinical Recommendation Statements:**

AACE/ACE, ADA, and American Academy of Ophthalmology (AAO): Recommend that a dilated eye examination be performed on patients with diabetes during an initial assessment and at least annually thereafter. (AACE/ACE, 2002; ADA, 2004; AAO, 1998; Hammond, 1998)

American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE): Recommend that the annual eye examination be performed as part of a retinal module. The module includes test of visual acuity (Snellen chart); funduscopy examination and intraocular pressure (IOP) test. The AACE/ACE recommends that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. AACE/ACE further believes that a dilated eye exam should only be done by an MD/DO. (AACE/ACE, 2002)

American Diabetes Association (ADA): Patients with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 3-5 years after the onset of diabetes. In general evaluation for diabetic eye disease is not necessary before 10 years of age. However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be used when applying these recommendations to individual patients. (Level of Evidence: B)

Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after diabetes diagnosis. (Level of Evidence: B)

Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist who is knowledgeable and experienced in diagnosing the presence of diabetic retinopathy and is aware of its management. Examination will be required more frequently if retinopathy is progressing. This follow-up interval is recommended recognizing that there are limited data addressing this issue. (Level of Evidence: B)

Seven standard field stereoscopic 30° fundus photography is an accepted method for examining diabetic retinopathy. (ADA, 2004)

American Academy of Ophthalmology (AAO): Recommends that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. Ophthalmologists with specialized knowledge and experience in managing the disease are best able to detect and treat serious disease. Stereoscopic photographs offer an advantage over nonstereoscopic photographs, and the traditional “seven stereo fields” provide the most complete coverage. (AAO, 1998; Hammond, 1996)

American Geriatrics Society (AGS): Dilated eye examinations should be performed every two years at a minimum, and more often if there are additional risk factors for diabetic eye disease or evidence of age-related eye disease. (CHF/AGS, 2003)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #119 (NQF 0062) HITECH: Diabetes: Urine Screening

**Description:** Percentage of patients aged 18 through 75 years with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy

**Denominator:** All patients aged 18 through 75 years with a diagnosis of diabetes

#### Denominator Inclusions:

All patients with an active diagnosis of diabetes during the measurement period and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT or ENCOUNTER OUTPATIENT – OPTHALMOLOGICAL SERVICES ) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

OR

ENCOUNTER OUTPATIENT-OPHTHAMOLOGICAL SERVICES

AND

DIABETES

OR

All patients between 18 and 75 years of age at the beginning of the measurement period who were prescribed or are currently a medication indicative of diabetes during the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT or ENCOUNTER OUTPATIENT – OPHTHALMOLOGICAL SERVICES) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER ED  
OR  
ENCOUNTER NON-ACUTE INPATIENT  
OR  
ENCOUNTER OUTPATIENT  
OR  
ENCOUNTER OUTPATIENT-OPHTHALMOLOGICAL SERVICES

**AND**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking medications indicative of diabetes during the measurement period and DRUG\_EXCLUSION = N.

**Numerator: Patients who had a nephropathy screening test or evidence of nephropathy during the measurement year**

**Numerator Inclusions:**

Patients who had a nephropathy screening test or evidence of nephropathy at least once during the measurement period.

PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

NEPHROPATHY-RELATED PROCEDURES  
OR  
NEPHROPATHY  
OR  
NEPHROPATHY SCREENING  
OR  
URINE MACROALBUMIN

**OR**

MEDICATIONS tab(s) in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking ACE Inhibitors/ARBs during the measurement period and DRUG\_EXCLUSION = N.

**Denominator Exclusions:** (*Exclusions only applied if the patient has not had a nephropathy screening test or evidence of nephropathy during the measurement period*)

Patients with an active diagnosis of polycystic ovaries at any time during the patient's history who were prescribed or are currently medications indicative of diabetes during the measurement period and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

**AND NOT**

Diabetic patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

OR

ENCOUNTER OUTPATIENT-OPHTHALMOLOGICAL SERVICES

OR

Patients with an active diagnosis of gestational diabetes or steroid induced diabetes who were prescribed or are currently taking medications indicative of diabetes during the measurement period and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

GESTATIONAL DIABETES

OR

STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for medications indicative of diabetes.

**AND NOT**

Diabetic patients who had at least one face-to-face with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

OR

ENCOUNTER OUTPATIENT-OPHTHALMOLOGICAL SERVICES

## Rationale:

This measure assesses the percentage of patients in a specific age demographic who were diagnosed with type 1 or type 2 diabetes and who are susceptible to developing kidney disease as a comorbidity. Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin (NIDDK 2007). It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death (NIDDK 2007). Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including end-stage kidney disease. Diabetes is the primary cause of kidney failure, accounting for 44% of newly diagnosed cases in 2005 (NIDDK 2007). Clinical guidelines recommend regular testing to evaluate urine albumin excretions and serum creatinine and the estimated glomerular filtration rate derived from serum creatinine, in addition to comparing measurements when screening for chronic kidney disease (ADA 2009; ACCE 2007). This measure facilitates the prevention and long-term management of kidney disease for patients diagnosed with diabetes.

## Clinical Recommendation Statements:

American Diabetes Association (ADA), 2009:

Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of  $\geq 5$  years and in all type 2 diabetic patients, starting at diagnosis. (E)

Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate GFR and stage the level of chronic kidney disease (CKD), if present. (E)

In the treatment of the nonpregnant patient with micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used. (A)

American Association of Clinical Endocrinologists (AACE), 2007: Screen all patients with diabetes mellitus for chronic kidney disease annually; screening should begin 5 years after diagnosis in patients with T1DM and at the time of diagnosis in patients with T2DM. Testing includes:

Measurement of albumin-to-creatinine ratio in a spot urine specimen and measurement of the estimated glomerular filtration rate derived from serum creatinine

The following are diagnostic criteria for chronic kidney disease:

Estimated glomerular filtration rate  $< 60$  mL/min/1.73 m<sup>2</sup> or albumin-to-creatinine ratio  $\geq 30$  mg albumin/g creatinine

Microalbuminuria  $\geq 30$  mg albumin/g creatinine

Macroalbuminuria  $\geq 300$  mg albumin/g creatinine (Grade A)

Prescribe an angiotensin-converting enzyme inhibitor or an angiotensin receptor blocker in the antihypertensive regimen in the absence of contraindications. (Grade A)

American Geriatrics Society (AGS), 2003: A test for the presence of microalbumin should be performed at diagnosis in patients with type 2 diabetes mellitus. After the initial screening and in the absence of previously demonstrated macro- or microalbuminuria, a test for the presence of microalbumin should be performed annually. (Level III, Grade A)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### Measure #128 (NQF 0421) HITECH CORE: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

**Description:** Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented

**Normal Parameters:** Age 65 years and older BMI  $\geq 23$  and  $< 30$   
Age 18 – 64 years BMI  $\geq 18.5$  and  $< 25$

**Denominator 1:** All patients aged 65 years and older

#### Denominator Inclusions – Population Stratification 1: (*Patients aged 65 and older*)

All patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

**NOTE:** BMI measured and documented in the medical record can be reported if done in the eligible professional's office/facility or if BMI calculation within the past six months is documented in an outside medical records obtained by the eligible professional. The documentation of a follow-up plan should be based on the most recently calculated BMI.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT CPT WITH CLINICIAN  
OR  
ENCOUNTER OUTPATIENT HCPCS WITH CLINICIAN  
OR  
FOLLOW-UP PLAN BMI MANAGEMENT

**Numerator 1:** Patients with BMI calculated within the past six months or during the current visit and a follow-up plan documented if the BMI is outside of parameters

#### Numerator Inclusions – Population Stratification 1: (*BMI < 30 kg/m<sup>2</sup> AND $\geq 23$ kg/m<sup>2</sup>*)

Patients with most recent Body Mass Index (BMI) calculated within the past six months of the current visit or during the current visit with a normal BMI (less than 30 kg/m<sup>2</sup> AND greater than or equal to 23 kg/m<sup>2</sup>) during the measurement period.

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

BMI  
WITH  
Documentation of BMI < 30 kg/m<sup>2</sup> AND  $\geq 23$  kg/m<sup>2</sup>

OR

Patients with most recent BMI calculated within the past six months or during the current visit with a high BMI (greater than or equal to 30 kg/m<sup>2</sup>) and a follow up plan during the visit documented during the measurement period.

**NOTE:** *A follow-up plan may include documentation of a future appointment, education, referral, prescription/administration of medication/dietary supplements, or weight loss surgery.*

PROBLEMS, PROCEDURES, VITAL SIGNS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**BMI**  
WITH

**Documentation of BMI  $\geq$  30 kg/m<sup>2</sup>**

AND

**FOLLOW-UP PLAN BMI MANAGEMENT**

OR

**DIETARY CONSULTATION ORDER**

OR

Patients with most recent BMI calculated within the past six months or during the current visit with a low BMI (less than 23 kg/m<sup>2</sup>) and a follow up plan during the visit documented during the measurement period.

**NOTE:** *A follow-up plan may include documentation of a future appointment, education, referral, or prescription/administration of medication/dietary supplements.*

PROBLEMS, PROCEDURES, VITAL SIGNS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**BMI**  
WITH

**Documentation of BMI < 23 kg/m<sup>2</sup>**

AND

**FOLLOW-UP PLAN BMI MANAGEMENT**

OR

**DIETARY CONSULTATION ORDER**

## Denominator 2: All patients aged 18 through 64 years

### Denominator Inclusions – Population Stratification 2: (Patients aged 18-64)

All patients between 18 and 64 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

**NOTE:** *BMI measured and documented in the medical record can be reported if done in the eligible professional's office/facility or if BMI calculation within the past six months is documented in outside medical records obtained by the eligible professional. The documentation of a follow-up plan should be based on the most recently calculated BMI.*

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**ENCOUNTER OUTPATIENT CPT WITH CLINICIAN**  
OR  
**ENCOUNTER OUTPATIENT HCPCS WITH CLINICIAN**  
OR  
**FOLLOW-UP PLAN BMI MANAGEMENT**

## Numerator 2: Patients with BMI calculated within the past six months or during the current visit and a follow-up plan documented if the BMI is outside of parameters

### Numerator Inclusions – Population Stratification 2: (BMI < 25 kg/m<sup>2</sup> AND ≥ 18.5 kg/m<sup>2</sup>)

Patients with most recent Body Mass Index (BMI) calculated within the past six months or during the current visit with a normal BMI (less than 25 kg/m<sup>2</sup> AND greater than or equal to 18.5 kg/m<sup>2</sup>) during the measurement period.

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**BMI**  
WITH  
**Documentation of BMI < 25 kg/m<sup>2</sup> AND ≥ 18.5 kg/m<sup>2</sup>**

OR

Patients with most recent BMI calculated within the past six months or during the current visit with a high BMI (greater than or equal to 25 kg/m<sup>2</sup>) and a follow up plan during the visit documented during the measurement period.

**NOTE:** *A follow-up plan may include documentation of a future appointment, education, referral, prescription/administration of medication/dietary supplements, or weight loss surgery.*

PROBLEMS, PROCEDURES, VITAL SIGNS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**BMI**  
WITH  
**Documentation of BMI ≥ 25 kg/m<sup>2</sup>**

AND

**FOLLOW-UP PLAN BMI MANAGEMENT**  
OR  
**DIETARY CONSULTATION ORDER**

OR

Patients with most recent BMI calculated within the past six months or during the current visit with a low BMI (less than 18.5 kg/m<sup>2</sup>) and a follow up plan during the visit documented during the measurement period.

**NOTE:** A follow-up plan may include documentation of a future appointment, education, referral, or prescription/administration of medication/dietary supplements

PROBLEMS, PROCEDURES, VITAL SIGNS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**BMI**  
WITH  
**Documentation of BMI < 18.5 kg/m<sup>2</sup>**

AND

**FOLLOW-UP PLAN BMI MANAGEMENT**  
OR  
**DIETARY CONSULTATION ORDER**

**Denominator Exclusions:** (*Exclusions only applied if the patient did not have a calculated BMI documented in the medical record as normal OR outside parameters with a follow-up plan documented within the past 6 months or during the current visit*)

Patients who have a terminal illness or who are pregnant during a qualifying visit are excluded.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**TERMINAL ILLNESS**  
OR  
**PREGNANCY**

OR

When a BMI measurement is not performed during the measurement period for a valid medical, patient or system reason, the BMI measurement that would have been performed should be submitted along with a negation code to indicate the reason the BMI measurement was not performed during the qualifying visit during the measurement period.

VITAL SIGNS and VITAL SIGNS(negation) tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**BMI**  
  
AND  
**MEDICAL REASON**  
OR  
**PATIENT REASON**  
OR  
**SYSTEM REASON**

## Rationale:

### BMI Above Upper Parameter

In 2009, no U.S. state met the Healthy People 2010 adult obesity prevalence target of 15 percent, and the number of states with an obesity prevalence  $\geq 30$  increased from zero in 2000 to 9 in 2009 (CDC, 2010). Further, the report revealed that the overall self-reported obesity prevalence in the United States was 26.7 percent, an increase of 1.1 percentage points from 2007 to 2009 among adults aged 18 years or older.

Obesity continues to be a public health concern in the United States and throughout the world. In the United States, obesity prevalence doubled among adults between 1980 and 2004 (Flegal, et al, 2002; Ogden, et al, 2006). Obesity is associated with increased risk of a number of conditions, including diabetes mellitus, cardiovascular disease, hypertension, and certain cancers, and with increased risk of disability and a modestly elevated risk of all-cause mortality. With obesity on the rise, the medical community anticipates an increase in the complications of obesity, including type 2 diabetes mellitus, hypertension, dyslipidemia, cardiovascular disease, obstructive sleep apnea, degenerative arthritis, non-alcoholic steatohepatitis, gallbladder disease and others.

Results from the 2005-2006 National Health and Nutrition Examination Survey (NHANES) indicate that an estimated 32.7 percent of U.S. adults 20 years and older are overweight, 34.3 percent are obese and 5.9 percent are extremely obese. Although the prevalence of adults in the U.S. who are obese is still high with about one-third of adults obese in 2007-2008, new data suggest that the rate of increase for obesity in the U.S. in recent decades may be slowing (Flegal, et al, 2010).

Finkelstein, et al. (2009), found increased prevalence of obesity is responsible for almost \$40 billion of increased medical spending through 2006, including \$7 billion in Medicare prescription drug costs. We estimate the medical costs of obesity may rise to \$147 billion per year by 2008.

Ma, et al (2009) performed a retrospective, cross-sectional analysis of ambulatory visits in the National Ambulatory Medical Care Survey from 2005 and 2006. The study findings on obesity and office-based quality of care concluded the evidence is compelling that obesity is underappreciated in office-based physician practices across the United States. Many opportunities are missed for obesity screening and diagnosis, as well as for the prevention and treatment of obesity and related health risks, regardless of patient and provider characteristics.

### BMI Below Normal Parameter

Poor nutrition or underlying health conditions can result in underweight. Results from the 2003-2006 National Health and Nutrition Examination Survey (NHANES, 2009), using measured heights and weights, indicate an estimated 1.8% of U.S. adults are underweight. A tremendous gap still exists between our knowledge of malnutrition, its sequelae and our actions in preventing and treating malnutrition. To date professionals in various disciplines have applied their own approaches to solving the problem. Yet the causes of malnutrition are multi-factorial and the solutions demand an integration of knowledge and expertise from the many different disciplines involved in geriatric care. Older people have special nutritional needs due to age and disease processes.

Elderly patients with unintentional weight loss are at higher risk for infection, depression and death. The leading causes of involuntary weight loss are depression (especially in residents of long-term care facilities), cancer (lung and gastrointestinal malignancies), cardiac disorders and benign gastrointestinal diseases. Medications that may cause nausea and vomiting, dysphagia, dysgeusia and anorexia have been implicated. Polypharmacy can cause unintended weight loss, as can psychotropic medication reduction (e.g., by unmasking problems such as anxiety). In one study it was found that a BMI of less than 22 kg per m<sup>2</sup> in women and less than 23.5 in men is associated with increased mortality. The optimal BMI in the elderly is 24 to 29 kg per m<sup>2</sup>. (In an observational study, Ranhoff, et al. (2005) identified using a BMI < 23, resulted in a positive screen for malnutrition (sensitivity 0.86, specificity 0.71), giving 0.75 correctly classified subjects, thus leading to the recommendation that a score of BMI < 23 should be followed by MNA-SF when the aim is to identify poor nutritional status in elderly.

## **Clinical Recommendation Statements:**

Although multiple clinical recommendations addressing Obesity have been developed by professional organizations, societies and associations, two recommendations, which exemplify the intent of the measure and address the numerator and denominator, have been identified.

The US Preventive Health Services Task Force (USPSTF) (2003) recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (Level Evidence B).

Institute for Clinical Systems Improvement (ICSI) (2009) Prevention and Management of Obesity (Mature Adolescents and Adults) provides the following guidance:

- Calculate the body mass index; classify the individual based on the body mass index categories. Educate patients about their body mass index and their associated risks.
- Weight management requires a team approach. Be aware of clinical and community resources. The patient needs to have an ongoing therapeutic relationship and follow-up with a health care team.
- Weight control is a lifelong commitment, and the health care team can assist with setting specific goals with the patient.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #163 (NQF 0056) HITECH: Diabetes Mellitus: Foot Exam

**Description:** The percentage of patients aged 18 through 75 years with diabetes who had a foot examination

**Denominator:** Patients aged 18 through 75 years with a diagnosis of diabetes

#### Denominator Inclusions:

All patients with an active diagnosis of diabetes during the measurement period and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT or ENCOUNTER OUTPATIENT – OPHTHALMOLOGICAL SERVICES) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

OR

ENCOUNTER OUTPATIENT-OPHTHALMOLOGICAL SERVICES

AND

DIABETES

OR

All patients between 18 and 75 years of age at the beginning of the measurement period who were prescribed or are currently taking a medication indicative of diabetes during the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT or ENCOUNTER OUTPATIENT – OPTHALMOLOGICAL SERVICES) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

OR

ENCOUNTER OUTPATIENT-OPHTHALMOLOGICAL SERVICES

#### AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking medications indicative of diabetes during the measurement period and DRUG\_EXCLUSION = N.

**Numerator: Patients who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam)**

#### Numerator Inclusions:

Patients who received a foot exam during the measurement period.

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

FOOT EXAM

**Denominator Exclusions:** (*Exclusions only applied if the patient has not received a foot exam at least once during the measurement period*)

Patients with an active diagnosis of polycystic ovaries at any time during the patient's history who were prescribed or are currently taking medications indicative of diabetes during the measurement period and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

#### AND NOT

Diabetic patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

OR

ENCOUNTER OUTPATIENT-OPHTHALMOLOGICAL SERVICES

OR

Patients with an active diagnosis of gestational diabetes or steroid induced diabetes who were prescribed or are currently taking medications indicative of diabetes during the measurement period and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

GESTATIONAL DIABETES

OR

STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for medications indicative of diabetes.

AND NOT

Diabetic patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

OR

ENCOUNTER OUTPATIENT-OPHTHALMOLOGICAL SERVICES

OR

Patients with a bilateral foot/leg amputation at any time in the patient's history before or during a qualifying visit.

PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ABSENCE OF LEG/FOOT

**Rationale:**

The most common consequences of diabetic neuropathy are amputation and foot ulceration. (ADA, 2006) In developed countries, up to five percent of diabetic patients have foot ulcers. (IDF, 2005) One in every six diabetics will have an ulcer during their lifetime. (IDF, 2005) Amputation and foot ulceration are also major causes of morbidity and mortality. One half to 80% of all amputations are diabetes-related. (Mayfield, 1998; Reiber, 1995; ADA, 2001; Unwin, 2000) The risk of ulcers or amputations increases the longer someone has diabetes. Early recognition and management of risk factors can prevent or delay adverse outcomes. (ADA, 2006)

**Clinical Recommendation Statements:**

American Association of Clinical Endocrinologists/American College of Endocrinology (AAACE/ACE) and American Diabetes Association (ADA) recommend that a foot examination (visual inspection, sensory exam, and pulse exam) be performed during an initial assessment.

AAACE/ACE (2002) recommends that a foot examination be a part of every follow-up assessment visit, which should occur quarterly.

ADA (2004) recommends that all individuals with diabetes should receive an annual foot examination to identify high-risk foot conditions. This examination should include assessment of protective sensation, foot structure and biomechanics, vascular status, and skin integrity.

The ADA (2004) recommends that people with one or more high-risk foot conditions should be evaluated more frequently for the development of additional risk factors. People with neuropathy should have a visual inspection of their feet at every contact with a health care professional.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ▲Measure #173: Preventive Care and Screening: Unhealthy Alcohol Use-Screening

**Description:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic method within 24 months

**Denominator:** All patients aged 18 years and older

#### Denominator Inclusions:

All patients greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

**Numerator:** Patients who were screened for unhealthy alcohol use using a systematic screening method within 24 months

#### Numerator Inclusions:

Patients who were screened for unhealthy alcohol use using a systematic screening method during the measurement period or the year prior to the measurement period.

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL ABUSE SCRNI

**Denominator Exclusions:** *(Exclusions only applied if patients were not screened for unhealthy alcohol use during the measurement period or year prior)*

Patients who had one of the following active conditions during the measurement period or year prior to the measurement period.

PROBLEMS tabs in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

OR

MEDICAL REASON

**Rationale:**

Screening for unhealthy alcohol use can identify patients whose habits may put them at risk for adverse health outcomes due to their alcohol use. While this measure does not require counseling for those patients to be found at risk, brief counseling interventions for unhealthy alcohol use have shown to be effective in reducing alcohol use. It would be expected that if a provider found their patient to be at risk after screening that intervention would be provided.

A systematic method of assessing for unhealthy alcohol use should be utilized. Please refer to the National Institute on Alcohol Abuse and Alcoholism publication: *Helping Patients Who Drink Too Much: A Clinician's Guide* for additional information regarding systematic screening methods.

**Clinical Recommendation Statements:**

The USPSTF strongly recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. (B Recommendation) (USPSTF, 2004)

During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (NQF, 2007)

All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive brief motivational counseling intervention by a healthcare worker trained in this technique. (NQF, 2007)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ► Measure #197 (NQF 0074) HITECH: Coronary Artery Disease (CAD): Lipid Control

**Description:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result  $\geq$  100 mg/dL and have a documented plan of care to achieve LDL-C < 100 mg/dL, including at a minimum the prescription of a statin

**Denominator:** All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period

#### Denominator Inclusions:

All patients with an active diagnosis of coronary artery disease (CAD) during the measurement period OR had a cardiac surgery at any time before or during their last qualifying visit and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the same eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY  
OR  
ENCOUNTER OUTPATIENT

AND

CORONARY ARTERY DISEASE INCLUDES MI  
OR  
CARDIAC SURGERY

**Numerator:** Patients who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result  $\geq$  100 mg/dL AND have a documented plan of care to achieve LDL-C < 100 mg/dL, including at a minimum the prescription of a statin

#### Numerator Inclusions:

Patients with most recent LDL-C test result less than 100 mg/dL during the measurement period

RESULTS tab in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

LDL LABORATORY TEST  
WITH  
*Documentation of LDL < 100 mg/dL*

OR

Patients with most recent LDL-C test result greater than or equal to 100 mg/dL during the measurement period AND have a documented plan of care to achieve LDL-C less than 100 mg/dL AND had a statin prescribed.

**NOTE:** Documented plan of care includes the prescription of a statin and may also include: documentation of discussion of lifestyle modifications (diet, exercise) or scheduled re-assessment of LDL-C. Prescribed may include prescription given to the patient for a statin at one or more visits within the measurement period OR patient already taking a statin as documented in current medication list

RESULTS, and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

**LDL LABORATORY TEST**

WITH

**Documentation of LDL  $\geq$  100 mg/dL**

AND

**PLAN OF CARE TO LOWER LDL**

AND

MEDICATIONS Tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking statin therapy during the measurement period and DRUG\_EXCLUSION = N.

**Denominator Exclusions:** (Exclusions only applied if the patient has not been prescribed statin therapy during the measurement period)

When the statin therapy is not prescribed for a valid medical, patient or system during the measurement period, the appropriate medication that would have been prescribed should be submitted along with a negation code to indicate the reason the statin therapy was not ordered received during the measurement period.

**NOTE:** When submitting the medication that the patient did not receive, the medication status may be identified as inactive.

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for the statin therapy.

AND

**MEDICAL REASON**

OR

**PATIENT REASON**

OR

**SYSTEM REASON**

OR

When statin therapy was not prescribed due to patient allergy, adverse effects, or intolerance identified at any time before or during their last qualifying visit, the medication that the patient would have been prescribed should be submitted along with negation code to indicate the reason the statin therapy was not ordered or received during the measurement period.

*NOTE: When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for the statin therapy.

**AND**

**MEDICATION ALLERGY**

**OR**

**MEDICATION ADVERSE EFFECTS**

**OR**

**MEDICATION INTOLERANCE**

**Rationale:**

Studies have demonstrated that active treatment with lipid-lowering therapy is associated with stabilization and regression of coronary atherosclerotic plaques and decreased incidence of clinical events. Recent clinical trials have further documented that LDL-lowering agents can decrease the risk of adverse ischemic events in patients with established CAD.

**Clinical Recommendation Statements:**

The LDL-C treatment goal is <100 mg/dl. Persons with established coronary heart disease (CHD) who have a baseline LDL-C  $\geq$ 130 mg/dl should be started on a cholesterol-lowering drug simultaneously with therapeutic lifestyle changes and control of nonlipid risk factors (National Cholesterol Education Program. [NCEP])

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ► Measure #200 (NQF 0084) HITECH: Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation

**Description:** Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy

**Denominator:** All heart failure patients aged 18 years and older with paroxysmal or chronic atrial fibrillation

#### Denominator Inclusions:

All patients with an active diagnosis of heart failure during the measurement period and an active diagnosis of atrial fibrillation during the measurement period and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the same eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY

OR

ENCOUNTER OUTPATIENT

AND

HEART FAILURE

AND

ATRIAL FIBRILLATION

**Numerator:** Patients who were prescribed warfarin therapy

#### Numerator Inclusions:

MEDICATIONS Tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking warfarin therapy during the measurement period and DRUG\_EXCLUSION = N.

**Denominator Exclusions:** (*Exclusions only applied if the patient has not been prescribed warfarin therapy at least once during the measurement period*)

When the warfarin therapy is not prescribed during the measurement period for a valid medical, patient or system reason, the appropriate medication that would have been prescribed should be submitted along with a negation code to indicate the reason the lipid-lowering therapy was not prescribed during the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for the warfarin therapy.

**AND**

MEDICAL REASON

OR

PATIENT REASON

OR

SYSTEM REASON

**OR**

When warfarin therapy is not prescribed due to allergy, adverse effects, or intolerance, the appropriate medication that the patient is not prescribed should be submitted along with a negation code to indicate the reason the warfarin therapy was not prescribed at any time before or during a qualifying encounter in the measurement period.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for the warfarin therapy.

**AND**

MEDICATION ALLERGY

OR

MEDICATION ADVERSE EFFECTS

OR

MEDICATION INTOLERANCE

**OR**

Patients who had one of the following conditions diagnosed before or during their last qualifying visit during the measurement period and the condition is active during their last qualifying visit.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ANEMIAS AND BLEEDING DISORDERS

OR

ESOPHAGEAL AND GI BLEED

OR

INTRACRANIAL HEMORRHAGE

OR

LEUKEMIAS/MYELOPROLIFERATIVE DISORDERS

OR

HEMATURIA

OR

HEMOPTYSIS

OR

HEMORRHAGE

OR

LIVER DISORDERS

**OR**

MEDICATIONS Tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or currently taking dabigatran therapy during the measurement period and DRUG\_EXCLUSION = Y

**Rationale:**

Adjusted-dose warfarin is highly efficacious in preventing thromboembolism in patients with AF and should be prescribed for all patients with AF and heart failure except those with contraindications to anticoagulation.

**Clinical Recommendation Statements:**

Physicians should prescribe anticoagulants in patients with HF who have paroxysmal or persistent atrial fibrillation or a previous thromboembolic event. (Class I, Level of Evidence: A)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #201 (NQF 0073) HITECH: Ischemic Vascular Disease (IVD): Blood Pressure Management Control

**Description:** Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who had most recent blood pressure in control (less than 140/90 mmHg)

**Denominator:** Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)

#### Denominator Inclusions:

All patients with an active diagnosis of IVD during the measurement period OR PTCA performed January 1 through November 1 of the year prior to the measurement period and a qualifying visit OR an active diagnosis of AMI during an inpatient encounter January 1 through November 1 of the year prior to the measurement period OR CABG performed during an inpatient encounter January 1 through November 1 of the year prior to the measurement period and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER OUTPATIENT

AND

ISCHEMIC VASCULAR DISEASE

OR

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER OUTPATIENT

AND

PTCA

OR

ENCOUNTER ACUTE INPT  
AND  
ACUTE MYOCARDIAL INFARCTION

OR

ENCOUNTER ACUTE INPT  
AND  
CABG

## Numerator: Patients whose most recent blood pressure < 140/90 mmHg

### Numerator Inclusions:

Patients who had a most recent blood pressure less than 140/90 mmHg during the last qualifying visit during the measurement period.

**NOTE:** *Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.*

ENCOUNTERS and VITAL SIGNS tab(s) in the Downloadable Resource table lists applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT

OR

ENCOUNTER OUTPATIENT

AND

SYSTOLIC BLOOD PRESSURE

WITH

*Documentation of Systolic BP < 140 mm[Hg]*

AND

DIASTOLIC BLOOD PRESSURE

WITH

*Documentation of Diastolic BP < 90 mm[Hg]*

### Denominator Exclusions:

None

**Rationale:**

Fifty million or more Americans have high blood pressure that warrants treatment, according to the NHANES survey (JNC-7, 2003). The USPSTF recommends that clinicians screen adults aged 18 and older for high blood pressure (USPSTF, 2007).

The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. The increased risks of hypertension are present in individuals ranging from 40 to 89 years of age. For every 20 mmHg systolic or 10 mmHg diastolic increase in BP, there is a doubling of mortality from both IHD and stroke. (JNC-7, 2003)

Better control of BP has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. Thus, the relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established. In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence (35-40%), myocardial infarction (20-25%) and heart failure. (>50%) (JNC-7, 2003)

**Clinical Recommendation Statements:**

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older.

The JNC-7 indicates that treating systolic BP and diastolic BP to targets that are <140/90 mmHg is associated with a decrease in CVD complications.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #204 (NQF 0068) HITECH: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

**Description:** Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or other antithrombotic

**Denominator:** Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)

#### Denominator Inclusions:

All patients with an active diagnosis of IVD during the measurement period OR PTCA performed January 1 through November 1 of the year prior to the measurement period and a qualifying visit OR an active diagnosis of AMI during an inpatient encounter January 1 through November 1 of the year prior to the measurement period OR CABG performed during an inpatient encounter January 1 through November 1 of the year prior to the measurement period and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER OUTPATIENT

AND

ISCHEMIC VASCULAR DISEASE

OR

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER OUTPATIENT

AND

PTCA

OR

ENCOUNTER ACUTE INPT  
AND  
ACUTE MYOCARDIAL INFARCTION

OR

ENCOUNTER ACUTE INPT  
AND  
CABG

## Numerator: Patients who are using aspirin or another antithrombotic therapy

### Numerator Inclusions:

MEDICATIONS Tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking oral anti-platelet therapy during the measurement period and DRUG\_EXCLUSION = N.

### Denominator Exclusions:

None

## **Rationale:**

Aspirin therapy has been shown to directly reduce 14% of the odds of cardiovascular events among men and 12% of the odds for women (Berger, 2006). Aspirin use reduced the number of strokes by 20%, MI by 30%, and other vascular events by 30%. (Weisman, 2002) Also, aspirin treatments have been shown to prevent 1 cardiovascular event over an average follow-up of 6.4 years. This means that on average in a 6.4 year time period the use of aspirin therapy results in a benefit of 3 cardiovascular events prevented per 1000 women and 4 events prevented per 1000 men. (Berger, 2006) Even for patients with peripheral arterial disease, aspirin has been shown to reduce CHD in people. (Kikano, 2007)

## **Clinical Recommendation Statements:**

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians discuss aspirin chemoprevention with adults who are at increased risk (5-year risk of greater than or equal to 3 percent) for coronary heart disease (CHD). Discussions with patients should address both the potential benefits and harms of aspirin therapy.

The USPSTF found good evidence that aspirin decreases the incidence of coronary heart disease in adults who are at increased risk for heart disease. They also found good evidence that aspirin increases the incidence of gastrointestinal bleeding and fair evidence that aspirin increases the incidence of hemorrhagic strokes. The USPSTF concluded that the balance of benefits and harms is most favorable in patients at high risk of CHD (5-year risk of greater than or equal to 3 percent) but is also influenced by patient preferences.

USPSTF encourages men age 45 to 79 years to use aspirin when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage. They encourage women age 55 to 79 years to use aspirin when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.

The ADA recommends use aspirin therapy (75-162 mg/day) as a primary prevention strategy in those with type 1 or 2 diabetes at increased cardiovascular risk, including those who are 40 years of age or who have additional risk factors (family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria).

AHA/ACC: Start aspirin 75 to 162 mg/d and continue indefinitely in all patients with coronary and other vascular disease unless contraindicated.

ICSI: Aspirin should be prescribed to all patients with stable coronary disease. If a patient is aspirin intolerant, then use clopidogrel.

VA/DoD: Ensure that all patients with ischemic heart disease or angina symptoms receive antiplatelet therapy (aspirin 81-325 mg/day). For patients who require warfarin therapy, aspirin may be safely used at a dose of 80 mg/day. If use of aspirin is contraindicated, clopidogrel (75 mg/day) may be used.

AHA/ASA: The use of aspirin is recommended for cardiovascular (including but not specific to stroke) prophylaxis among persons whose risk is sufficiently high for the benefits to outweigh the risks associated with treatment (a 10-year risk of cardiovascular events of 6% to 10%).

ACCP: For long-term treatment after PCI, the guideline developers recommend aspirin, 75 to 162 mg/day. For long-term treatment after PCI in patients who receive anti-thrombotic agents such as clopidogrel or warfarin, the guideline developers recommend lower-dose aspirin, 75 to 100 mg/day. For patients with ischemic stroke who are not receiving thrombolysis, the guideline developers recommend early aspirin therapy, 160 to 325 mg/day.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ▲ Measure #226 (NQF 0028) HITECH CORE: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

**Description:** Percentage of patients aged 18 years or older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

**Denominator 1:** All patients aged 18 years and older

#### Denominator Inclusions 1:

All patients greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER PREV MED GROUP COUNSELING, ENCOUNTER PREV MED OTHER SERVICES, ENCOUNTER PREV MED SERVICES 18 AND OLDER, ENCOUNTER PREV MED 40 & OLDER or ENCOUNTER PREV MED – INDIVIDUAL COUNSELING) OR at least two face-to-face visits (ENCOUNTER HEALTH AND BEHAVIOR ASSESSMENT, ENCOUNTER OCCUPATIONAL THERAPY, ENCOUNTER OFFICE VISIT, or ENCOUNTER PSYCHIATRIC & PSYCHOLOGIC) with the same eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER PREV MED GROUP COUNSELING  
OR  
ENCOUNTER PREV MED OTHER SERVICES  
OR  
ENCOUNTER PREV MED SERVICES 18 AND OLDER  
OR  
ENCOUNTER PREV MED 40 & OLDER  
OR  
ENCOUNTER PREV MED – INDIVIDUAL COUNSELING  
OR  
ENCOUNTER HEALTH AND BEHAVIOR ASSESSMENT  
OR  
ENCOUNTER OCCUPATIONAL THERAPY  
OR  
ENCOUNTER OFFICE VISIT  
OR  
ENCOUNTER PSYCHIATRIC & PSYCHOLOGIC

## Numerator 1: Patients who were screened for tobacco use\* at least once within 24 months

### Numerator Inclusions 1:

Patients who were screened for tobacco use\* before or during a qualifying visit at least once during the measurement period or within the 24 months prior to the last qualifying visit during the measurement period.

\* Includes use of any type of tobacco

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

TOBACCO USER  
OR  
TOBACCO NON-USER

**AND**

## Denominator 2: All patients aged 18 years and older who were identified as tobacco users

### Denominator Inclusions 2:

All patients who were identified as tobacco users during a qualifying visit in the measurement period and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER PREV MED GROUP COUNSELING, ENCOUNTER PREV MED OTHER SERVICES, ENCOUNTER PREV MED SERVICES 18 AND OLDER, ENCOUNTER PREV MED 40 & OLDER or ENCOUNTER PREV MED – INDIVIDUAL COUNSELING) OR at least two face-to-face visits (ENCOUNTER HEALTH AND BEHAVIOR ASSESSMENT, ENCOUNTER OCCUPATIONAL THERAPY, ENCOUNTER OFFICE VISIT, or ENCOUNTER PSYCHIATRIC & PSYCHOLOGIC) with the same eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER PREV MED GROUP COUNSELING  
OR  
ENCOUNTER PREV MED OTHER SERVICES  
OR  
ENCOUNTER PREV MED SERVICES 18 AND OLDER  
OR  
ENCOUNTER PREV MED 40 & OLDER  
OR  
ENCOUNTER PREV MED – INDIVIDUAL COUNSELING  
OR  
ENCOUNTER HEALTH AND BEHAVIOR ASSESSMENT  
OR  
ENCOUNTER OCCUPATIONAL THERAPY  
OR  
ENCOUNTER OFFICE VISIT  
OR  
ENCOUNTER PSYCHIATRIC & PSYCHOLOGIC

AND

TOBACCO USER

## Numerator 2: Patients who received tobacco cessation counseling intervention\*\*

### Numerator Inclusions 2:

Patients who received tobacco cessation counseling intervention\*\* before or during a qualifying visit at least once during the measurement period or within 24 months prior to the last qualifying visit during the measurement period.

*\*\* Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy*

PROBLEMS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

TOBACCO USE CESSATION COUNSELING

### OR

MEDICATIONS Tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently using prescribed smoking cessation agents before or during a qualifying visit during the current year or year prior and DRUG\_EXCLUSION = N.

### Denominator Exclusions:

None

**Rationale:**

There is good evidence that tobacco screening and brief cessation intervention (including counseling and pharmacotherapy) in the primary care setting is successful in helping tobacco users quit (USPSTF, 2003). Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke. (USPSTF, 2003)

**Clinical Recommendation Statements:**

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (USPSTF, 2003)

During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (NQF, 2007)

All patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

All *physicians* should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #236 (NQF 0018) HITECH: Hypertension (HTN): Controlling High Blood Pressure

**Description:** Percentage of patients aged 18 through 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mmHG)

**Denominator:** Patients aged 18 through 85 years with the diagnosis of hypertension

#### Denominator Inclusions:

All patients with an active diagnosis of hypertension within the *first six months* of the measurement period and patient is between 18 and 85 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT  
AND  
HYPERTENSION

#### AND NOT

Patients with an active diagnosis of end stage renal disease (ESRD), who had a procedure indicative of ESRD or who are pregnant during the measurement period.

PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ESRD  
OR  
PROCEDURES INDICATIVE OF ESRD  
OR  
PREGNANCY

## Numerator: Patients whose most recent blood pressure < 140/90 mmHg

### Numerator Inclusions:

Patients who had their blood pressure taken at the most recent visit during the measurement period and blood pressure measurement was less than 140/90 mmHg during the measurement period.

**NOTE:** *Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.*

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**SYSTOLIC BLOOD PRESSURE**

WITH

*Documentation of Systolic BP < 140 mm[Hg]*

AND

**DIASTOLIC BLOOD PRESSURE**

WITH

*Documentation of Diastolic BP < 90 mm[Hg]*

### Denominator Exclusions:

None

**Rationale:**

This measure assesses the percentage of patients demonstrating adequate control of systolic and diastolic blood pressure levels. Over 50 million Americans warrant treatment for high blood pressure, according to the NHANES survey (JNC-7 2003). Financially, hypertension and associated disorders and health complications, such as coronary heart disease and congestive heart failure, cost the U.S. economy more than \$100 billion each year. The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen adults 18 and older for high blood pressure. (2007) This guideline is further endorsed by research studies and clinical trials that have demonstrated decline in costly health outcomes as a direct result of improved blood pressure control. This measure is important in efforts to promote blood pressure control and improve quality of life.

**Clinical Recommendation Statements:**

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation JNC-7: Treating SBP and DBP to targets that are <140/90 mmHg is associated with a decrease in CVD complications.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ▲ Measure #237 (NQF 0013) HITECH CORE: Hypertension (HTN): Blood Pressure Measurement

**Description:** Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension with blood pressure (BP) recorded

**Denominator:** All visits for patients aged 18 years and older with a diagnosis of HTN

#### Denominator Inclusions:

All patient visits with an active diagnosis of hypertension at any time before or during the measurement period and the patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face visits with the same eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER NURSING FACILITY  
OR  
ENCOUNTER OUTPATIENT

AND

HYPERTENSION

**Numerator:** Patient visits with blood pressure measurement recorded

#### Numerator Inclusions:

Patient visits with a blood pressure measurement recorded during a qualifying visit during the measurement period.

**NOTE:** Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SYSTOLIC BLOOD PRESSURE  
WITH  
*Documentation of Systolic BP mm[Hg]*

AND

DIASTOLIC BLOOD PRESSURE  
WITH  
*Documentation of Diastolic BP mm[Hg]*

#### Denominator Exclusions:

None

**Rationale:**

Data from the National Health and Nutrition Examination Survey (NHANES) have indicated that 50 million or more Americans have high blood pressure (BP) warranting some form of treatment. Worldwide prevalence estimates for hypertension may be as much as 1 billion individuals, and approximately 7.1 million deaths per year may be attributable to hypertension. The World Health Organization reports that suboptimal BP (>115 mm Hg SBP) is responsible for 62% of cerebrovascular disease and 49% of ischemic heart disease, with little variation by sex. In addition, suboptimal blood pressure is the number one attributable risk for death throughout the world. (JNC 7: Complete Report)

Hypertension is an increasingly important medical and public health issue. The prevalence of hypertension increases with advancing age to the point where more than half of people aged 60 to 69 years old and approximately three-fourths of those aged 70 years and older are affected. The age-related rise in SBP is primarily responsible for an increase in both incidence and prevalence of hypertension with increasing age. (JNC 7: Complete Report)

**Clinical Recommendation Statements:**

Obtaining proper blood pressure (BP) measurements at each health care encounter is recommended for hypertension detection. Repeated BP measurements ( $\geq 2$  per patient visit) will determine if initial elevations persist and require prompt attention (Level 1 Recommendation, Level-C Evidence)

Classification of adult BP (including stages 1-3 of hypertension) is useful for making treatment decisions and is based on the average of  $\geq 2$  readings taken at each of 2 or more visits after an initial screening.

Hypertension is defined as systolic BP of 140 mm Hg or greater, diastolic BP of 90 mm Hg or greater or taking antihypertensive medication.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #238 (NQF 0022) HITECH: Drugs to be Avoided in the Elderly

**Description:** Percentage of patients ages 65 years and older who received at least one drug to be avoided in the elderly and/or two different drugs to be avoided in the elderly in the measurement period

**Denominator:** All patients ages 65 years and older

#### Denominator Inclusions:

All patients greater than or equal to 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**ENCOUNTER OUTPATIENT**

**Numerator:** Patients who received at least one drug to be avoided in the elderly and/or two different drugs to be avoided in the elderly in the measurement period

#### Numerator Inclusion – Option #1: (Received one drug to be avoided in the elderly)

**NOTE:** For performance, a lower rate indicates better performance/control.

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking drugs to be avoided in the elderly (Amphetamines; Analgesics; Anti Anxiety; Antiemetics; Antihistamines; Antipsychotic, typical; Barbiturates; Belladonna alkaloids; Calcium channel blockers; Gastrointestinal anti-spasmodics; Long-acting benzodiazepines; Narcotics; Oral estrogens; oral hypoglycemic; Other (Desiccated Thyroid; Methyltestosterone; Nitrofurantoin group); Skeletal muscle relaxants; Vasodilators) during the measurement period and DRUG\_EXCLUSION = N.

OR

#### Numerator Inclusion – Option #2: (Received at least two different drugs to be avoided in the elderly)

**NOTE:** For performance, a lower rate indicates better performance/control.

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking at least **two different** drugs to be avoided in the elderly (Amphetamines; Analgesics; Anti Anxiety; Antiemetics; Antihistamines; Antipsychotic, typical; Barbiturates; Belladonna alkaloids; Calcium channel blockers; Gastrointestinal anti-spasmodics; Long-acting benzodiazepines; Narcotics; Oral estrogens; oral hypoglycemic; Other (Desiccated Thyroid; Methyltestosterone; Nitrofurantoin group); Skeletal muscle relaxants; Vasodilators) during the measurement period and DRUG\_EXCLUSION = N.

#### Denominator Exclusions:

None

## **Rationale:**

Despite widely-accepted medical consensus that certain drugs increase the risk of harm to the elderly and should generally be avoided, (Fick, 2003) these drugs are still frequently prescribed to the elderly. Studies have found that 21% to almost 37% of elderly patients filled at least one potentially inappropriate prescription and more than 15% filled at least two (Curtis, 2004 and Simon, 2005). A study of elderly managed care patients found that almost 29% receive at least one potentially inappropriate medication (Simon, 2005). While some drugs are generally appropriate to prescribe in the elderly, the side-effects commonly associated with these drugs pose an extra risk to elderly people with certain pre-existing conditions. For example, the unsteadiness (ataxia) frequently associated with antidepressants may be a particular danger for elderly patients with a history of falls. Clinical guidelines identify drugs that are generally inappropriate for the elderly, as well as drugs that are inappropriate for elderly populations with specific diagnoses or conditions (Fick, 2003).

Seniors receiving inappropriate medications are more likely to report poorer health status at follow-up, compared to seniors who receive appropriate medications (Fu, 2004). In 2005, rates of potentially inappropriate medication use in the elderly were as large or larger than in a 1996 national sample, highlighting the need for progress in this area (Simon, 2005). While some adverse drug events are not preventable, studies estimate that between 30% and 80% of adverse drug events in the elderly are preventable (MacKinnon, 2003).

Reducing the number of inappropriate prescriptions can lead to improved patient safety and significant cost savings. Conservative estimates of extra costs due to potentially inappropriate medications in the elderly average \$7.2 billion a year (Fu, 2004).

## **Clinical Recommendation Statements:**

The measure is based on the literature and key clinical expert consensus processes by Beers in 1997, Zahn in 2001 and an updated process by Fick in 2003, which identified drugs of concern in the elderly based on various high-risk criteria. NCOA's Medication Management expert panel selected a subset of drugs that should be used with caution in the elderly for inclusion in the proposed measure based upon these two lists. NCOA analyzed the prevalence of drugs prescribed according to their Beers and Zhan's classifications and determined that drugs identified by Zhan that are classified as never or rarely appropriate would form the basis for the list (Fick, 2003). Certain medications (MacKinnon, 2003) are associated with increased risk of harms from drug side-effects and drug toxicity and pose a concern for patient safety. There is clinical consensus that these drugs pose increased risks in the elderly (Kaufman, 2005). Studies link prescription drug use by the elderly with adverse drug events that contribute to hospitalization, increased length of hospital stay, increased duration of illness, nursing home placement and falls and fractures that are further associated with physical, functional and social decline in the elderly (AHRQ, 2009).

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #239 (NQF 0024) HITECH ALT CORE: Weight Assessment and Counseling for Children and Adolescents

**Description:** Percentage of children 2 through 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement period

**Denominator:** All patients aged 2 through 17 years

#### Denominator Inclusion – Population Stratification 1: (*Patients aged 2-17*)

All patients between 2 and 17 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face office visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OB/GYN

OR

ENCOUNTER OUTPATIENT

#### AND NOT

Patients who are pregnant during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER PREGNANCY

OR

PREGNANCY

#### Denominator Inclusion – Population Stratification 2: (*Patients aged 2-11*)

All patients between 2 and 11 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face office visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OB/GYN

OR

ENCOUNTER OUTPATIENT

#### AND NOT

Patients who are pregnant during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER PREGNANCY

OR

PREGNANCY

### Denominator Inclusion – Population Stratification 3: *(Patients aged 12-17)*

All patients between 12 and 17 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face office visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OB/GYN

OR

ENCOUNTER OUTPATIENT

#### AND NOT

Patients who are pregnant during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER PREGNANCY

OR

PREGNANCY

### Numerator: Patients who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement period

#### Numerator Inclusion – Criterion #1: *(BMI percentile recorded)*

Patients with Body Mass Index (BMI) percentile for age and gender documented during the measurement period.

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

BMI PERCENTILE

WITH

*Documentation of BMI percentile for age and gender (%)*

AND

**Numerator Inclusion – Criterion #2: (*Counseling for nutrition performed*)**

Patients who were counseled based on their nutrition during the measurement period.

PROBLEMS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

COUNSELING FOR NUTRITION

**AND**

**Numerator Inclusion – Criterion #3: (*Counseling for physical activity performed*)**

Patients who were counseled based on their physical activity during the measurement period.

PROBLEMS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

COUNSELING FOR PHYSICAL ACTIVITY

**Denominator Exclusions:**

None

**Rationale:**

This measure assesses the percentage of age-appropriate patients who had an outpatient visit with a PCP or OB/GYN and who had evidence of a BMI percentile assessment, counseling for nutrition or counseling for physical activity. The prevalence of overweight and obesity has increased sharply for children over the last 30 years: from 5.0% to 13.9% for those aged 2–5 years; from 6.5% to 18.8% for those aged 6–11 years; and from 5.0% to 17.4% for those aged 12–19 years. This increasing prevalence has had significant economic ramifications, with economic costs correlated to obesity and related comorbidities estimated at over \$70 billion, or 7% of the national health care budget. To address this problem and its long-term implications effectively, promotion of routine physical activity and healthy eating and lifestyle changes are essential (CDC 2007). This measure is important in efforts to improve long-term health outcomes and quality of life.

**Clinical Recommendation Statements:**

U.S. Preventive Services Task Force (USPSTF): "I" Recommendation. Insufficient evidence to recommend for or against screening for overweight in children and adolescents reflects the paucity of strong evidence of the effectiveness of interventions for this problem in the clinical setting.

The American Academy of Pediatrics (AAP): The child's height, weight and percentiles for age should be determined at the start of the physical examination. Because obesity is strongly linked to hypertension, BMI should be calculated from the height and weight, and the BMI percentile should be calculated. Poor growth may indicate an underlying chronic illness.

The American Medical Association (AMA), Health Resources and Services Administration (HRSA), and Centers for Disease Control and Prevention (CDC): The Expert Committee recommends that physicians and allied healthcare providers perform, at a minimum, a yearly assessment of weight status in all children, and that this assessment include calculation of height, weight (measured appropriately), and body mass index (BMI) for age and plotting of those measures on standard growth charts.

The American Academy of Pediatrics and the American College of Clinical Endocrinology (ACCE): The AAP and the ACCE recommend and encourage pediatric providers to screen children for obesity using BMI; examine overweight children for obesity-related diseases; initiate weight management practices to improve diet and physical activity habits; and increase frequency of visits to reinforce behavior changes.

The Centers for Disease Control and Prevention (CDC): The CDC recommends using the percentile BMI for age and gender as the most appropriate and easily available method to screen for childhood overweight or at risk for overweight. BMI is calculated by dividing the weight in kilograms by the height in meters squared. Age and gender norms for BMI are readily accessible. BMI correlates with adiposity and with complications of childhood overweight such as hypercholesterolemia, hypertension and later development of cardiovascular disease. Although more precise measures of lean body mass and body fat such as dual x-ray absorptiometry (DEXA) may be appropriate for clinical studies, BMI norms are particularly helpful for screening in busy office practices and for population assessment.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #240 (NQF 0038) HITECH ALT CORE: Childhood Immunization Status

**Description:** The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

**Denominator:** All patients who turn two years of age during the measurement period

#### Denominator Inclusions:

All patients who are 1 year of age at the beginning of the measurement period and who will turn 2 years of age during the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OB/GYN

OR

ENCOUNTER OUTPATIENT

**Numerator:** Patients who received four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, rubella (MMR); three H influenza type B (HIB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday

**Numerator Inclusion – Criterion a:** *(Patients who received all four doses of DTaP vaccination)*

Patients who received all four doses of the diphtheria, tetanus and acellular pertussis (DTaP) vaccination on different dates of service between the ages of 42 days old and 2 years old for patients who turn 2 years old during the measurement period. IMMUNIZATIONS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DTAP VACCINATION

**AND/OR**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered **four** doses of DTaP Vaccine with different dates of service between the ages of 42 days and 2 years and DRUG\_EXCLUSION = N.

**OR Numerator Exclusions (Criterion a):**

Eligible children with at least one of the medical exclusions listed below may not need to receive the complete DTaP vaccination series if identified prior to their second birthday. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

PROBLEMS and ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCEPHALOPATHY

OR

PROGRESSIVE NEUROLOGIC DISORDER

OR

EXCLUSION CODE

**OR**

When immunizations are not prescribed due to patient allergy identified before their second birthday, the immunization that the patient is allergic to should be submitted along with a negation code to indicate the reason the immunization was not ordered or received.

**NOTE:** *When submitting the immunization that the patient did not receive, the immunization status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for DTaP Vaccine.

**AND**

MEDICATION ALLERGY

**AND**

**Numerator Inclusion – Criterion b: (Patients who received at least three polio vaccinations (IPV))**

Patients who received all three doses of the polio (IPV) vaccination on separate dates of service between the ages of 42 days old and 2 years old for patients who turn 2 years old during the measurement period.

IMMUNIZATIONS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**IPV VACCINATION**

**AND/OR**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least **three** doses of IPV with different dates of service between the ages of 42 days and 2 years and DRUG\_EXCLUSION = N.

**OR Numerator Exclusions (Criterion b):**

Eligible children with at least one of the medical exclusions listed below may not need to receive the complete polio (IPV) series if identified prior to their second birthday. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**EXCLUSION CODE**

**OR**

When immunizations are not prescribed due to patient allergy identified before their second birthday, the immunization that the patient is allergic to should be submitted along with a negation code to indicate the reason the immunization was not ordered or received.

**NOTE:** *When submitting the immunization that the patient did not receive, the immunization status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for IPV, neomycin, streptomycin and polymyxin.

**AND**

**MEDICATION ALLERGY**

**AND**

**Numerator Inclusion – Criterion C:** (*Patients who received one measles, mumps and rubella (MMR) vaccination*)

**MMR Numerator Inclusions (Criterion c):**

Patients who received one dose of the MMR vaccination before the child's second birthday for patients who turn 2 years old during the measurement period.

IMMUNIZATIONS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MMR VACCINATION

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least *one* dose of the MMR Vaccine before the child's second birthday and DRUG\_EXCLUSION = N.

**OR MMR Numerator Exclusions (Criterion c):**

Eligible children who currently have at least one of the medical exclusions listed below or who has or had CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE at any time before their second birthday may not need to receive the MMR vaccination. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

PROBLEMS and ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE

OR

HIV DISEASE

OR

MULTIPLE MYELOMA

OR

LEUKEMIA

OR

IMMUNODEFICIENCY

OR

EXCLUSION CODE

**OR**

When immunizations are not prescribed due to patient allergy identified before their second birthday, the immunization that the patient is allergic to should be submitted along with a negation code to indicate the reason the immunization was not ordered or received.

**NOTE:** *When submitting the immunization that the patient did not receive, the immunization status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for the MMR Vaccine.

**AND**

MEDICATION ALLERGY

**OR**

### Measles Numerator Inclusion (Criterion c1):

Patients who received an equivalent combination of MMR vaccinations before the child's second birthday and/or who currently have or had measles, mumps and/or rubella by the child's second birthday for patients who turn 2 years old during the measurement period.

IMMUNIZATIONS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MEASLES VACCINATION

OR

MEASLES

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least **one** dose of Measles Vaccine before the child's second birthday and DRUG\_EXCLUSION = N.

### OR Measles Numerator Exclusions (Criterion c1):

Eligible children with at least one of the medical exclusions listed below may not need to receive the Measles portion of the vaccination if identified prior to their second birthday . Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

### OR

When immunizations are not prescribed due to patient allergy identified before their second birthday, the immunization that the patient is allergic to should be submitted along with a negation code to indicate the reason the immunization was not ordered or received.

*NOTE: When submitting the immunization that the patient did not receive, the immunization status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Measles Vaccine.

AND

MEDICATION ALLERGY

AND

### Mumps Numerator Inclusion (Criterion c2):

IMMUNIZATIONS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

MUMPS VACCINATION

OR

MUMPS

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least *one* dose of Mumps Vaccine before the child's second birthday and DRUG\_EXCLUSION = N.

### OR Mumps Numerator Exclusions (Criterion c2):

Eligible children with at least one of the medical exclusions listed below may not need to receive the MMR vaccination if identified prior to their second birthday. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

OR

When immunizations are not prescribed due to patient allergy identified before their second birthday, the immunization that the patient is allergic to should be submitted along with a negation code to indicate the reason the immunization was not ordered or received.

**NOTE:** *When submitting the immunization that the patient did not receive, the immunization status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for mumps Vaccine.

AND

MEDICATION ALLERGY

AND

**Rubella Numerator Inclusion (Criterion c3):**

IMMUNIZATIONS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

RUBELLA VACCINATION

OR

RUBELLA

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least *one* dose of Rubella Vaccine before the child's second birthday and DRUG\_EXCLUSION = N.

**OR Rubella Numerator Exclusions (Criterion c3):**

Eligible children with at least one of the medical exclusions listed below may not need to receive the MMR vaccination if identified prior to their second birthday. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

**OR**

When immunizations are not prescribed due to patient allergy identified before their second birthday, the immunization that the patient is allergic to should be submitted along with a negation code to indicate the reason the immunization was not ordered or received.

*NOTE: When submitting the immunization that the patient did not receive, the immunization status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Rubella Vaccine.

**AND**

MEDICATION ALLERGY

**AND**

**Numerator Inclusion – Criterion d:** (*Patients who received at least three influenza type B (HiB) vaccinations*)

Patients who received at least three HiB vaccinations on separate dates of service between the ages of 42 days old and 2 years old for patients who turn 2 years old during the measurement period.

IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**HIB VACCINATION**

**AND/OR**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least **three** doses of HiB vaccine with different dates of service between the ages of 42 days and 2 years and DRUG\_EXCLUSION = N.

**OR Numerator Exclusions (Criterion d):**

Eligible children with at least one of the medical exclusions listed below may not need to receive the complete HiB vaccination series if identified prior to their second birthday. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**EXCLUSION CODE**

**OR**

When immunizations are not prescribed due to patient allergy identified before their second birthday, the medication that the patient is allergic to should be submitted along with a negation code to indicate the reason the medication was not ordered or received.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for HiB vaccine.

**AND**

**MEDICATION ALLERGY**

**AND**

**Numerator Inclusion – Criterion e: (Patients who received at least three Hepatitis B immunizations)**

Patients who received all three doses of the Hepatitis B vaccinations on separate dates of service and/or who currently have or had Hepatitis B before 2 years of age and the patient turns 2 years old during the measurement period.

IMMUNIZATIONS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HEPATITIS B VACCINATION

OR

HEPATITIS B DIAGNOSIS

**AND/OR**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who received all *three* doses of the Hepatitis B Vaccine on separate dates of service before 2 years of age and DRUG\_EXCLUSION = N.

**OR Numerator Exclusions (Criterion e):**

Eligible children with at least one of the medical exclusions listed below may not need to receive the complete Hepatitis B immunization series if identified prior to their second birthday. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

EXCLUSION CODE

**OR**

When immunizations are not prescribed due to patient allergy identified before their second birthday, the immunization that the patient is allergic to should be submitted along with a negation code to indicate the reason the immunization was not ordered or received.

*NOTE: When submitting the immunization that the patient did not receive, the immunization status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Hepatitis B vaccine.

**AND**

MEDICATION ALLERGY

**AND**

**Numerator Inclusion – Criterion f: (*Patients who received one Chicken Pox (VZV) immunization*)**

Patients who received one dose of the Chicken Pox (VZV) vaccination and/or who currently have or had the chicken pox before 2 years of age and the patient turns 2 years old during the measurement period. *Evidence of the combination vaccine, or documented history of the illness, or a seropositive test result must be found.*

PROBLEMS and IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

VZV VACCINATION

OR

VZV

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least *one* dose of the Chicken Pox (VZV) Vaccine before 2 years of age and DRUG\_EXCLUSION = N.

**OR Numerator Exclusions (Criterion f):**

Eligible children who currently have at least one of the medical exclusions listed below or who has or had CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE at any time before their second birthday may not need to receive the chicken pox (VZV) vaccine. . Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

PROBLEMS and ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE

OR

HIV DISEASE

OR

MULTIPLE MYELOMA

OR

LEUKEMIA

OR

IMMUNODEFICIENCY

OR

EXCLUSION CODE

**AND**

**Numerator Inclusion – Criterion g:** (*Patients who received all four doses of the pneumococcal conjugate vaccinations*)

Patients who received all four doses of the Pneumococcal Conjugate vaccination on separate dates of service before 2 years of age and the patient turns 2 years old during the measurement period.

IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**PNEUMOCOCCAL VACCINATION**

**AND/OR**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered all **four** doses of the Pneumococcal Conjugate Vaccine on separate dates of service before 2 years of age and DRUG\_EXCLUSION = N.

**OR Numerator Exclusions (Criterion g):**

Eligible children with at least one of the medical exclusions listed below may not need to receive the complete Pneumococcal Conjugate vaccination series if identified prior to their second birthday. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**EXCLUSION CODE**

**OR**

When immunizations are not prescribed due to patient allergy identified before their second birthday, the immunization that the patient is allergic to should be submitted along with a negation code to indicate the reason the immunization was not ordered or received.

**NOTE:** *When submitting the immunization that the patient did not receive, the immunization status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Pneumococcal Conjugate Vaccine.

**AND**

**MEDICATION ALLERGY**

**AND**

**Numerator Inclusion – Criterion h: (Patients who received both doses of the Hepatitis A vaccination)**

Patients who received both doses of the Hepatitis A vaccination on separate dates of service and/or who currently have or had Hepatitis A before 2 years of age and the patient turns 2 years old during the measurement period.

PROBLEMS and IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**HEPATITIS A VACCINATION**

OR

**HEPATITIS A DIAGNOSIS**

**AND/OR**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered **both** doses of the Hepatitis A Vaccine on separate dates of service before 2 years of age and DRUG\_EXCLUSION = N.

**OR Numerator Exclusions (Criterion h):**

Eligible children with at least one of the medical exclusions listed below may not need to receive the complete Pneumococcal conjugate vaccination series if identified prior to their second birthday . Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**EXCLUSION CODE**

**OR**

When immunizations are not prescribed due to patient allergy identified before their second birthday, the immunization that the patient is allergic to should be submitted along with a negation code to indicate the reason the immunization was not ordered or received.

**NOTE:** *When submitting the immunization that the patient did not receive, the immunization status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Hepatitis A Vaccine.

**AND**

**MEDICATION ALLERGY**

**AND**

**Numerator Inclusion – Criterion i:** (*Patients who received at least two doses of the Rotavirus (RV) vaccination*)

Patients who received at least two doses of the RV immunization on separate dates of service between the ages of 42 days old and 2 years old and the patient turns 2 years old during the measurement period.

IMMUNIZATIONS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**ROTAVIRUS VACCINATION**

**AND/OR**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered at least **two** doses of the Rotavirus Vaccine on separate dates of service between the age of 42 days and 2 years old and DRUG\_EXCLUSION = N.

**OR Numerator Exclusions (Criterion i):**

When immunizations are not prescribed due to patient allergy identified before their second birthday, the immunization that the patient is allergic to should be submitted along with a negation code to indicate the reason the immunization was not ordered or received.

**NOTE:** *When submitting the immunization that the patient did not receive, the immunization status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for Rotavirus Vaccine.

**AND**

**MEDICATION ALLERGY**

**AND**

**Numerator Inclusion – Criterion j:** (*Patients who received both doses of the Influenza vaccination*)

Patients who received both doses of the Influenza immunization administered on separate dates of service between the ages of 42 days old and 2 years old and the patient turns 2 years old during the measurement period.

IMMUNIZATIONS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

INFLUENZA VACCINATION

**AND/OR**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered **both** doses of the influenza vaccine on separate dates of service between the age of 42 days and 2 years old and DRUG\_EXCLUSION = N.

**OR Numerator Exclusions (Criterion j):**

Eligible children who currently have at least one of the medical exclusions listed below or who has or had CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE at any time before or during the measurement period may not need to receive the influenza vaccination if identified prior to their second birthday. Each immunization criterion should be evaluated individually and each will be used to generate a composite score for the patient.

PROBLEMS and ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

CANCER OF LYMPHORETICULAR OR HISTIOCYTIC TISSUE

OR

HIV DISEASE

OR

MULTIPLE MYELOMA

OR

LEUKEMIA

OR

IMMUNODEFICIENCY

OR

EXCLUSION CODE

**OR**

When immunizations are not prescribed due to patient allergy identified before their second birthday, the immunization that the patient is allergic to should be submitted along with a negation code to indicate the reason the immunization was not ordered or received.

*NOTE: When submitting the immunization that the patient did not receive, the immunization status may be identified as inactive.*

MEDICATIONS and MEDICATIONS(negation) tab(s) in the Downloadable Resource table list applicable codes for influenza vaccine.

**AND**

MEDICATION ALLERGY

**Denominator Exclusion:**

None

## **Rationale:**

For the general community, high childhood immunization rates prevent the resurgence of many infectious diseases, such as polio, that have been virtually eradicated from most developed countries (CDC, 1999). The general clinical consensus is that if immunization practices ceased, most infectious and contagious diseases currently prevented by vaccinations would reemerge as lethal health threats. Potential for exposure to infectious disease is even greater with the increase in international travel. By ensuring proper immunization of children by the age of two, health plans can help contain the transmission of these diseases and help protect the general population.

Immunization is a critical aspect of preventive care. Lack of proper immunization lead to an increase in illness, doctor visits and hospitalizations, all of which translate into higher costs. The measles resurgence of 1989-1991, which cost \$100 million in direct medical care costs, demonstrates the potential cost to the health care delivery system if the immunization system fails (Battelle, 1994b).

In 1998, the U.S. Centers for Disease Control estimated that without any vaccines there would have been over 500,000 measles related deaths in comparison to the 89 actual American cases. Furthermore, all of these cases were associated with international importations (CDC, 1999). This trend has been seen over the years as more of the population is vaccinated. However, the viruses and bacteria that cause vaccine-preventable diseases and deaths still exist and can be passed on to people who are not protected by vaccines. Immunizations are very important because they can protect people who are not immunized. The importance of vaccines is shown by the reappearance of diseases when immunization coverage drops (Kane, 2002). Vaccine-preventable diseases have a costly impact, resulting in doctor's visits, hospitalizations, and premature deaths. Sick children can also cause parents to lose time from work. Therefore, there is continued interest in strategies to increase immunization levels.

## **Clinical Recommendation Statements:**

Concern over poor immunization rates has fostered a number of initiatives including, but not limited to, policy goals in Health People 2010. One of Healthy People 2010's objectives is to increase the proportion of providers who have measured the vaccination coverage levels among children in their practice population within the past two years (USDHHS, 2000).

Variations in immunization coverage exist among some populations. Children of lower socioeconomic status are slightly less likely to be fully immunized. According to data from the Center for Disease Control and Prevention's National Immunization Survey, white, non-Hispanic children are more likely to be fully immunized by 35 months of age than children of other race categories are. This difference in immunization rates, however, is small (0-9%) and the gap is narrowing (CDC, 2005).

Data show that in 2005 children living below the poverty level have lower immunization coverage rates as well (CDC, 2005). Although great progress has been made in improving childhood immunization rates, some disparities in overall immunization coverage rates among racial and ethnic groups still exist (NIP, 2003). This disparity is of great concern in large urban areas with underserved populations because of the potential for outbreaks of vaccine-preventable diseases. In the 2004 National Immunization Survey showed that first dose coverage for children 23 – 35 months was 54 percent for states for which the vaccination is recommended, while there is 27 percent coverage in states for which the vaccination is considered and 2 percent coverage for the rest of the United States (CDC MMWR Hepatitis A, 2006). In the United States, four of five children will have rotavirus gastroenteritis, one in seven will require a clinic or emergency department visit, one in 70 will be hospitalized, and one in 200,000 will die from the disease (CDC MMWR Rotavirus, 2006). A 2007 CDC study found across six demonstration states that less than 30 percent of children aged 6 – 23 months were fully vaccinated, with vaccination coverage for children 6 – 23 months ranging from 13.9 percent to 46.6 percent for children who received at least one dose and 3.0 percent to 26.9 percent for children who were fully vaccinated (CDC, 2007).

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #241 (NQF 0075) HITECH: Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control

**Description:** Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and whose most recent LDL-C level in control (less than 100 mg/dL)

**Denominator:** Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)

#### Denominator Inclusions:

All patients with an active diagnosis of IVD during the measurement period OR PTCA performed January 1 through November 1 of the year prior to the measurement period and a qualifying visit OR an active diagnosis of AMI during an inpatient encounter January 1 through November 1 of the year prior to the measurement period OR CABG performed during an inpatient encounter January 1 through November 1 of the year prior to the measurement period and patient is greater than or equal to 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT

OR

ENCOUNTER OUTPATIENT

AND

ISCHEMIC VASCULAR DISEASE

OR

ENCOUNTER ACUTE INPT

OR

ENCOUNTER OUTPATIENT

AND

PTCA

OR

ENCOUNTER ACUTE INPT

AND

ACUTE MYOCARDIAL INFARCTION

OR

ENCOUNTER ACUTE INPT

AND

CABG

## Numerator 1: Patients who received at least one lipid profile (or ALL component tests)

### Numerator Inclusions:

Patients who had at least one LDL Test during the measurement period.

ENCOUNTERS, PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT

OR

ENCOUNTER OUTPATIENT

AND

LDL TEST

AND

## Numerator 2: Patients with most recent LDL-C < 100 mg/dL

### Numerator Inclusions:

Patients with most recent LDL-C less than 100 mg/dL during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

LDL TEST

WITH

Documentation of LDL Test < 100 mg/dL

### Denominator Exclusions:

None

## Rationale:

There is general agreement in the literature that individuals with existing coronary artery disease can reduce their risk of subsequent morbidity and premature mortality by management of cholesterol levels. Total cholesterol in general and LDL level specifically, is the leading indicator for management of these patients. Treatments include limits on dietary fat and cholesterol, or in certain cases, cholesterol lowering medications.

A 10% decrease in total cholesterol levels (population wide) may result in an estimated 30% reduction in the incidence of CHD (CDC, 2000). Based on data from the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults:

- Less than half of persons who qualify for any kind of lipid-modifying treatment for CHD risk reduction are receiving it.
- Less than half of even the highest-risk persons, those who have symptomatic CHD, are receiving lipid-lowering treatment.
- Only about a third of treated patients are achieving their LDL goal; less than 20% of CHD patients are at their LDL goal. (2002)

Several studies have shown that reducing high lipid levels will reduce cardiovascular morbidity and mortality. These studies include the Coronary Primary Prevention Trial, the Framingham Heart Study, the Oslo Study Diet and Anti-smoking Trial, the Helsinki Heart Study, the Coronary Drug Project, the Stockholm Ischemic Heart Study, the Scandinavian Simvastatin Survival Study, the West of Scotland Coronary Prevention Study, the Program on the Surgical Control of the Hyperlipidemias, and Cholesterol and Recurrent Events trial.

## Clinical Recommendation Statements:

Third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). (2001) AND Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines (2004)

In high-risk persons, the recommended LDL-C goal is <100 mg/dL.

- An LDL-C goal of <70 mg/dL is a therapeutic option on the basis of available clinical trial evidence, especially for patients at very high risk.
- If LDL-C is >100 mg/dL, an LDL-lowering drug is indicated simultaneously with lifestyle changes.
- If baseline LDL-C is <100 mg/dL, institution of an LDL-lowering drug to achieve an LDL-C level <70 mg/dL is a therapeutic option on the basis of available clinical trial evidence.
- If a high-risk person has high triglycerides or low HDL-C, consideration can be given to combining a fibrate or nicotinic acid with an LDL-lowering drug. When triglycerides are >200 mg/dL, non-HDL-C is a secondary target of therapy, with a goal 30 mg/dL higher than the identified LDL-C goal.

The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders and recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. The USPSTF also strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease and recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

♦Measure #305 (NQF 0004) HITECH: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement

**Description:** Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment AND who had two or more additional services with an AOD diagnosis within 30 days of the initial visit

**Denominator:** Patients aged 13 years and older with a new episode of alcohol and other drug (AOD) dependence

### Denominator Inclusion – Population Stratification 1: (*Patients aged 13-17*)

All patients between 13 and 17 years old at the beginning of the measurement period with a documented diagnosis of their first episode of alcohol and other drug (AOD) dependence during an encounter with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol and other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED  
OR  
ENCOUNTER OUTPATIENT BH  
OR  
ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPT BH REQ POS  
WITH  
*Encounter Point of Service Modifier*

### AND

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for inclusion in this measure and are associated with the following data element(s):

ALCOHOL OR DRUG DEPENDENCE

OR

All patients between 13 and 17 years old at the beginning of the measurement period who had their first AOD intervention during an inpatient AOD admission (ENCOUNTER ACUTE INPT or ENCOUNTER NON-ACUTE INPATIENT) with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol and other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER NON-ACUTE INPATIENT

#### AND

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS

#### OR

All patients between 13 and 17 years old at the beginning of the measurement period who have their first AOD (DETOXIFICATION INTERVENTIONS) intervention during the first ten and a half months of the year. Patients presenting with a subsequent episode of alcohol and other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have an intervention within the first ten and a half months of the measurement period and patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED  
OR  
ENCOUNTER OUTPATIENT BH  
OR  
ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER NON-ACUTE INPATIENT

#### OR

ENCOUNTER OUTPT BH REQ POS  
WITH  
*Encounter Point of Service Modifier*

#### AND

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DETOXIFICATION INTERVENTIONS

## Denominator Inclusion – Population Stratification 2: (Patients aged greater than or equal to 18)

All patients greater than or equal to 18 years old at the beginning of the measurement period with a documented diagnosis of their first episode of alcohol and other drug (AOD) dependence during an encounter with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol and other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED

OR

ENCOUNTER OUTPATIENT BH

OR

ENCOUNTER ACUTE INPT

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPT BH REQ POS

WITH

Encounter Point of Service Modifier

**AND**

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL OR DRUG DEPENDENCE

OR

All patients greater than or equal to 18 years old at the beginning of the measurement period who had their first AOD *intervention* during an inpatient AOD admission (ENCOUNTER ACUTE INPT or ENCOUNTER NON-ACUTE INPATIENT) with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol and other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT

OR

ENCOUNTER NON-ACUTE INPATIENT

**AND**

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS

OR

All patients greater than or equal to 18 years old at the beginning of the measurement period who have their first AOD (DETOXIFICATION INTERVENTIONS) intervention during the first ten and a half months of the year. Patients presenting with a subsequent episode of alcohol and other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have an intervention within the first ten and a half months of the measurement period and patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED

OR

ENCOUNTER OUTPATIENT BH

OR

ENCOUNTER ACUTE INPT

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPT BH REQ POS

WITH

*Encounter Point of Service Modifier*

**AND**

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DETOXIFICATION INTERVENTIONS

### Denominator Inclusion – Population Stratification 3: *(Patients aged greater than or equal to 13)*

All patients greater than or equal to 13 years old at the beginning of the measurement period with a documented diagnosis of their first episode of alcohol and other drug (AOD) dependence during an encounter with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol and other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED

OR

ENCOUNTER OUTPATIENT BH

OR

ENCOUNTER ACUTE INPT

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPT BH REQ POS

WITH

*Encounter Point of Service Modifier*

**AND**

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL OR DRUG DEPENDENCE

OR

All patients greater than or equal to 13 years old at the beginning of the measurement period who had their first AOD intervention during an inpatient AOD admission (ENCOUNTER ACUTE INPT or ENCOUNTER NON-ACUTE INPATIENT) with an eligible professional within the first ten and a half months of the measurement period. Patients presenting with a subsequent episode of alcohol and other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT

OR

ENCOUNTER NON-ACUTE INPATIENT

AND

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS

OR

All patients greater than or equal to 13 years old at the beginning of the measurement period who have their first AOD (DETOXIFICATION INTERVENTIONS) intervention during the first ten and a half months of the year. Patients presenting with a subsequent episode of alcohol and other drug (AOD) dependence are not eligible for this measure. To be eligible for performance calculations, patients must have an intervention within the first ten and a half months of the measurement period and patients must have at least one face-to-face visit with the eligible professional within the first ten and a half months of the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED

OR

ENCOUNTER OUTPATIENT BH

OR

ENCOUNTER ACUTE INPT

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPT BH REQ POS

WITH

Encounter Point of Service Modifier

AND

PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

DETOXIFICATION INTERVENTIONS

**Numerator:** Patients who initiated treatment within 14 days of the initial diagnosis of AOD or intervention for AOD AND had two or more additional services with an AOD diagnosis within 30 days of the initial visit

**Numerator Inclusion – Criterion 1:** (*Initiation of Treatment - Patients who initiated treatment within 14 days of the initial diagnosis of AOD or intervention for AOD*)

Patients who had an AOD detoxification intervention and an inpatient admission (ENCOUNTER ACUTE INPT or ENCOUNTER NON-ACUTE INPATIENT) within 14 days after their first diagnosis of AOD or first intervention for AOD.

ENCOUNTERS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

Patients who had an outpatient or inpatient visit (ENCOUNTER OUTPATIENT BH, ENCOUNTER ACUTE INPT, ENCOUNTER NON-ACUTE INPATIENT, or ENCOUNTER OUTPATIENT BH REQ POS with ENCOUNTER POINT OF SERVICE MODIFIER) within 14 days after their first diagnosis of AOD or first intervention for AOD.

ENCOUNTERS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS

AND

ENCOUNTER OUTPATIENT BH

OR

ENCOUNTER ACUTE INPT

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPT BH REQ POS

WITH

Encounter Point of Service Modifier

AND

**Numerator Inclusion – Criterion 2:** (Engagement of Treatment - Patients who had two or more additional services with an AOD diagnosis within 30 days of the initial visit)

Patients with a diagnosis of AOD who had at least *two* of the following services and/or procedures (ENCOUNTER NON-ACUTE INPATIENT, ENCOUNTER ACUTE INPT, ENCOUNTER OUTPATIENT BH, ENCOUNTER OUTPT BH REQ POS with qualifying ENCOUNTER POINT OF SERVICE MODIFIER, or ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS) within 30 days of the Initiation of Treatment.

ENCOUNTERS, PROBLEMS, PROCEDURES, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ALCOHOL OR DRUG DEPENDENCE

AND

ENCOUNTER OUTPATIENT BH

OR

ENCOUNTER ACUTE INPT

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPT BH REQ POS

WITH

Encounter Point of Service Modifier

OR

ALCOHOL, DRUG REHAB AND DETOX INTERVENTIONS

**Denominator Exclusions:**

None

**Rationale:**

There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance use and abuse places a huge burden on the health care system. According to a report from the 2001 National Household Survey on Drug Abuse (NHSDA), an estimated 16.6 million Americans aged 12 or older in 2001 were classified with dependence on or abuse of either alcohol or illicit drugs (7.3 percent of the total population). Of these, 2.4 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.2 million were dependent on or abused illicit drugs but not alcohol, and 11.0 million were dependent on or abused alcohol but not illicit drugs.(SAMHSA, 2002).

**Clinical Recommendation Statements:**

The identification of individuals with AOD (Alcohol and Other Drug) disorders is an important first step in the process of care. However, the identification of AOD disorders often does not routinely lead to the initiation of care. Reasons that an individual may not initiate treatment include the social stigma associated with AOD disorder, denial that there is an AOD problem, non-compliance to AOD treatment offered, or the lack of immediately available treatment services. This measure is designed to ensure that treatment is initiated once the need has been identified, and will permit comparison of effectiveness in initiating care.

Treatment engagement is defined as an intermediate step between initially accessing care (in the first visit) and completing a full course of treatment. Numerous studies have indicated that individuals who remain in treatment longer have improved outcomes. However, a 1990 Drug Service Research Survey has suggested that many clients (52%) with AOD disorders leave treatment prematurely. This measure is seen as an important intermediate indicator that is closely related to outcomes. In fact, studies have tied the frequency and intensity of engagement as important in treatment outcomes and reducing drug-related illnesses.

AOD problems left untreated, cause a significant burden that extends beyond individuals to their communities and to society. Empirical evidence links better outcomes to the identification and treatment of people with AOD disorders. This measure may influence performance by increasing screening for AOD problems in primary care settings and increasing communication between primary care and specialty providers. Moving forward, performance measures are needed to establish clear standards of accountability that, in turn, will lead to efforts to improve the quality of care for people with AOD disorders.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ▲Measure #306 (NQF 0012) HITECH : Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)

**Description:** Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal visit

**Denominator:** All patients, regardless of age, who gave birth during a 12-month period, seen for continuing prenatal care

#### Denominator Inclusions:

All female patients, regardless of age, who gave birth during the measurement period and were seen for prenatal care. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

**NOTE:** *The prenatal visit must have occurred within 10 months prior to the date of delivery and after the estimated date of conception.*

ENCOUNTERS, PROBLEMS, and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ESTIMATED DATE OF CONCEPTION  
AND  
PRENATAL VISIT  
AND  
DELIVERY LIVE BIRTHS-DIAGNOSIS  
AND  
DELIVERY LIVE BIRTHS-PROCEDURE

**Numerator:** Patients who were screened for HIV infection during the first or second prenatal visit

#### Numerator Inclusions:

Patients who were screened for HIV infection during or within 30 days after either their first or second prenatal visit (PRENATAL VISIT) during the measurement period.

PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HIV SCREENING

**Denominator Exclusions:** *(Exclusions only applied if patient was not screened for HIV infection during the first or second prenatal visit)*

When HIV screening is not performed during the first or second prenatal visit for a valid medical or patient reason, the appropriate screening that would have been done should be submitted along with a negation code (within 30 days of either the first or second PRENATAL VISIT) to indicate the reason the appropriate screening was not performed prior to delivery.

PROBLEMS, PROBLEMS(negation), PROCEDURES, PROCEDURES(negation), RESULTS, and RESULTS(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HIV SCREENING

AND

MEDICAL REASON

OR

PATIENT REASON

OR

Patients who currently have or have had a diagnosis of HIV before or during a prenatal visit (PRENATAL VISIT) within 10 months prior to the date of delivery and after the estimated date of conception.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HIV

**Rationale:**

While the number of perinatally transmitted cases of HIV has decreased, perinatal transmission still accounts for the majority of new cases of HIV in children.

Benefits of knowing a woman's HIV status early on in pregnancy have been well documented and allow the health care provider to initiate treatment early on in the pregnancy, thereby decreasing the risk of transmission of HIV to the child.

**Clinical Recommendation Statements:**

Universal HIV testing with patient notification should be a routine component of prenatal care; however, this must be in accordance with current state laws (ACOG/AAP). PHS recommends that all pregnant women in the United States be tested for HIV infection. All health-care providers should recommend HIV testing to all of their pregnant patients, pointing out the substantial benefit of knowledge of HIV status for the health of women and their infants. HIV screening should be a routine part of prenatal care for all women (CDC). Clinicians should screen all pregnant women for HIV. There is good evidence that both standard and FDA-approved rapid screening tests accurately detect HIV infection in pregnant women and fair evidence that introduction of universal prenatal counseling and voluntary testing increases the proportion of HIV-infected women who are diagnosed and are treated before delivery (USPSTF) (A Recommendation).

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ▲Measure #307 (NQF 0014) HITECH: Prenatal Care: Anti-D Immune Globulin

**Description:** Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation

**Denominator:** All patients, regardless of age, who are D (Rh) negative and unsensitized who gave birth during a 12-month period, seen for continuing prenatal care

#### Denominator Inclusions:

All female patients, regardless of age, who are D (Rh) negative and unsensitized who gave birth to their first child (primigravida) during the measurement period and were seen for continuing prenatal care.

**NOTE:** A prenatal visit must have occurred within 10 months prior to the date of delivery and after the estimated date of conception where the patient's pregnancy status (*primigravida* or *multigravida*) was identified along with the patient's (RH STATUS MOTHER) D (Rh) status.

ENCOUNTERS, PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ESTIMATED DATE OF CONCEPTION  
AND  
PRENATAL VISIT  
AND  
DELIVERY LIVE BIRTHS-DIAGNOSIS  
AND  
DELIVERY LIVE BIRTHS-PROCEDURE  
AND  
D(RH) NEGATIVE

AND

PRIMIGRAVIDA  
AND

RH STATUS MOTHER  
WITH  
*Negative*

OR

All female patients, regardless of age, who are D (Rh) negative and unsensitized with another child who was already identified as being D (Rh) negative prior to giving birth to a child succeeding their first child (multigravida) during the measurement period and were seen for continuing prenatal care.

**NOTE:** A prenatal visit must have occurred within 10 months prior to the date of delivery and after the estimated date of conception where the patient's pregnancy status (primigravida or **multigravida**) was identified along with the **patient's (RH STATUS MOTHER) and prior child's (RH STATUS BABY) D (Rh) status.**

ENCOUNTERS, PROBLEMS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ESTIMATED DATE OF CONCEPTION

AND

PRENATAL VISIT

AND

DELIVERY LIVE BIRTHS-DIAGNOSIS

AND

DELIVERY LIVE BIRTHS-PROCEDURE

AND

D(RH) NEGATIVE

AND

MULTIGRAVIDA

AND

RH STATUS MOTHER

WITH

Negative

AND

RH STATUS BABY

WITH

Negative

**Numerator: Patients who received anti-D immune globulin at 26-30 weeks gestation**

**Numerator Inclusions:**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were administered Anti-D Immune Globulin during the measurement period and DRUG\_EXCLUSION = N.

**Denominator Exclusions:** (*Exclusions only applied if patient did not receive anti-D immune globulin at 26-30 weeks gestation*)

Patient who had one of the following conditions during the measurement period.

ALERTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ANTI-D IMMUNE GLOBULIN DECLINED

**OR**

When Anti-D Immune Globulin therapy is not prescribed between the 26<sup>th</sup> and 30<sup>th</sup> week of pregnancy (based on the estimated date of conception) for a valid medical, patient or system reason, the appropriate therapy that would have been prescribed should be submitted along with a negation code to indicate the reason the appropriate treatment was not prescribed prior to delivery.

**NOTE:** *When submitting the medication that the patient did not receive, the medication status may be identified as inactive.*

MEDICATIONS, MEDICATIONS(negation), and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for Anti-D Immune Globulin medication.

**AND**

MEDICAL REASON

OR

PATIENT REASON

OR

SYSTEM REASON

OR

ANTI-D IMMUNE GLOBULIN DECLINED

**AND**

ESTIMATED DATE OF CONCEPTION

**Rationale:**

Rh sensitization is a serious complication of pregnancy that places the lives of both mother and child at risk. This complication can be avoided through the prophylactic administration of anti-D immune globulin.

**Clinical Recommendation Statements:**

Antibody tests can be repeated in an unsensitized, D-negative patient at 26-28 weeks gestation. She should also receive anti-D immune globulin prophylactically at that time. In addition, any unsensitized, D-negative patient should receive anti-D immune globulin if she has one of the following conditions or procedures:

- Ectopic gestation
- Abortion (either threatened, spontaneous, or induced)
- Procedure associated with possible fetal-to-maternal bleeding, such as chorionic villus sampling (CVS) or amniocentesis
- Condition associated with fetal-maternal hemorrhage (eg, abdominal trauma, abruptio placentae)
- Delivery of a D-positive newborn(AAP/ACOG)(LevelA)

The USPSTF recommends the repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks gestation, unless the biological father is known to be Rh (D)-negative (USPSTF) (B Recommendation).

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

◆ **Measure #308 (NQF 0027) HITECH: Smoking and Tobacco Use Cessation, Medical Assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies**

**Description:** Percentage of patients aged 18 years and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies

**Denominator:** All patients aged 18 years and older

### Denominator Inclusions:

All patients 18 years or older at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**ENCOUNTER OUTPATIENT**

**Numerator:** Patients who were identified as a current smoker or tobacco user AND received cessation, medical assistance

### Numerator Inclusion:

Patients identified as a current smoker or tobacco user during the measurement period.

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**TOBACCO USER**

### AND

Smokers and tobacco users who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies received during the current measurement period.

PROBLEMS and PLAN OF CARE tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**TOBACCO USE CESSATION COUNSELING**

**Denominator Exclusions:** *(Exclusions only applied if patient is not a current smoker or tobacco user)*

Patients identified as a current \*non-tobacco user during the measurement period.

\* Patients must be identified as BOTH a non-chewer and non-smoker

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

NON CHEWER CODE

AND

NON SMOKER CODE

## **Rationale:**

This measure assesses different facets of providing medical assistance with smoking cessation or tobacco use. Smoking is the leading preventable cause of premature death in the United States and is identified as a causal factor in more than 25 diseases and health problems (USDHHS 2004). In 2003, based on evidence that cessation strategies are effective in improving health outcomes, the USPSTF recommended that clinicians screen adults for tobacco use and provide tobacco cessation interventions. Interventions to control smoking are also strategically important because of the financial burden: approximately \$167 billion in annual health related economic losses, when considered with other tobacco use causes. This measure facilitates efforts to implement recommended clinical practices and guidelines and subsequently reduce mortality rates and health problems related to smoking and tobacco use.

## **Clinical Recommendation Statements:**

United States Preventative Services Task Force (USPSTF): The USPSTF guideline strongly recommends that clinicians screen all adult for tobacco use and provide tobacco cessation interventions for those who use tobacco products. The USPSTF found good evidence that brief smoking cessation interventions, including screening, brief behavioral counseling (less than 3 minutes), and pharmacotherapy delivered in primary care settings, are effective in increasing the proportion of smokers who successfully quit smoking and remain abstinent after 1 year.

Veterans' Affairs/Department of Defense: The VA/DoD's Clinical Practice Guideline for the Management of Tobacco Use recommends that any person (age greater than 12 years) who is eligible for care in the Veterans Health Administration (VHA) or the Department of Defense (DoD) health care delivery system should be screened for tobacco use and should be asked about tobacco use at most visits. Tobacco users should be advised to quit and assessed for willingness to quit at every visit. All tobacco users who are willing to quit should be offered an effective tobacco cessation intervention, including: pharmacotherapy, counseling, and follow-up. Tobacco users attempting to quit should be prescribed one or more effective first-line pharmacotherapies for tobacco use cessation. The guideline also cites strong evidence that minimal counseling (lasting less than three minutes) increases overall tobacco abstinence rates.

Public Health Service: The Public Health Service Clinical Practice Guideline recommends that clinicians engage in a number of activities to aid tobacco users in quitting, which include:

[1]Implement an officewide system that ensures that, for EVERY patient at EVERY clinic visit, tobacco-use status is queried and documented (repeated assessment is not necessary in the case of the adult who has never used tobacco or has not used tobacco for many years, and for whom this information is clearly documented in the medical record).

[2]In a clear, strong, and personalized manner, urge every tobacco user to quit.

[3]As every tobacco user if he or she is willing to make a quit attempt at this time (e.g., within the next 30 days).

[4]Provide practical counseling (problem solving/training).

[5]Recommend the use of approved pharmacotherapy, except in special circumstances.

[6]Provide supplementary materials.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #309 (NQF 0032) HITECH: Cervical Cancer Screening

**Description:** Percentage of women aged 21 through 63 years who received one or more Pap tests to screen for cervical cancer

**Denominator:** All female patients aged 21 through 63 years

#### Denominator Inclusions:

All female patients between 21 and 63 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OB/GYN  
OR  
ENCOUNTER OUTPATIENT

#### AND NOT

PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

HYSTERECTOMY

**Numerator:** Patients who had one or more Pap tests during the measurement year or within two years prior

#### Numerator Inclusions:

Female patients who had one or more Pap tests during the measurement period or within two years prior to the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PAP TEST

#### Denominator Exclusions:

None

**Rationale:**

American Cancer Society (ACS, Nov 2002): Test approximately 3 years after onset of vaginal intercourse, but no later than age 21; intervals annually, every 2-3 years for women  $\geq 30$  with 3 negative cytology tests.

U. S. Preventive Services Task Force (USPSTF, Jan 2003): Test within 3 years of onset of sexual activity or age 21, whichever comes first; intervals of at least every 3 years.

American College of Obstetricians and Gynecologists (ACOG, Aug 2003): Approximately 3 years after onset of sexual intercourse, but no later than age 21; annually, every 2-3 years for women  $\geq 30$  with 3 negative cytology tests.

**Clinical Recommendation Statements:**

This measure assesses the percentage of women in a specific age demographic who receive appropriate screening for cervical cancer. The American Cancer Society predicted that in 2009, nearly 11,270 women would be newly diagnosed with cervical cancer and 4,070 women would die of cervical cancer. The financial burden is also noteworthy: treatment for cervical cancer cost about \$2 billion in 2004 (CDC). The American Cancer Society reported that screening can save lives, stating that the overall five-year survival rate for cervical cancer is nearly 71%, with a survival rate of 92% for detection in the earliest stage (2010). This evidence is corroborated by the fact that from 1955–1992, the mortality rate from cervical cancer declined by 74% because of screening. This measure facilitates efforts toward early detection of cervical cancer and acceleration of treatment upon diagnosis.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #310 (NQF 0033) HITECH: Chlamydia Screening for Women

**Description:** Percentage of women aged 15 through 24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement year

**Denominator:** Female patients aged 15 through 24 years who were identified as sexually active

#### Denominator Inclusion – Population Stratification 1: *(Patients aged 15-24)*

All female patients who were identified as sexually active and patient is between 15 and 24 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

AND

All female patients who ever had a procedure indicative of a sexually active woman, an IUD device applied, an allergy to an IUD, contraceptive use, contraceptive use education, laboratory tests indicative of sexually active women, or identified as being sexually active.

PROBLEMS, PROCEDURES, RESULTS, PLAN OF CARE, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PROCEDURES INDICATIVE OF SEXUALLY ACTIVE WOMEN

OR

IUD USE

OR

CONTRACEPTIVE USE

OR

CONTRACEPTIVE USE EDUCATION

OR

LABORATORY TESTS INDICATIVE OF SEXUALLY ACTIVE WOMEN

OR

SEXUALLY ACTIVE WOMAN

OR

When IUD device was not used due to a patient allergy, the device that the patient is allergic to should be submitted along with a negation code to indicate the reason the IUD device was not used during the measurement period.

**NOTE:** *When submitting the IUD device that the patient is allergic to, the device status may be identified as inactive.*

PROBLEMS, PROBLEMS(negation), PROCEDURES, and PROCEDURES(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

IUD USE

AND

DEVICE ALLERGY

OR

All female patients who had a pregnancy test performed, a pregnancy encounter, or contraceptives ordered during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY TEST

OR

ENCOUNTER PREGNANCY

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed contraceptives during the measurement period and DRUG\_EXCLUSION = N.

### Denominator Inclusion – Population Stratification 2: (*Patients aged 15-20*)

All female patients who were identified as sexually active and patient is between 15 and 20 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

AND

All female patients who ever had a procedure indicative of a sexually active status, an IUD device applied, an allergy to an IUD device, contraceptive use, contraceptive use education, laboratory tests indicative of sexually active women, or identified as being sexually active.

PROBLEMS, PROCEDURES, RESULTS, PLAN OF CARE, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PROCEDURES INDICATIVE OF SEXUALLY ACTIVE WOMEN

OR

IUD USE

OR

CONTRACEPTIVE USE

OR

CONTRACEPTIVE USE EDUCATION

OR

LABORATORY TESTS INDICATIVE OF SEXUALLY ACTIVE WOMEN

OR

SEXUALLY ACTIVE WOMAN

OR

When IUD device was not used due to a patient allergy, the device that the patient is allergic to should be submitted along with a negation code to indicate the reason the IUD device was not used during the measurement period.

**NOTE:** *When submitting the IUD device that the patient is allergic to, the device status may be identified as inactive.*

PROBLEMS, PROBLEMS(negation), PROCEDURES, and PROCEDURES(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

IUD USE  
AND  
DEVICE ALLERGY

**OR**

All female patients who had a pregnancy test performed, a pregnancy encounter, or contraceptives ordered during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY TEST  
OR  
ENCOUNTER PREGNANCY

**OR**

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed contraceptives during the measurement period and DRUG\_EXCLUSION = N.

### Denominator Inclusion – Population Stratification 3: *(Patients aged 21-24)*

All female patients who were identified as sexually active and patient is between 21 and 24 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

**AND**

All female patients who ever had a procedure indicative of a sexually active woman, an IUD device applied, an allergy to an IUD device, contraceptive use, contraceptive use education, laboratory tests indicative of sexually active women, or identified as being sexually active.

PROBLEMS, PROCEDURES, RESULTS, PLAN OF CARE, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PROCEDURES INDICATIVE OF SEXUALLY ACTIVE WOMEN

OR

IUD USE

OR

CONTRACEPTIVE USE

OR

CONTRACEPTIVE USE EDUCATION

OR

LABORATORY TESTS INDICATIVE OF SEXUALLY ACTIVE WOMEN

OR

SEXUALLY ACTIVE WOMAN

OR

When IUD device was not used due to a patient allergy, the IUD device that the patient is allergic to should be submitted along with a negation code to indicate the reason the IUD device was not used during the measurement period.

*NOTE: When submitting the IUD device that the patient is allergic to, the device status may be identified as inactive.*

PROBLEMS, PROBLEMS(negation), PROCEDURES, and PROCEDURES(negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

IUD USE

AND

DEVICE ALLERGY

OR

All female patients who had a pregnancy test performed, a pregnancy encounter, or contraceptives ordered during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY TEST

OR

ENCOUNTER PREGNANCY

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed contraceptives during the measurement period and DRUG\_EXCLUSION = N.

## Numerator: Patients who had at least one chlamydia test during the measurement period

### Numerator Inclusions:

All female patients who had at least one chlamydia test during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**CHLAMYDIA SCREENING**

### Denominator Exclusions: *(Exclusions only applied if at least one chlamydia test was not performed during the measurement period)*

All female patients who received an x-ray study or a retinoid prescription within one week (seven days) after a pregnancy test is taken during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**X-RAY STUDY**

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for female patients who were prescribed retinoid within in one week (seven days) after a pregnancy test is taken during the measurement period and DRUG\_EXCLUSION = Y.

OR

All female patients who had a pregnancy test performed during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**PREGNANCY TEST**

**Rationale:**

This measure assesses appropriate screening for chlamydia among women in a specific age demographic. Chlamydia is one of the most frequently occurring sexually-transmitted diseases in the United States, resulting in over 2.8 million new cases each year. Women 14–30 are particularly susceptible and account for over 80% of new cases, according to the U.S. National Health and Nutrition Examination Survey. Additionally, health care costs attributable to chlamydia and its complications exceed \$3.5 billion per year in the U.S.. Early detection and treatment have proven to be effective in preventing and managing chlamydia. Several studies have shown that screening reduces overall disease prevalence by 4.2% and is strongly correlated with a reduced incidence of pelvic inflammatory disease (PID). This measure facilitates efforts toward early screening and treatment to improve health outcomes for infected women and prevent the spread of disease.

**Clinical Recommendation Statements:**

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians routinely screen all sexually active women aged 25 years and younger, and other asymptomatic women at increased risk for infection, for chlamydial infection. Rating: A recommendation (<http://www.ahrq.gov/clinic/uspstf/uspschl.htm>).

The American Academy of Family Physicians (AAFP, 2005) strongly recommends screening all sexually active females age 25 years or younger and other women at increased risk for chlamydia.

American College of Preventive Medicine: Sexually active women with risk factors should be screened annually by any well-validated, laboratory-based amplification or antigen method, using cervical or urine specimens. Risk factors include age  $\leq 25$  years, a new male sex partner or two or more partners during the preceding year, inconsistent use of barrier contraception, history of a prior sexually transmitted disease (STD), African-American race, and cervical ectopy. All partners of women with positive tests should be tested for *Chlamydia trachomatis*. Women with mucopurulent discharge, suggestive of cervicitis, should be tested immediately.

The American College of Obstetricians and Gynecologists recommends routine screening for chlamydial infection for all sexually active adolescents and other asymptomatic women at high risk for infection.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #311 (NQF 0036) HITECH: Use of Appropriate Medications for Asthma

**Description:** Percentage of patients aged 5 through 50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year

**Denominator:** Patients aged 5 through 50 years with a diagnosis of persistent asthma

#### Denominator Inclusions – Population Stratification 1: (*Patients aged 5-11*)

Patients with an active diagnosis of persistent asthma during the measurement period and patient is between 5 and 11 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face (ENCOUNTER ED or ENCOUNTER ACUTE INPT) visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED

OR

ENCOUNTER ACUTE INPT

AND

ASTHMA

OR

Patients between 5 and 11 years of age at the beginning of the measurement period with an active diagnosis of persistent asthma who had at least four face-to-face (ENCOUNTER OUTPATIENT) visits during the measurement period and were prescribed at least *two* qualifying medications (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist) at any time in the patient's history.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

AND

ASTHMA

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking or using at least *two* of the following: antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist at any time in the patient's history and DRUG\_EXCLUSION = N.

OR

Patients between 5 and 11 years of age at the beginning of the measurement period who had at least one face-to-face (ENCOUNTER OUTPATIENT) visit during the measurement period and who were prescribed at least **four** qualifying medications (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist) at any time in the patient's history.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**ENCOUNTER OUTPATIENT**

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking or using at least **four** of the following: antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist at any time in the patient's history and DRUG\_EXCLUSION = N.

OR

Patients between 5 and 11 years of age at the beginning of the measurement period with an active diagnosis of persistent asthma who had at least one face-to-face (ENCOUNTER OUTPATIENT) visit during the measurement period and who were prescribed a qualifying medication (leukotriene inhibitors) at least **four** times at any time in the patient's history.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**ENCOUNTER OUTPATIENT**

AND

**ASTHMA**

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who are currently taking or were prescribed leukotriene inhibitors at least **four** times at any time in the patient's history and DRUG\_EXCLUSION = N.

### Denominator Inclusions – Population Stratification 2: *(Patients aged 12-50)*

Patients with an active diagnosis of persistent asthma during the measurement period and patient is between 12 and 50 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face (ENCOUNTER ED or ENCOUNTER ACUTE INPT) visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**ENCOUNTER ED**

OR

**ENCOUNTER ACUTE INPT**

AND

**ASTHMA**

OR

Patients between 12 and 50 years of age at the beginning of the measurement period with an active diagnosis of persistent asthma who had at least **four** face-to-face (ENCOUNTER OUTPATIENT) visits during the measurement period and were prescribed at least **two** qualifying medications (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist) at any time in the patient's history.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

AND

ASTHMA

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking or using at least **two** of the following: antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist at any time in the patient's history and DRUG\_EXCLUSION = N.

OR

Patients between 12 and 50 years of age at the beginning of the measurement period who had at least one face-to-face (ENCOUNTER OUTPATIENT) visit during the measurement period and who were prescribed at least **four** qualifying medications (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist) at any time in the patient's history.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking or using at least **four** of the following: antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist at any time in the patient's history and DRUG\_EXCLUSION = N.

OR

Patients between 12 and 50 years of age at the beginning of the measurement period with an active diagnosis of persistent asthma who had at least one face-to-face (ENCOUNTER OUTPATIENT) visit during the measurement period and were prescribed the qualifying medication (leukotriene inhibitors) at least **four** times at any time in the patient's history.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

AND

ASTHMA

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who are currently taking or were prescribed leukotriene inhibitors at least **four** times at any time in the patient's history and DRUG\_EXCLUSION = N.

### Denominator Inclusions – Population Stratification 3: (*Patients aged 5-50*)

Patients with an active diagnosis of persistent asthma during the measurement period and patient is between 5 and 50 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face (ENCOUNTER ED or ENCOUNTER ACUTE INPT) visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED

OR

ENCOUNTER ACUTE INPT

AND

ASTHMA

OR

Patients between 5 and 50 years of age at the beginning of the measurement period with an active diagnosis of persistent asthma who had at least four face-to-face (ENCOUNTER OUTPATIENT) visits during the measurement period and were prescribed at least **two** qualifying medications (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist) at any time in the patient's history.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER OUTPATIENT

AND

ASTHMA

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or currently taking or using at least **two** of the following: antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist at any time in the patient's history and DRUG\_EXCLUSION = N.

OR

Patients between 5 and 50 years of age at the beginning of the measurement period who had at least one face-to-face (ENCOUNTER OUTPATIENT) visit during the measurement period and who were prescribed at least **four** qualifying medications (antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist) at any time in the patient's history.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**ENCOUNTER OUTPATIENT**

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking or using at least **four** of the following: antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, long acting inhaled beta 2 agonist, mast cell stabilizer or short acting beta 2 agonist at any time in the patient's history and DRUG\_EXCLUSION = N.

OR

Patients between 5 and 50 years of age with an active diagnosis of persistent asthma who had at least one face-to-face (ENCOUNTER OUTPATIENT) visit during the measurement period and were prescribed the qualifying medication (leukotriene inhibitors) at least **four** times at any time in the patient's history.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**ENCOUNTER OUTPATIENT**

AND

**ASTHMA**

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who are currently taking or were prescribed leukotriene inhibitors at least **four** times at any time in the patient's history and DRUG\_EXCLUSION = N.

## Numerator: Patients who were appropriately prescribed asthma medication

### Numerator Inclusions:

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking or using antiasthmatic combinations, antibody inhibitor, inhaled corticosteroids, inhaled steroid combinations, leukotriene inhibitors or mast cell stabilizer during the measurement period and DRUG\_EXCLUSION = N.

**NOTE:** *Long acting inhaled beta 2 agonist and short acting beta 2 agonist do not meet numerator compliance.*

**Denominator Exclusions:** (*Exclusions only applied if patients were not appropriately prescribed asthma medication*)

Patient who had one of the following conditions during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

COPD

OR

CYSTIC FIBROSIS

OR

EMPHYSEMA

OR

ACUTE RESPIRATORY FAILURE

**Rationale:**

This measure assesses the appropriate and timely use of medications for long-term control of asthma symptoms and offers meaningful and actionable information to health care providers and consumers. Asthma is the most common chronic childhood disease, affecting an estimated 6.2 million children and resulting in more than 6.5 million office visits, 500,000 hospitalizations, 1.51 million nonemergency outpatient department visits and 1.81 million ER visits for children and adults. In 1998, over \$10 billion was spent on related medical expenditures in the United States. The financial and disease burden can be alleviated if patients have appropriate medications and medical management. This measure facilitates efforts toward effective disease management and prevention of traumatic outcomes.

**Clinical Recommendation Statements:**

The US DHHS National Asthma Education Program Expert Panel Report-2 recommends inhaled corticosteroids over other long-term control medications in improving asthma outcomes, with the acknowledgement of a potential but small risk of adverse events with use of inhaled corticosteroids. Bronchodilators (e.g., beta2-adrenergic agonists, methylxanthines) act to relieve the symptoms of the disease during acute events, but do not lead to long-term improvement. Studies cited by the Expert Panel Report 2002 Update demonstrate inhaled corticosteroids improve asthma control compared to as-needed beta2-agonists without any other long-term control medication. Therefore, disease management relies on the use of combination therapy including anti-inflammatory medications to ensure clinical improvement of patient care.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #312 (NQF 0052) HITECH: Low Back Pain: Use of Imaging Studies

**Description:** Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis

**Denominator:** Patients aged 18 through 50 years with a diagnosis of low back pain

#### Denominator Inclusions:

All patients with the *first* documented diagnosis of low back pain during the measurement period and patient is between 18 and 50 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ED

OR

ENCOUNTER OUTPATIENT

OR

ENCOUNTER OUTPATIENT INCLUDING ORTHOPEDICS AND CHIRPORACTICS

AND

LOW BACK PAIN

#### AND NOT

Patients who had one of the following conditions during the current measurement period or year prior to the measurement period.

PROBLEMS and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

CANCER

OR

TRAUMA

OR

IV DRUG ABUSE

OR

NEUROLOGIC IMPAIRMENT

#### OR

Patients who had a prior diagnosis of low back pain at any time in the patient's history.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LOW BACK PAIN

**Numerator:** Patients who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis

**Numerator Inclusions:**

Patients who did not have an imaging study (plain X-ray, MRI, CT scan) performed within 28 days of the first diagnosis during the measurement period.

**NOTE:** *This measure is intended to identify an overuse of imaging studies for patients with the first diagnosis of low back pain during the measurement period. The lack of IMAGING STUDY-SPINAL codes will indicate that the imaging study was not performed and will meet the quality action for this measure.*

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**IMAGING STUDY-SPINAL**

**Denominator Exclusions:**

None

## **Rationale:**

This measure assesses the percentage of patients in a specific age demographic who did not receive an imaging study (i.e., x-ray, MRI, CT scan) in the 28 days following a new episode of low back pain. Low back pain is the second most frequently listed reason for physician office visits. It is a common cause of lost productivity and absenteeism from work in the United States. The general consensus from literature reviews indicates that nearly half of American adults will experience low back pain in a year, and about two-thirds will suffer from it in their lifetime. Low back pain is particularly prevalent among men and women between 30 and 50 years of age, and most likely results from aging and an inactive lifestyle. Low back pain has a significant financial impact, costing an average of \$8,000 per claim (Atlas, Devo 2001). This measure facilitates efforts toward improved musculoskeletal condition and individual quality of life.

## **Clinical Recommendation Statements:**

Agency for Healthcare Policy and Research (AHCPR): Plain x-rays are not recommended for routine evaluation of patients with acute low back problems within the first month of symptoms unless a "red flag" [indicator of potentially serious spinal pathology or other nonspinal pathology] is noted on clinical examination. (Strength of evidence: B) Plain x-rays of the lumbar spine are recommended for ruling out fractures in patients with acute low back problems when any of the following red flags are present: recent significant trauma (any age), recent mild trauma (patient over age 50), history of prolonged steroid use, osteoporosis, patient over age 70. (Strength of evidence: C) Plain x-rays in combination with CBC and ESR may be useful for ruling out tumor or infection in patients with acute low back problems when any of the following red flags are present: prior cancer or recent infection, fever over 100 degrees F, IV drug abuse, prolonged steroid use, low back pain worse with rest, unexplained weight loss. (Strength of evidence: C). AHCPR recommendations reaffirmed by Jarvik and Deyo, 2002.

American Academy of Orthopaedic Surgeons/ North American Spine Society: When critical exclusionary diagnoses (eg, cauda equina syndrome, fracture, neoplasm, etc.) NOT suspected, plain lumbar spine x-rays recommended if non-specific lower back pain without radicular symptoms or lower back pain with radicular symptoms remains unresolved after 4-6 weeks of activity modification (e.g., medications, self-applied thermal modalities, etc.). (Evidence not rated)

American College of Radiology: Uncomplicated low back pain is a benign, self-limited condition that does not warrant any imaging studies. The vast majority of these patients are back to their usual activities in 30 days. The challenge for the clinician, therefore, is to distinguish that small segment within this large patient population that should be evaluated further because of suspicion of a more serious problem.

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ◆ Measure #313 (NQF 0575) HITECH: Diabetes Mellitus: Hemoglobin A1c Control (<8%)

**Description:** The percentage of patients 18 through 75 years of age with a diagnosis of diabetes (type 1 or type 2) who had HbA1c < 8%

**Denominator:** All patients 18 through 75 years of age with a diagnosis of diabetes (type 1 or type 2)

#### Denominator Inclusions:

All patients with an active diagnosis of diabetes during the measurement period and patient is between 18 and 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER ED  
OR  
ENCOUNTER NON-ACUTE INPATIENT  
OR  
ENCOUNTER OUTPATIENT

AND

DIABETES

OR

All patients between 18 and 75 years of age at the beginning of the measurement period who were prescribed or are currently taking a medication indicative of diabetes during the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face visit (ENCOUNTER ACUTE INPT or ENCOUNTER ED) with the eligible professional during the measurement period OR at least two face-to-face visits (ENCOUNTER NON-ACUTE INPATIENT or ENCOUNTER OUTPATIENT) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER ACUTE INPT  
OR  
ENCOUNTER ED  
OR  
ENCOUNTER NON-ACUTE INPATIENT  
OR  
ENCOUNTER OUTPATIENT

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients **who** were prescribed or are currently taking medications indicative of diabetes during the measurement period and DRUG\_EXCLUSION = N.

## Numerator: Patients with a most recent HbA1c test < 8%

### Numerator Inclusions:

Patients with a most recent HbA1c test less than 8% during the measurement period.

RESULTS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

HbA1c TEST  
WITH  
Documentation of HbA1c < 8%

### Denominator Exclusions: (*Exclusions only applied if the patient's most recent HbA1c test is not less than 8%*)

Patients with an active diagnosis of polycystic ovaries at any time during the patient's history who were prescribed medications indicative of diabetes during the measurement period and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

POLYCYSTIC OVARIES

### AND NOT

Diabetic patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

OR

Patients with an active diagnosis of gestational diabetes or steroid induced diabetes who were prescribed medications indicative of diabetes during the measurement period and who did not have an active diagnosis of diabetes during an eligible encounter during the measurement period

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

GESTATIONAL DIABETES

OR

STEROID INDUCED DIABETES

AND

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for medications indicative of diabetes.

### AND NOT

Diabetic patients who had at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

DIABETES

AND

ENCOUNTER ACUTE INPT

OR

ENCOUNTER ED

OR

ENCOUNTER NON-ACUTE INPATIENT

OR

ENCOUNTER OUTPATIENT

## Rationale:

This measure evaluates the percentage of patients in a specific age demographic who were diagnosed with type 1 or type 2 diabetes and who demonstrate adequate blood sugar control with an HbA1c level lower than 8 percent. Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including poor blood sugar control. Studies have shown that improved glycemic control is correlated with a 40% decline in the development of associated microvascular complications (i.e., eye, kidney and nerve diseases)( ADA 2009). Clinical guidelines recommend regular HbA1c testing to facilitate patients ability to improve and sustain acceptable levels (ADA 2009). This measure facilitates the maintenance and long-term management of adequate blood sugar levels for patients diagnosed with diabetes.

## Clinical Recommendation Statements:

American Geriatric Society:

[1]For frail older adults, persons with life expectancy of less than 5 years, and others in whom the risks of intensive glycemic control appear to outweigh the benefits, a less stringent target such as 8% is appropriate. (Level III, Grade B)

[2]For older persons, target hemoglobin A1C should be individualized. A reasonable goal for A1C in relatively healthy adults with good functional status is 7% or lower. (Level III, Grade B)

American Diabetes Association:

[1]Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. Therefore, for microvascular disease prevention, the A1C goal for nonpregnant adults in general is <7%. (A)

[2]In type 1 and type 2 diabetes, randomized controlled trials of intensive versus standard glycemic control have not shown a significant reduction in CVD outcomes during the randomized portion of the trials. Long-term follow-up of the Diabetes Control and Complications Trial (DCCT) and UK Prospective Diabetes Study (UKPDS) cohorts suggests that treatment to A1C targets below or around 7% in the years soon after the diagnosis of diabetes is associated with long-term reduction in risk of macrovascular disease. Until more evidence becomes available, the general goal of <7% appears reasonable for many adults for macrovascular risk reduction. (B)

[3]Subgroup analyses of clinical trials such as the DCCT and UKPDS and the microvascular evidence from the ADVANCE (Action in Diabetes and Vascular Disease: Preterax and Diamicon MR Controlled Evaluation) trial suggest a small but incremental benefit in microvascular outcomes with A1C values closer to normal. Therefore, for selected individual patients, providers might reasonably suggest even lower A1C goals than the general goal of <7%, if this can be achieved without significant hypoglycemia or other adverse effects of treatment. Such patients might include those with short duration of diabetes, long life expectancy, and no significant CVD. (B)

[4]Conversely, less stringent A1C goals than the general goal of <7% may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, and extensive comorbid conditions and those with longstanding diabetes in whom the general goal is difficult to attain despite diabetes self-management education, appropriate glucose monitoring, and effective doses of multiple glucose lowering agents including insulin. (C)

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ♣ Measure #316: Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed AND Risk-Stratified Fasting LDL

Measure #316a: Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed

*This is a two-part measure which is paired with Measure #316b: Preventive Care and Screening: Cholesterol – Risk-Stratified Fasting LDL. If the fasting LDL test is performed, #316b should also be reported.*

**Description:** Percentage of patients aged 20 through 79 years whose risk factors\* have been assessed and a fasting LDL test has been performed

\* Based on risk factors defined below

There are three criteria for this measure based on the patient's risk category.

1. Highest Level of Risk: Coronary Heart Disease (CHD) or CHD Risk Equivalent
2. Moderate Level of Risk: Multiple (2+) Risk Factors
3. Lowest Level of Risk: 0 or 1 Risk Factor

*This measure will be calculated for each of the criteria as well as a composite performance rate for all patients aged 20 through 79 years who were seen by the eligible professional during the measurement period.*

**Denominator 1:** All patients aged 20 through 79 years who have CHD or CHD Risk Equivalent

#### Denominator Inclusions 1 – Criteria #1 (*High Risk*):

All patients 20 through 79 years of age at the beginning of the measurement period who have CHD or CHD Risk Equivalent. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROCEDURES and PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

AND

CHD OR CHD RISK EQUIVALENT

## Numerator 1: Patients who had a fasting LDL test performed during the measurement period

### Numerator Inclusions 1 – (Fasting LDL test):

Patients who had a fasting LDL test performed during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE

OR

TOTAL CHOLESTEROL

AND

HIGH DENSITY LIPOPROTEIN (HDL)

AND

TRIGLYCERIDES

### Denominator Exclusions 1: *(Exclusions only applied if the fasting LDL test is not performed during the measurement period)*

Patients who had one of the following conditions active at any time during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY

OR

TERMINAL ILLNESS

OR

When a fasting LDL test is not performed during the measurement period for a valid patient reason, the appropriate test that should have been performed should be submitted along with a negation code to indicate the reason the appropriate test was not performed during the measurement period.

PROCEDURES, PROCEDURES (negation), RESULTS and RESULTS (negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE

OR

TOTAL CHOLESTEROL

OR

HIGH DENSITY LIPOPROTEIN (HDL)

OR

TRIGLYCERIDES

AND

PATIENT REQUEST

OR

PATIENT REFUSE

**Denominator 2: All patients aged 20 through 79 years who have Multiple Risk Factors (2+) of the following: Cigarette Smoking, Hypertension, Low High Density Lipoprotein (HDL), Family History of Premature CHD, or Age (men  $\geq$  55; women  $\geq$  65)**

**Denominator Inclusions 2 – Criteria #2 (*Moderate Risk*):**

All patients 20 through 79 years of age at the beginning of the measurement period with Multiple Risk Factors (greater than or equal to 2). To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**ENCOUNTER CODE**

**AND**

All patients with two or more of the applicable risk factors including smoking, hypertension (diagnosis, blood pressure greater than or equal to 140/90 mmHg, or antihypertension medications prescribed), HDL (less than 40 mg/dL)\*\*, family history of CHD (Male first degree relative less than 55 years old; Female first degree relative less than 65 years), and age (men greater than or equal to 45 years; women greater than or equal to 55 years) during the measurement period.

\*\*HDL-C greater than or equal to 60 mg/dL subtracts 1 risk from the above (it is a negative risk factor)

PROBLEMS, SOCIAL HISTORY, FAMILY HISTORY, VITAL SIGNS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**SMKG**

OR

**HYPERTENSION**

OR

**SYSTOLIC BLOOD PRESSURE**

WITH

**Documentation of Systolic Blood Pressure  $\geq$  140mm[Hg]**

OR

**DIASTOLIC BLOOD PRESSURE**

WITH

**Documentation of Diastolic Blood Pressure  $\geq$  90mm[Hg]**

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking antihypertensive medications during the measurement period and DRUG\_EXCLUSION = N.

OR

**HIGH DENSITY LIPOPROTEIN (HDL)**

WITH

**Documentation of HDL  $<$ 40 mg/dL**

OR

**FAMILY HISTORY CHD**

## Numerator 2: Patients who had a fasting LDL test performed during the measurement period

### Numerator Inclusions 2:

Patients who had a fasting LDL test performed during the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE

OR

TOTAL CHOLESTEROL  
AND  
HIGH DENSITY LIPOPROTEIN (HDL)  
AND  
TRIGLYCERIDES

### Denominator Exclusions 2: *(Exclusions only applied if the fasting LDL test is not performed during the measurement period)*

Patients who had one of the following conditions active at any time during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY  
OR  
TERMINAL ILLNESS

### OR

When a fasting LDL test is not performed during the measurement period for a valid patient reason, the appropriate test that should have been performed should be submitted along with a negation code to indicate the reason the appropriate test was not performed during the measurement period.

PROCEDURES, PROCEDURES (negation), RESULTS and RESULTS (negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE

OR

TOTAL CHOLESTEROL  
OR  
HIGH DENSITY LIPOPROTEIN (HDL)  
OR  
TRIGLYCERIDES

AND

PATIENT REQUEST  
OR  
PATIENT REFUSE

### Denominator 3: All patients aged 20 through 79 years who have 0 or 1 risk factors

#### Denominator Inclusions 3 – Criteria #3 (*Low Risk*):

All patients 20 through 79 years of age at the beginning of the measurement period with 0 or exactly 1 risk factor. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**ENCOUNTER CODE**

#### AND

All patients with zero or exactly one of the applicable risk factors including smoking, hypertension (diagnosis, blood pressure greater than or equal to 140/90 mmHg, or antihypertension medications prescribed), HDL (less than 40 mg/dL)\*\*, family history of CHD (Male first degree relative less than 55 years old; Female first degree relative less than 65 years), and age (men greater than or equal to 45 years; women greater than or equal to 55 years) during the measurement period.

\*\*HDL-C greater than or equal to 60 mg/dL subtracts 1 risk from the above (it is a negative risk factor)

PROBLEMS, SOCIAL HISTORY, FAMILY HISTORY, VITAL SIGNS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**SMKG**

OR

**HYPERTENSION**

OR

**SYSTOLIC BLOOD PRESSURE**

WITH

**Documentation of Systolic Blood Pressure  $\geq$  140mm[Hg]**

OR

**DIASTOLIC BLOOD PRESSURE**

WITH

**Documentation of Diastolic Blood Pressure  $\geq$  90mm[Hg]**

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking antihypertensive medications during the measurement period and DRUG\_EXCLUSION = N.

OR

**HIGH DENSITY LIPOPROTEIN (HDL)**

WITH

**Documentation of HDL  $<$ 40 mg/dL**

OR

**FAMILY HISTORY CHD**

### Numerator 3: Patients who had a fasting LDL test performed during the measurement period or four years prior to the measurement period

#### Numerator Inclusions 3:

Patients who had a fasting LDL test performed during the measurement period or four years prior to the measurement period.

PROCEDURES and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE

OR

TOTAL CHOLESTEROL  
AND  
HIGH DENSITY LIPOPROTEIN (HDL)  
AND  
TRIGLYCERIDES

#### Denominator Exclusions 3: *(Exclusions only applied if the fasting LDL test is not performed during the measurement period)*

Patients who had one of the following conditions active at any time during the measurement period.

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY  
OR  
TERMINAL ILLNESS

#### OR

When a fasting LDL test is not performed during the measurement period for a valid patient reason, the appropriate test that should have been performed should be submitted along with a negation code to indicate the reason the appropriate test was not performed during the measurement period.

PROCEDURES, PROCEDURES (negation), RESULTS and RESULTS (negation) tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE

OR

TOTAL CHOLESTEROL  
OR  
HIGH DENSITY LIPOPROTEIN (HDL)  
OR  
TRIGLYCERIDES

AND

PATIENT REQUEST  
OR  
PATIENT REFUSE

## Measure #316b: Preventive Care and Screening: Cholesterol – Risk-Stratified Fasting LDL

*This is a two-part measure which is paired with Measure #316a: Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed. If the fasting LDL results are documented, #316a should also be reported.*

**Description:** Percentage of patients aged 20 through 79 years who had a fasting LDL test performed and whose risk-stratified\* fasting LDL is at or below the recommended LDL goal

\* Based on risk factors defined below and on the calculation of the Framingham Risk Score

There are three criteria for this measure based on the patient's risk category.

1. Highest Level of Risk: Coronary Heart Disease (CHD) or CHD Risk Equivalent OR Multiple Risk Factors (2+) and 10-year Framingham risk >20%
2. Moderate Level of Risk: Multiple (2+) Risk Factors and 10-year Framingham risk ≤20%
3. Lowest Level of Risk: 0 or 1 Risk Factor

*This measure will be calculated for each of the criteria as well as a composite performance rate for all patients aged 20 through 79 years who were seen by the eligible professional during the measurement period.*

**Denominator 1:** All patients aged 20 through 79 years who had a fasting LDL test performed and have CHD or CHD Risk Equivalent OR Multiple Risk Factors (2+) and 10-year Framingham risk >20%

### Denominator Inclusions 1 – Criteria #1 (High Risk):

All patients 20 through 79 years of age at the beginning of the measurement period who had a fasting LDL test performed and have either CHD (or CHD Risk Equivalent) OR Multiple Risk Factors (2+) and 10-year Framingham risk greater than 20%. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

AND

LDL CODE

OR

TOTAL CHOLESTEROL

AND

HIGH DENSITY LIPOPROTEIN (HDL)

AND

TRIGLYCERIDES

AND

PROBLEMS and PROCEDURES tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

CHD OR CHD RISK EQUIVALENT

OR

All patients with two or more of the applicable risk factors including smoking, hypertension (diagnosis, blood pressure greater than or equal to 140/90 mmHg, or antihypertension medications prescribed), HDL (less than 40 mg/dL)\*\*, family history of CHD (Male first degree relative less than 55 years old; Female first degree relative greater than 65 years), and age (men greater than or equal to 45 years: women greater than or equal to 55 years) during the measurement period.

\*\*HDL-C greater than or equal to 60 mg/dL subtracts 1 risk from the above (it is a negative risk factor)

PROBLEMS, SOCIAL HISTORY, FAMILY HISTORY, VITAL SIGNS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SMKG

OR

HYPERTENSION

OR

SYSTOLIC BLOOD PRESSURE

WITH

*Documentation of Systolic Blood Pressure  $\geq$  140mm[Hg]*

OR

DIASTOLIC BLOOD PRESSURE

WITH

*Documentation of Diastolic Blood Pressure  $\geq$  90mm[Hg]*

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking antihypertensive medications during the measurement period and DRUG\_EXCLUSION = N.

OR

HIGH DENSITY LIPOPROTEIN (HDL)

WITH

*Documentation of HDL <40 mg/dL*

OR

FAMILY HISTORY CHD

AND

Patients with a 10-year Framingham Risk Score greater than 20%. The Framingham Risk Score will be calculated based on the following patient data received (along with age and gender) and will follow the Adult Treatment Panel (ATP) III Guidelines.

RESULTS, VITAL SIGNS, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**TOTAL CHOLESTEROL**

WITH

*Documentation of Total Cholesterol in mg/dL*

AND

**SMKG STATUS**

AND

**HIGH DENSITY LIPOPROTEIN (HDL)**

WITH

*Documentation of HDL in mg/dL*

AND

**SYSTOLIC BLOOD PRESSURE**

WITH

*Documentation of Systolic BP in mm[Hg]*

## Numerator 1: Patients whose most recent fasting LDL test is <100 mg/dL

### Numerator Inclusions 1:

Patients whose most recent fasting LDL test is less than 100 mg/dL during the measurement period.

**NOTE:** *LDL results are acceptable if directly reported (LDL CODE) from the laboratory, or if the other elements (TRIGLYCERIDES, TOTAL CHOLESTEROL, and HIGH DENSITY LIPOPROTEIN (HDL)) listed below are submitted and triglyceride value is less than or equal to 400 mg/dL. Directly reported values or calculated LDL values must be less than 100 mg/dL for Numerator Inclusion purposes.*

$$\text{LDL value} = [\text{TOTAL CHOLESTEROL value} - \text{HIGH DENSITY LIPOPROTEIN (HDL) value} - (\text{TRIGLYCERIDE value}/5)]$$

RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

**LDL CODE**

WITH

*Documentation of LDL <100 mg/dL*

OR

**TOTAL CHOLESTEROL**

WITH

*Documentation of Total Cholesterol in mg/dL*

AND

**HIGH DENSITY LIPOPROTEIN (HDL)**

WITH

*Documentation of HDL in mg/dL*

AND

TRIGLYCERIDES

WITH

Documentation of Triglycerides  $\leq$  400 mg/dL

**Denominator Exclusions 1:** *(Exclusions only applied if the fasting LDL test is not performed during the measurement period)*

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY

OR

TERMINAL ILLNESS

**Denominator 2:** All patients aged 20 through 79 years who had a fasting LDL test performed and have Multiple Risk Factors (2+) and 10-year Framingham risk  $\leq$ 20%

**Denominator Inclusions 2 – Criteria #2 (Moderate Risk):**

All patients 20 through 79 years of age at the beginning of the measurement period who had a fasting LDL test performed and Multiple Risk Factors (2+) and 10-year Framingham risk less than or equal to 20%. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

AND

LDL CODE

OR

TOTAL CHOLESTEROL

AND

HIGH DENSITY LIPOPROTEIN (HDL)

AND

TRIGLYCERIDES

**AND**

All patients with two or more of the applicable risk factors including smoking, hypertension (diagnosis, blood pressure greater than or equal to 140/90 mmHg, or antihypertension medications prescribed), HDL (less than 40 mg/dL)\*\*, family history of CHD (Male first degree relative less than 55 years old; Female first degree relative less than 65 years), and age (men greater than or equal to 45 years; women greater than or equal to 55 years) during the measurement period.

\*\*HDL-C greater than or equal to 60 mg/dL subtracts 1 risk from the above (it is a negative risk factor)

PROBLEMS, SOCIAL HISTORY, FAMILY HISTORY, VITAL SIGNS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SMKG

OR

HYPERTENSION

OR

SYSTOLIC BLOOD PRESSURE

WITH

*Documentation of Systolic Blood Pressure  $\geq$  140mm[Hg]*

OR

DIASTOLIC BLOOD PRESSURE

WITH

*Documentation of Diastolic Blood Pressure  $\geq$  90mm[Hg]*

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking antihypertensive medications during the measurement period and DRUG\_EXCLUSION = N.

OR

HIGH DENSITY LIPOPROTEIN (HDL)

WITH

*Documentation of HDL  $<$ 40 mg/dL*

OR

FAMILY HISTORY CHD

**AND**

Patients with a 10-year Framingham Risk Score  $\leq$ 20%. The Framingham Risk Score will be calculated based on the following patient data received (along with age and gender) and will follow the Adult Treatment Panel (ATP) III Guidelines.

RESULTS, VITAL SIGNS, and SOCIAL HISTORY tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

TOTAL CHOLESTEROL

WITH

*Documentation of Total Cholesterol in mg/dL*

AND

SMKG STATUS

AND

HIGH DENSITY LIPOPROTEIN (HDL)

WITH

*Documentation of HDL in mg/dL*

AND

SYSTOLIC BLOOD PRESSURE

WITH

*Documentation of Systolic BP in mm[Hg]*

## Numerator 2: Patients whose most recent fasting LDL test is <130 mg/dL

### Numerator Inclusions 2:

Patients whose most recent fasting LDL test is less than 130 mg/dL during the measurement period.

**NOTE:** LDL results are acceptable if directly reported (LDL CODE) from the laboratory, or if the other elements (TRIGLYCERIDES, TOTAL CHOLESTEROL, and HIGH DENSITY LIPOPROTEIN (HDL)) listed below are submitted and triglyceride value is less than or equal to 400 mg/dL. Directly reported values or calculated LDL values must be less than 100 mg/dL for Numerator Inclusion purposes.

$$\text{LDL value} = [\text{TOTAL CHOLESTEROL value} - \text{HIGH DENSITY LIPOPROTEIN (HDL) value} - (\text{TRIGLYCERIDE value}/5)]$$

RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE

WITH

Documentation of LDL <130 mg/dL

OR

TOTAL CHOLESTEROL

WITH

Documentation of Total Cholesterol in mg/dL

AND

HIGH DENSITY LIPOPROTEIN (HDL)

WITH

Documentation of HDL in mg/dL

AND

TRIGLYCERIDES

WITH

Documentation of Triglycerides ≤ 400 mg/dL

### Denominator Exclusions 2: (Exclusions only applied if the fasting LDL test is not performed during the measurement period)

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY

OR

TERMINAL ILLNESS

### Denominator 3: All patients aged 20 through 79 years who have 0 or 1 risk factors

#### Denominator Inclusions 3 – Criteria #3 (*Low Risk*):

All patients 20 through 79 years of age at the beginning of the measurement period with 0 or exactly 1 risk factor. To be eligible for performance calculations, patients must have at least one face-to-face visit with the eligible professional during the measurement period.

ENCOUNTERS, PROCEDURES, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

AND

LDL CODE

OR

TOTAL CHOLESTEROL

AND

HIGH DENSITY LIPOPROTEIN (HDL)

AND

TRIGLYCERIDES

AND

All patients with zero or exactly one of the applicable risk factors including smoking, hypertension (diagnosis, blood pressure greater than or equal to 140/90 mmHg, or antihypertension medications prescribed), HDL (less than 40 mg/dL)\*\*, family history of CHD (Male first degree relative less than 55 years old; Female first degree relative less than 65 years), and age (men greater than or equal to 45 years: women greater than or equal to 55 years) during the measurement period.

\*\*HDL-C greater than or equal to 60 mg/dL subtracts 1 risk from the above (it is a negative risk factor)

PROBLEMS, SOCIAL HISTORY, FAMILY HISTORY, VITAL SIGNS, and RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SMKG

OR

HYPERTENSION

OR

SYSTOLIC BLOOD PRESSURE

WITH

*Documentation of Systolic Blood Pressure  $\geq$  140mm[Hg]*

OR

DIASTOLIC BLOOD PRESSURE

WITH

*Documentation of Diastolic Blood Pressure  $\geq$  90mm[Hg]*

OR

MEDICATIONS tab in the Downloadable Resource table lists applicable codes for patients who were prescribed or are currently taking antihypertensive medications during the measurement period and DRUG\_EXCLUSION = N.

OR

HIGH DENSITY LIPOPROTEIN (HDL)

WITH

*Documentation of HDL <40 mg/dL*

OR

FAMILY HISTORY CHD

### Numerator 3: Patients whose most recent fasting LDL test is <160 mg/dL

#### Numerator Inclusions 3:

Patients whose most recent fasting LDL test is less than 160 mg/dL during the measurement period or four years prior to the measurement period.

**NOTE:** LDL results are acceptable if directly reported (LDL CODE) from the laboratory, or if the other elements (TRIGLYCERIDES, TOTAL CHOLESTEROL, and HIGH DENSITY LIPOPROTEIN (HDL)) listed below are submitted and triglyceride value is less than or equal to 400 mg/dL. Directly reported values or calculated LDL values must be less than 100 mg/dL for Numerator Inclusion purposes.

$$\text{LDL value} = [\text{TOTAL CHOLESTEROL value} - \text{HIGH DENSITY LIPOPROTEIN (HDL) value} - (\text{TRIGLYCERIDE value}/5)]$$

RESULTS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

LDL CODE

WITH

Documentation of LDL <160 mg/dL

OR

TOTAL CHOLESTEROL

WITH

Documentation of Total Cholesterol in mg/dL

AND

HIGH DENSITY LIPOPROTEIN (HDL)

WITH

Documentation of HDL in mg/dL

AND

TRIGLYCERIDES

WITH

Documentation of Triglycerides ≤ 400 mg/dL

#### Denominator Exclusions 3: (Exclusions only applied if the fasting LDL test is not performed during the measurement period)

PROBLEMS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

PREGNANCY

OR

TERMINAL ILLNESS

## Rationale:

The Agency for Healthcare Research and Quality (AHRQ) conducts systematic evidence reviews prior to recommendations issued by the U.S. Preventive Services Task Force (USPSTF). In the systematic evidence review, *Screening for Lipid Disorders*, (Pignone MP, Phillips CJ, Lannon CM, et al. Screening for Lipid Disorders, Systematic Evidence Review No.4 (Prepared by the Research Triangle Institute. University of North Carolina Evidence-based Practice Center, under contract No. 290-98-0011. AHRQ Publication No. AHRQ 01-S004. Rockville, MD: Agency for Healthcare Research and Quality. April 2001.), "Coronary Heart Disease (CHD) was identified as the leading cause of morbidity and mortality in the United States, causing nearly 500,000 deaths each year and requiring nearly 12 million hospital days of care per year. It is the leading cause of disabled life-years and is second only to injuries as a cause of life-years lost. The age-adjusted annual death rate for CHD is 100 per 100,000 persons overall and 140 per 100,000 persons among African Americans. The lifetime risk of having a CHD event, calculated at age 40, is estimated to be 49% for men and 32% for women in the United States. CHD accounted for \$78 billion in health care costs in 1995."

The risk of CHD is independently related to several potentially modifiable risk factors besides abnormal lipids, including smoking, diabetes, hypertension, and physical inactivity. Recent epidemiologic studies and basic science research expanded knowledge about several new potential CHD risk factors. Use of a Framingham risk-based algorithm that directly incorporates age, the presence and magnitude of other risk factors, and measures of total cholesterol and HDL is the most accurate approach. "Screening for lipid disorders by measuring cholesterol levels in adult patients is quite feasible for physicians because it involves ordering only a blood test. Providers appear to have achieved high levels of lipid screening based on population-based patient survey data." (AHRQ, 2001) This systematic review recommends using a supplemental table to improve the feasibility of a risk-based strategy.

The primary recommendation of several advisory bodies state adults should undergo an office-based assessment as the first step to identify patients at a higher CHD risk. The National Cholesterol Education Program Panel III (NCEP-III) has adopted using an adaptation of the risk prediction algorithm originating from the Framingham Heart Study estimating a patient's 10-year risk for developing CHD and has recommended its' use as the primary goal of preventive treatment. Stratifying CHD risk includes determining if CHD is present as well as CHD risk equivalents and major CHD risk factors. A history of CHD includes myocardial infarction, myocardial ischemia, angina (stable, unstable), percutaneous transluminal coronary angioplasty & coronary artery bypass surgery. CHD risk equivalents include peripheral artery disease, abdominal aortic aneurysm, thrombotic stroke, transient ischemic attacks, diabetes & Framingham 10-yr CHD risk > 20%. Major CHD risk factors include age, yr (men  $\geq$  45; women  $\geq$  55), cigarette smoking, hypertension (BP  $\geq$ 140/90 mm Hg) or anti hypertensive medication, Low HDL-C (<40 mg/dL) & negative risk factor: high HDL-C (>60 mg/dL). The Framingham risk categories include gender, age, systolic blood pressure, smoking status, total cholesterol, and HDL-C levels.

A potential limitation of the NCEP-III guidelines is the underestimation of risk in young individuals and women, as highlighted in previous reports. While the NCEP Panel III guidelines are generally valuable in predicting CVD, etc., they may under-predict the risk for relatively young persons (men under age 55 and women under age 65) and women in general. This is further supported by Akosah et al. (2003) that "75% of 222 asymptomatic young adults presenting with their first and unheralded myocardial infarction would not have been considered candidates for statin therapy in the days preceding the event, and the finding by Hecht et al. (2001) "that only 59% of 304 asymptomatic women submitted to EBT screening were correctly identified by NCEP guidelines as either high or low risk."

In multiple clinical trials, greater LDL-C reduction in both primary and secondary prevention populations can achieve greater reductions in relative risk of CHD. The Adult Treatment Panel (ATP)-II and ATP-III goals were adjusted downward to the current recommendations. (Grundy, 2008)

## Clinical Recommendation Statements:

Routine cholesterol testing should begin in young adulthood ( $\geq 20$  years of age). When LDL cholesterol concentrations range from 100–129 mg/dL, young adults should be encouraged to modify life habits to minimize long-term risk. In those with borderline high LDL cholesterol (130–159 mg/dL), clinical attention through therapeutic lifestyle changes is needed both to lower LDL cholesterol and to minimize other risk factors. If LDL cholesterol is high (160–189 mg/dL), more intensive clinical intervention should be initiated, with emphasis on therapeutic lifestyle changes.

However, if LDL cholesterol remains elevated despite therapeutic lifestyle changes, particularly when LDL cholesterol is  $\geq 190$  mg/dL, consideration should be given to long-term management with LDL-lowering drugs.

ATP III recognizes that detection of cholesterol disorders and other coronary heart disease (CHD) risk factors occurs primarily through clinical case finding. Risk factors can be detected and evaluated as part of a person's work-up for any medical problem. Alternatively, public screening programs can identify risk factors, provided that affected individuals are appropriately referred for physician attention. The identification of cholesterol disorders in the setting of a medical examination has the advantage that other cardiovascular risk factors—including prior CHD, PVD, stroke, age, gender, family history, cigarette smoking, high blood pressure, diabetes mellitus, obesity, physical inactivity—co-morbidities, and other factors can be assessed and considered prior to treatment.

*National Cholesterol Education Program*

*National Heart, Lung, and Blood Institute*

*National Institutes of Health*

*NIH Publication No. 02-5215*

*September 2002*

The U.S. Preventive Services Task Force (USPSTF), 2008 strongly recommends screening men aged 35 and older for lipid disorders.

The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.

The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.

The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.

The USPSTF makes no recommendation for or against routine screening for lipid disorders in men aged 20 to 35, or in women aged 20 and older who are not at increased risk for coronary heart disease.

The National Strategy for Quality Improvement in Health Care for 2011 has identified the promotion of the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease as one of its' national priorities. These priorities are based on the most recent research as well as stakeholder input. Opportunities for success include increase blood pressure control in adults, reduced high cholesterol levels in adults, and decrease smoking among adults and adolescents. Illustrative measures include:

- Percentage of patients ages 18 years and older with ischemic vascular disease whose most recent blood pressure during the measurement year is  $< 140/90$  mm Hg
- Percentage of patients with ischemic vascular disease whose most recent low-density cholesterol is  $< 100$
- Percentage of patients who received evidence-based smoking cessation services (e.g., medications)

The U.S. Department of Health and Human Service's Healthy People 2020 has set a target of 82.1% for HDS-6 : Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years (a 10% improvement over the next decade).

# 2013 EHR Measure Specifications

## ANALYTIC NARRATIVES

### ♣ Measure #317: Preventive Care and Screening: Screening for High Blood Pressure

**Description:** Percentage of patients aged 18 years and older who are screened for high blood pressure

**Denominator:** All patients aged 18 and older without known hypertension

#### Denominator Inclusions:

All patients aged 18 and older at the beginning of the measurement period without a known diagnosis of hypertension. To be eligible for performance calculations, patients must have at least two face-to-face visits (ENCOUNTER OUTPATIENT or ENCOUNTER NURSING FACILITY) with the same eligible professional, one visit may be during the year prior to the measurement period, but at least one visit must be during the measurement period.

ENCOUNTERS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

ENCOUNTER CODE

#### AND NOT

Patients who were diagnosed with hypertension at any time in the patient's history or whose 2 most recent systolic blood pressure greater than or equal to 140 mm Hg or diastolic blood pressure greater than 90 mm Hg.

*NOTE: Due to variability in individual blood pressure measurements, it is recommended that hypertension be diagnosed before or during a qualifying visit only after 2 or more elevated readings are obtained on at least 2 visits (at least one day apart) over a period of one day to four weeks apart.*

PROBLEMS and VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes in this measure and are associated with the following data element(s):

HYPERTENSION

#### OR

SYSTOLIC BLOOD PRESSURE

WITH

*Documentation of Systolic BP  $\geq$  140 mm[Hg]*

OR

DIASTOLIC BLOOD PRESSURE

WITH

*Documentation of Diastolic BP  $>$  90 mm[Hg]*

**Numerator: Patients who were screened for high blood pressure according to defined recommended screening intervals**

**Numerator Inclusions:**

Patients who were screened for high blood pressure

Recommended screening intervals:

- Screening every 2 years for patient with blood pressure less than 120/80 mm Hg
- Screening every year with systolic blood pressure of 120-139 mm Hg or diastolic blood pressure of 80-90 mm Hg
- Patients with one elevated reading of systolic blood pressure greater than or equal to 140 mm Hg or diastolic blood pressure greater than 90 mm Hg should be screened every year

*NOTE: Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.*

VITAL SIGNS tab(s) in the Downloadable Resource table list applicable codes for this measure and are associated with the following data element(s):

SYSTOLIC BLOOD PRESSURE  
WITH  
Documentation of Systolic BP

AND

DIASTOLIC BLOOD PRESSURE  
WITH  
Documentation of Diastolic BP

**Denominator Exclusions:**

None

**Rationale:**

This measure assesses the percentage of patients aged 18 and older without known hypertension who were screened for high blood pressure. Hypertension is a prevalent condition that contributes to important adverse health outcomes, including premature death, heart attack, renal insufficiency and stroke. The United States Preventive Services Task Force (USPSTF) found good evidence that blood pressure measurement can identify adults at increased risk for cardiovascular disease from high blood pressure. The relationship between systolic blood pressure and diastolic blood pressure and cardiovascular risk is continuous and graded. The actual level of blood pressure elevation should not be the sole factor in determining treatment. Clinicians should consider the patient's overall cardiovascular risk profile, including smoking, diabetes, abnormal blood lipid values, age, sex, sedentary lifestyle, and obesity, when making treatment decisions. The seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) recommends screening every 2 years in person with blood pressure less than 120/80 mm Hg and every year in persons with systolic blood pressure of 120 to 139 mm Hg or diastolic blood pressure of 80 to 90 mm Hg.

**Clinical Recommendation Statements:**

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

Reference: U.S. Preventive Services Task Force. Screening for high blood pressure: U.S. Preventive Services Task Force reaffirmation recommendation statement. *Ann Intern Med* 2007 Dec 4;147(11):783-6. [6 references]

# 2013 EHR Measure Specifications

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